

BLIND AND VISUAL IMPAIRMENT REHABILITATION CONTINUUM OF CARE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive outlines the provision of comprehensive interdisciplinary blind rehabilitation services for eligible Veterans and Service members as they transition from the Visual Impairment Services Team (VIST) to the Blind Rehabilitation Centers (BRC) or the Blind Rehabilitation Outpatient Clinics in the Blind Rehabilitation Services (BRS) Continuum of Care.

2. SUMMARY OF MAJOR CHANGES:

Amendment dated February 23, 2023:

a. Updates responsibilities for the National Director of Blind Rehabilitation Service in paragraph 5.e.(12)., Blind Rehabilitation Center Service Chief in paragraph 5.k.(2). and 5.k.(6)., Blind Rehabilitation Specialists and Blind Rehabilitation Outpatient Specialists in paragraph 5.m.(7)., Visual Impairment Services Team Coordinator in paragraph 5.n.(17).(b). and 5.n.(18)., and Outpatient Low Vision Clinic Supervisor and the Visual Impairment Services Outpatient Rehabilitation Chief in paragraph 5.o.

b. Corrects typo in table found in Appendix J, Blind Rehabilitation Service Continuum of Care Regional Distribution.

c. Adds an informational paragraph about Rehabilitation Program Accreditation to Appendix K, Blind Rehabilitation Service Resource Requirements (see paragraph 6).

This directive dated April 19, 2021 includes the following updates:

a. Providing new procedures for calculating appointment and wait times for admissions and honoring Veterans' choices for BRC sites and admission dates. These changes are found in Appendix C and paragraph 9.

b. Tracking Veteran referrals to BRCs and the Veteran's preference for admission dates (see Appendix B and paragraphs 8 and 9).

c. Adding a category for Veteran with visual impairment to be added to VIST rosters due to excess disability (see Appendix I).

d. Providing Telehealth service procedures within BRS Continuum of Care to increase access to care. These changes are found in Appendix G.

e. Updating the algorithm for Veterans with visual impairment. These changes are found in Appendix A.

f. Clarifying the roles of Blind Rehabilitation Specialists and the administrative responsibilities for program oversight. These changes are found in paragraph 5.

g. Redefining the responsibilities, scope and operational procedures of the Blind Rehabilitation Services (BRS) National Program Consultants (NPC) and the supporting guidance, direction and provisions of VHA officials. These changes are found in paragraph 5.

3. RELATED ISSUES: VHA Directive 1034, Prescribing and Providing Eyeglasses, Contact Lenses and Hearing Aids, dated October 24, 2019; VHA Directive 1121, VHA Eye and Vision Care, dated October 2, 2019; VHA Handbook 1006.02 VHA Site Classifications and Definitions, dated December 30, 2013.

4. RESPONSIBLE OFFICE: The Office of Patient Care Services, Deputy Chief Patient Care Services Officer for Rehabilitation and Prosthetic Services (12RPS) is responsible for the contents of this directive. Questions and follow up may be referred to Blind Rehabilitation Service at vha12rpsrehabandprostheticsaction@va.gov.

5. RESCISSIONS: VHA Handbook 1173.05, Aids For The Blind And Visually Impaired, dated October 27, 2008; VHA Handbook 1174.01, Blind Rehabilitation Outpatient Specialist Program Procedures, dated February 19, 2016; VHA Handbook 1174.02, Blind Rehabilitation Service National Program Consultant Procedures, dated September 6, 2015; VHA Handbook 1174.03, Visual Impairment Services Team Program Procedures, dated November 5, 2009; VHA Handbook 1174.04, Blind Rehabilitation Center Program Procedures, dated December 2, 2009; VHA Handbook 1174.05, Outpatient Blind And Vision Rehabilitation Clinic Procedures, dated July 1, 2011; VHA Directive 2009-049, Audible Prescription Reading Devices, dated October 6, 2009; and VHA Directive 2011-040, Referral To Inpatient Blind Rehabilitation Centers And Calculation Of The Waiting Time Prior To Admission, dated December 7, 2011, are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of April 2026. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF THE
UNDER SECRETARY FOR HEALTH:**

/s/ Beth Taylor, DHA
Assistant Under Secretary for Health
for Patient Care Services

April 19, 2021

VHA DIRECTIVE 1174(1)

NOTE: All references herein to Department of Veterans Affairs (VA) and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

DISTRIBUTION: Emailed to the VHA Publication Distribution List on April 21, 2021.

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BLIND AND VISUAL IMPAIRMENT REHABILITATION CONTINUUM OF CARE**1. PURPOSE**

The purpose of this Veterans Health Administration (VHA) directive is to set forth requirements for the provision of comprehensive interdisciplinary blind and visual impairment rehabilitation and coordination of care. **AUTHORITY:** 38 U.S.C. §§ 1706, 7301(b) and 38 C.F.R. §§ 17.38, 17.149, 17.154.

2. BACKGROUND

a. The Department of Veterans Affairs (VA) provides blind and vision rehabilitation programs to Veterans and active duty Service members with visual impairment. The mission of Blind Rehabilitation Service (BRS) is to assist eligible Veterans and Service members with a visual impairment in developing the skills needed for personal independence and successful reintegration into the community and family environment.

b. Rehabilitation in BRS is Veteran-centered and interdisciplinary, developing and deploying integrated plans of care that address the Veterans' needs and goals to guide service delivery. BRS programs provide a model of care that extends from the Veteran's community home environment to the local VHA care site, the regional Advanced and Intermediate low vision clinics, the VISOR outpatient programs and inpatient Blind Rehabilitation Center (BRC) training programs.

c. The BRS National Program Office provides support and oversight of blind and low visual impairment rehabilitation services for all Veterans and Service members with visual impairment served in VHA.

d. Across all Veteran Integrated Service Networks (VISNs), BRS partners provide rehabilitation care through:

(1) Visual Impairment Service Team (VIST) Coordinators.

(2) Blind Rehabilitation Outpatient Specialists (BROS).

(3) Inpatient Blind Rehabilitation Centers (BRCs).

(4) Intermediate Low Vision Clinics (ILVC).

(5) Advanced Low Vision Clinics (ALVC).

(6) Visual Impairment Services Outpatient Rehabilitation (VISOR) programs.

e. BRS programs provide a model of care that extends from the Veteran's community home environment to the local VHA care site, Intermediate and Advanced Low Vision Clinics, the Vision Impairment Services in Outpatient Rehabilitation (VISOR) programs and inpatient BRC training programs.

f. VHA is committed to maintaining the respect and dignity of Veterans and active duty Service members served in BRS. For this reason, BRS does not define the person by their disability; instead, referring first to the person who happens to possess a disability. In this case, BRS uses the term Veteran with visual impairment instead of blind Veteran. **NOTE:** *When referring to eligible Veterans and active duty Service members with visual impairment, this directive frequently uses the term “Veteran with visual impairment” for purpose of brevity. This shortening is not to detract from nor discourage active duty Service members from using BRS services, but rather is only meant to enhance the readability of this directive. Anywhere the term “Veteran with visual impairment” is used, it is implied that active duty Service members with visual impairment are eligible or included in that portion of the directive. Active duty Service members may receive VA medical care pursuant to the Memorandum of Agreement between the VA and the Department of Defense (DOD) for Medical Treatment Provided to Active Duty Service members (ADSM) with Spinal Cord Injury, Traumatic Brain Injury, Blindness or Polytraumatic Injuries (see <https://health.mil/Reference-Center/Policies/2009/08/04/MOA-Referrals-of-AD-Personnel-Who-Sustain-Spinal-Cord-Injury-TBI-or-Blindness>). This also does not detract nor discourage family and caregivers from using BRS services. Family and caregivers are integral parts of the Blind and Visual Impairment Rehabilitation Continuum of Care and are encouraged to participate throughout the care process.*

3. DEFINITIONS

a. **Activities of Daily Living/Instrumental Activities of Daily Living.** Activities of daily living/instrumental activities of daily living (ADL/IADL) is the therapeutic instructional area focused on fundamental skills that are required to independently care for oneself and those activities that allow an individual to live independently in a community. ADL/IADLs include, but are not limited to, self-care management, medication management, hygiene/grooming, dressing, cooking, eating, home management, cleaning, personal management, communication, managing finances.

b. **Administrative Consult.** An administrative consult is a consult documented in the electronic health record used as one-way communication on behalf of a patient to make a clinical request to transfer care or communicate an order or series of orders. Administrative consult orders include requests to schedule where clinical review is not required.

c. **Blind Rehabilitation Services Continuum of Care.** Continuum of Care (CoC) for Veterans with visual impairment refers to blind and visual impairment rehabilitation ranging across multiple levels of care, including: basic outpatient low vision care provided by licensed eye care providers; intermediate and advanced outpatient low-vision care involving a team of licensed eye care providers and blind rehabilitation professionals; outpatient blind rehabilitation services; inpatient blind rehabilitation services; and telehealth to or from Veterans’ nearest VA medical facility or home. Multiple episodes of care (including readmission to inpatient BRC irrespective of fiscal year) may be provided across BRS CoC as deemed necessary. **NOTE:** *Refer to Paragraph 6 Blind Rehabilitation Service Continuum of Care for description of Basic*

Low Vision Care, Intermediate Low Vision Clinic (ILVC), Advanced Low Vision Clinic (ALVC), Vision Impairment Services in Outpatient Rehabilitation (VISOR) Program, Blind Rehabilitation Center (BRC) and Blind Rehabilitation Outpatient Services.

d. **Clinical Video Telehealth.** Clinical Video Telehealth (CVT) is the utilization of real-time (i.e., synchronous) interactive video conferencing, sometimes with supportive peripheral technologies, to assess, treat and provide care to a beneficiary remotely.

e. **Computer Assistive Technology Training.** Computer Assistive Technology (CAT) training provides training in the use of specialized access technology devices necessary for a Veteran with visual impairment to independently operate computers, tablets, smartphones and other digital electronic devices to achieve their computing and communication goals.

f. **Device.** For the purpose of this directive, a device is an item of equipment or animal used in assisting a Veteran with a visual impairment in overcoming the functional deficits associated with vision loss, see 38 C.F.R. §§ 17.3200, 17.154.

g. **Electronic Health Record.** Electronic health record (EHR) is the digital collection of patient health information resulting from clinical patient care, medical testing and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including Computerized Patient Record System (CPRS), Veterans Information Systems and Technology Architecture (VistA) and Cerner platforms. **NOTE:** *The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software-specific terms while VA transitions platforms.*

h. **Episode of Care.** An episode of care (EoC) is a set of services required to manage a specific condition or conditions, over a defined period of time. An EoC can be provided face-to-face, over the telephone or using a telehealth. **NOTE:** *For further information, see paragraph 11.*

i. **Excess Disability.** Excess disability refers to problems and task performance difficulties related to vision loss that impact the Veteran's functional independence or personal safety and that are out of proportion to the degree of visual impairment as measured by visual acuities or visual fields. **NOTE:** *For further information, see paragraph 8.*

j. **Hoptel Program.** Hoptel is a temporary lodging located at a VA health care facility, other than a VA Fisher House as defined by 38 C.F.R. part 60. Such eligible patients may receive safe, comfortable lodging, but do not receive medical care from physicians or nurses during their stay.

k. **Licensed Eye Care Provider.** A licensed eye care provider is a professional who is licensed to provide eye examinations, treat visual problems and prescribe ophthalmic lenses (e.g., an optometrist or ophthalmologist).

l. **Living Skills.** Living Skills is the therapeutic instructional area focused on ADL and IADL areas of instruction.

m. **Legal blindness.** VHA defines legal blindness using the definition found in 42 U.S.C. § 416(i)(1)(B). Legal blindness is central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of this paragraph as having a central visual acuity of 20/200 or less.

n. **Low Vision.** For the purpose of this directive, low vision is defined as a condition in which there is significant loss of vision uncorrectable by conventional means (eyeglasses, contact lenses, medicines or surgery) that negatively impacts patient safety or impairs or restricts one or more activities of daily living (ADLs and/or Instrumental ADLs). Low vision can encompass loss of visual acuity or visual field loss or a combination of loss of visual acuity, visual field loss, contrast sensitivity loss, loss of stereopsis or eye motility impairment.

o. **Low Vision Clinical Examination.** A low vision clinical examination is an evaluation by a licensed eye care provider with training in low vision rehabilitation that should be conducted in accordance with nationally published eye care provider clinical practice guidelines that should include the assessment and determination of the Veteran's:

- (1) Ocular health status.
- (2) Level of visual impairment and current visual functioning.
- (3) Visual and functional needs as related to vision loss.
- (4) Ability to benefit from adaptive vision training/rehabilitation/prescription optics.
- (5) Best possible optical refractive correction(s).
- (6) Need for prescription optical low vision devices.

p. **Low Vision Therapy.** Low Vision Therapy is the therapeutic instructional area focused on low vision instruction, low vision training, vision rehabilitation therapy and vision rehabilitation training.

q. **Manual Skills Training.** Manual Skills training is the therapeutic instructional area focused on organization, tactual awareness, eye-hand coordination, spatial awareness, memory sequencing, problem solving and confidence building. Activities emphasize adaptive and safety techniques and range from basic and advanced tasks utilizing hand tools, ceramic equipment, power tools and woodworking machinery.

r. **Ocular Health Examination.** The ocular health examination must be conducted by a licensed eye care provider and should include:

(1) A refraction to establish best-corrected central visual acuities (not using preferred retinal loci).

(2) A thorough assessment of the visual system and ocular health to establish the diagnosis primarily responsible for the impairment.

(3) Prescription of any ophthalmic lenses, including optical low vision devices.

(4) Assurance that all ocular and visual disorders are being appropriately managed.

(5) If there is a significant visual field loss, a Goldmann Perimeter, Humphrey Field Analyzer or equivalent device, is used to determine the extent of the field loss.

s. **Optical Low Vision Devices.** Optical low vision devices are instruments that optically alter the image focus, size (magnification or minification), contrast, brightness, color or directionality of an object through use of lenses or other technology. These devices must be prescribed by a licensed eye care provider and include but are not limited to:

(1) Habitual prescription spectacles (with or without tint).

(2) Microscopic spectacles.

(3) Hand-held magnifiers.

(4) Stand magnifiers.

(5) Telescopes (monocular or binocular).

(6) Head borne lenses.

(7) Minifiers.

(8) Prisms.

(9) Closed circuit televisions (CCTVs).

(10) Electronic optical enhancement devices (EOEDs).

t. **Orientation and Mobility Training.** Orientation and Mobility (O&M) training is the therapeutic instructional area that addresses establishing and maintaining one's orientation to the environment as well as safe, efficient and confident travel.

u. **Other Temporary Lodging.** Other temporary lodging includes:

(1) Lodging at a temporary lodging facility, other than a VA Fisher House, located at a VA medical facility (generally referred to as a "Hoptel").

(2) A hotel or motel.

(3) Non-utilized beds at a VA medical care facility designated as lodging beds.

(4) Other donated lodging to be used on a temporary basis in accordance with 38 U.S.C. 1708.

v. **Rehabilitation Beds.** Inpatient rehabilitation beds are associated with care that enables Veterans to acquire the skills and capabilities necessary for the development of personal independence and emotional stability. Rehabilitation beds are defined by the treating specialty. Rehabilitation programs are dedicated to inpatient life skill development, such as: Spinal Cord Injury, Blind Rehabilitation, Polytrauma, Physical Rehabilitation and others. **NOTE:** For further information, see VHA Handbook 1006.02, VHA Site Classifications and Definitions, dated December 30, 2013.

w. **Statutory Blindness.** VHA defines statutory blindness according to criteria used by the Social Security Administration (SSA). Statutory blindness is evaluated by the following methodology. Most test charts that use Snellen methodology do not have lines that measure visual acuity between 20/100 and 20/200. Newer test charts, such as the Bailey-Lovie or the Early Treatment Diabetic Retinopathy Study (ETDRS), do have lines that measure visual acuity between 20/100 and 20/200. If a patient's visual acuity is measured with one of these newer charts and they cannot read any of the letters on the 20/100 line, it will be determined that they have statutory blindness based on a visual acuity of 20/200 or less. For example, if a patient's best-corrected visual acuity for distance in the better eye was determined to be 20/160 using an ETDRS chart, it will be determined that the patient has statutory blindness. Regardless of the type of test chart used, a patient does not have statutory blindness if they can read at least one letter on the 20/100 line. For example, if a patient's best corrected visual acuity for distance in the better eye was determined to be 20/125+1 using an ETDRS chart, it will be determined that the patient does not have statutory blindness as the patient is able to read one letter on the 20/100 line.

x. **Visual Impairment.** Visual impairment is a functional limitation of the eye(s) or visual system and can manifest as reduced visual acuity or contrast sensitivity, visual field loss, photophobia, diplopia, visual distortion, visual perceptual difficulties or any combination of the above. A visual impairment can cause disability(ies) by significantly interfering with one's ability to function independently, such as performing ADL/IADL, travelling safely and self-care management. Specific problems include, but are not limited to, loss of the ability to read standard-sized print, inability or limitation with respect to driving, difficulty performing work-related tasks, leisure activities and inability to recognize faces. **NOTE:** See paragraph 3 for definition of Legal Blindness, Low Vision and Statutory Blindness.

y. **Visual Impairment Center to Optimize Remaining Sight.** The VA Optometric Service Visual Impairment Center to Optimize Remaining Sight (VICTORS) program provides team-based low-vision rehabilitation services to Veterans with a visual impairment from a large service area covering numerous VA medical facilities, as in a VISN. **NOTE:** For further information, see VHA Directive 1121, VHA Eye and Vision Care, dated October 2, 2019.

z. **Visual Impairment Services Team Review.** The Visual Impairment Services Team (VIST) Review is a comprehensive evaluation of needs for all identified Veterans experiencing functional difficulty due to visual impairment. For a detailed description of the VIST review components, see paragraph 7, VIST Review.

aa. **Visual Impairment Services Team.** VIST members collaborate to facilitate and enhance the provision of rehabilitation services where deemed appropriate. VIST representatives include, but are not limited to: Social Work, Ophthalmology, Optometry, Prosthetics, Primary Care, Vocational Rehabilitation, Library Service, Nursing, Audiology, Podiatry, Dietetics, Psychology, Physical Medicine and Rehabilitation, Veterans Benefits Administration (VBA) and Veteran Service Organizations (VSO).

4. POLICY

It is VHA policy to provide comprehensive blind and visual impairment rehabilitation continuum of care services to eligible Veterans and active duty Service members with visual impairment.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring VHA's overall compliance with this directive.

b. **Assistant Under Secretary for Health for Patient Care Services.** The Assistant Under Secretary for Health for Patient Care Services is responsible for:

(1) Communicating the contents of this directive across the Health for Policy and Services program offices.

(2) Ensuring that the VHA BRS program has the sufficient resources to fulfill the terms of this directive.

(3) Providing oversight to the BRS National Program Office to assure compliance with this directive.

(4) Supporting the program office with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the VISNs.

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight to VISNs to ensure compliance with this directive and its effectiveness.

d. **Deputy to the Assistant Under Secretary for Patient Care Services.** The Deputy to the Assistant Under Secretary for Patient Care Services is responsible for ensuring that Veterans with visual impairment receive the full continuum of rehabilitative services that VHA provides.

e. **National Director, Blind Rehabilitation Service.** The National Director, BRS, is responsible for:

(1) Ensuring all BRS staff are knowledgeable of and comply with the requirements of this directive, through local orientation and training, as appropriate.

(2) Ensuring the strategic direction, employment of evidence-based practices and continuous quality improvement for VHA BRS programs support VA and VHA strategic goals and objectives.

(3) Partnering with the VA medical facility Director, VA medical facility Chief of Staff/VA medical facility Associate Director of Patient Care Services (ADPCS), performance improvement and quality management staff and other clinical partners within the CoC for quality improvement to review and monitor:

(a) Providing recommendations and action plans to improve quality of services at BRS sites.

(b) Data and outcomes including workload, productivity, access, Veteran experience and other key operational metrics collected by the BRS National Program Office.

(c) BRS local training and annual conferences.

(d) Education and workforce development.

(4) Consulting, communicating with and assisting VA medical facilities regarding all BRS programs throughout the CoC spectrum.

(5) Overseeing the data management, analysis and validation of the Blind Rehabilitation (BR) National Database, to ensure inclusion of all Veterans who require blind rehabilitation.

(6) Establishing and monitoring catchment areas in consultation with the BRC Service Chiefs, VISOR Chiefs, VIST Coordinators, National Program Consultants (NPCs) and affected regional leadership.

(7) Ensuring VA medical facilities have necessary support from the national BRS program office in recruitment efforts. This includes, but is not limited to, participating with direct supervisors in the selection of essential leadership positions within the Continuum of Care, (e.g., BRC Service Chief, VISOR Chief, National Program Consultant (NPC)).

(8) Renegotiating or establishing Continuum of Care Memoranda of Understanding (MOU) between VA BRS and VISNs with VA medical facility Directors and obtaining signatures of agreement for new documents, as needed.

(9) Supporting new NPCs and NPCs' supervisors with the development and deployment of a professional development plan.

(10) Partnering with VHA Rehabilitation and Prosthetics Service to provide support for mission critical events and meetings (e.g., site visits, attendance at the BRS national conference).

(11) Ensuring any proposed changes to authorized and operating beds reported by the Service Chief are reviewed and agreed on prior to processing the requested change.

(12) Designating specific Blind Rehabilitation Service programs required to successfully attain and maintain rehabilitation program accreditation. For additional information, see VHA Office of Quality and Patient Safety, Office of Quality Management, Office of External Accreditation Services and Programs at <https://vaww.qps.med.va.gov/divisions/gm/ea/carf.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

(13) Collaborating with the Office of External Accreditation and other VHA leaders for coordinated activity related to the management of the VHA Rehabilitation Program Accreditation Services contract (e.g., fundings needs/forecasting, expansion or termination of requirements, etc.).

f. **Veterans Integrated Service Network Director.** Each VISN Director is responsible for:

(1) Ensuring that support and resources provided for Veterans with visual impairment in the VISN are accessible, high quality and efficient and supportive of VA and VHA strategic priorities.

(2) Providing support for the VISN's blind and visual impairment rehabilitation CoC for Veterans with visual impairment such as access to care, consistency and coordination of services.

(3) Ensuring that the VA medical facility Directors support the BRS CoC.

(4) Ensuring that VA medical facilities housing outpatient blind and vision rehabilitation clinics adhere to the MOU between the VISN and VHA Office of Patient Care Services that established the placement, services and resources required for blind and visual impairment rehabilitation clinical programs within the VISN. If changes to the MOU are proposed, the changes must be negotiated with the office of VHA Blind Rehabilitation Service and documented in a revised MOU.

(5) Supporting all components and services in the blind and visual impairment rehabilitation Continuum of Care described in this directive.

g. **VA Medical Facility Director.** The VA Medical facility Director is responsible for:

(1) Ensuring high-quality, efficient provision of blind rehabilitation services through appropriate resources including personnel, budget, space, vehicles and training-related devices and supplies. For more information, see Appendix K.

(2) Ensuring organizational alignment that contributes to the efficient operation of BRS, reflects appropriate staffing to meet Veterans with blind and visual impairment rehabilitation care needs and promotes optimal program performance.

(3) Ensuring that budget requirements are modified when advances in technology and innovative programs create a demand.

(4) Notifying the National Director, BRS of any BRC Service Chief, VISOR Chief and NPC vacancies and requesting assistance in recruitment.

(5) Ensuring that VA medical facilities where outpatient rehabilitation care is provided are in alignment with the BRS and VISN MOU.

(6) Ensuring that the NPC functional statement and organizational chart are up to date and reflect organizational alignment under the VA medical facility Director, VA medical facility Chief of Staff/VA medical facility ADPCS or designee.

(7) In BRS outpatient clinics, ensuring that the functional statements and organizational chart are updated and reflects organizational alignment under the VA medical facility Director, VA medical facility Chief of Staff/VA medical facility ADPCS or appropriate alignment based on local needs.

(8) Assuring that the NPC has a private office, necessary office equipment and supplies to conduct VHA business.

(9) Ensuring partnership between Blind Rehabilitation Service (BRS) and Prosthetics and Sensory Aids Service (PSAS) staff to improve service delivery. **NOTE:** *This responsibility only applies to the VA medical facility Director if the VA medical facility does not have a BRS Service Chief or Supervisor.* This includes:

(a) Ensuring Blind Rehabilitation Specialists follow national clinical practice recommendations and PSAS guidance pertaining to evaluation and management, including recommending ordering and issuing devices. (See paragraph 12.b.(6).)

(b) Ensuring adequate supply of devices issued for therapeutic instruction. (See Appendix K.)

(c) Ensuring BRS providers evaluate various aids, devices, appliances and technologies to determine their clinical effectiveness for Veterans with visual impairment

and recommend inclusion and exclusion criteria for use. (See Appendix F.)

(10) Ensuring partnership between BRS and Logistics Management Services staff to improve access, record-keeping and logistical processes for stocking devices. **NOTE:** *This responsibility only applies to the VA medical facility Director if the VA medical facility does not have a BRS Service Chief or Supervisor.*

(11) Ensuring rehabilitation program accreditation and assuring applicable accreditation standards are being met. For additional information, see VHA Office of Quality and Patient Safety, Office of Quality Management, Office of External Accreditation Services and Programs at <https://vaww.qps.med.va.gov/divisions/gm/ea/carf.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

h. VA Medical Facility Chief of Staff or VA Medical Facility Associate Director of Patient Care Services. The VA medical facility Chief of Staff or VA medical facility ADPCS, depending on the VA medical facility, is responsible for:

(1) Ensuring the VIST Program is implemented at the VA medical facility by following the VIST roster staffing guidelines in Appendix I.

(2) Ensuring that VIST and Blind Rehabilitation Outpatient Specialists (BROS) office spaces are located in or adjacent to, the VA medical facility eye care clinics or clinical area where blind and visual impairment services are provided to maximize efficient referral management and promote access to care. The office(s) must be large enough to accommodate the Veteran, a guide dog, wheelchair and other accompanying individuals (e.g., family member, aide).

(3) Ensuring the VA medical facility has a process in place to promptly notify the VIST Coordinator of a VA medical facility inpatient admission of a Veteran with visual impairment, new diagnoses of legal blindness or low vision for a Veteran not already on the VIST roster.

(4) Ensuring BRS providers have immediate access to government vehicles for therapeutic and clinical services for Veterans with visual impairment, as necessary.

i. National Program Consultant Supervisor. The National Program Consultant (NPC) Supervisor reports to the VA medical facility Director, VA medical facility Chief of Staff/VA medical facility ADPCS or designee. The supervision is primarily administrative, collaborative and consultative in nature. Primary responsibility for assignments is the responsibility of the National Director, BRS (see paragraph 5). The NPC's Supervisor is responsible for evaluating the performance of the NPC by collaborating with the National Director, BRS.

j. National Program Consultants. NPCs provide oversight to support efficient and cohesive delivery of BRS care, develop and maintain efficient lines of communication among the various VHA blind and visual impairment rehabilitation programs, serve as a conduit between BRS field operations and the BRS National Program Office and fulfill

prescribed BRS program objectives as stated below. NPC allotment of time for duties assigned to the national BRS program office is 75% with 25% dedicated to the VA medical facility. **NOTE:** *Due to NPC's allotment of time, the maximum supervisory load of NPCs is recommended to be no more than one full-time equivalent (FTE).* BRS NPCs may be assigned to special projects at the discretion of the National Director, BRS, which may not necessarily be confined to the NPCs' respective catchment areas. NPCs are responsible for supporting the BRS National Program Office by:

(1) Assisting the BRS National Program Office with development of new program goals and objectives. This includes development and provision of recommendations for needed revisions and additions to national BRS policy and program management strategy based on present and future projected needs.

(2) Planning, facilitating and developing national, regional and local training initiatives for BRS educational programs. For national training, NPCs must partner with VHA's Employee Education System and the BRS National Program Office to plan and execute the continuing education courses and the annual national BRS conference. See paragraph 13 for additional training information.

(3) Providing oversight of BRS programmatic compliance with rehabilitation program accreditation standards and applicable regulatory standards (e.g., Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission) as they apply to BRS programs.

(4) Overseeing internal BRS oversight and compliance. As needed, the NPC oversees adherence of BRS field staff with internal BRS procedures and related VHA policies.

(5) Developing and maintaining collaborative relationships with VHA health care system's programmatic partners (e.g., Mental Health Services, Care Management and Social Work Services, Optometry, Ophthalmology, Patient Aligned Care Teams, Recreation Therapy, Nursing Service, Physical Medicine and Rehabilitation, Chaplain Service, PSAS, Telehealth Services, Veteran Service Organizations).

(6) Conducting formal site visits on behalf of the BRS National Program Office to evaluate the implementation of core business management principles and evidence-based best practices in patient care within BRS programs. The NPC will generate a formal report of its findings that will be routed to the National Director, BRS.

(7) Providing outreach to current and potential stakeholders to continue cultivating professional support through in-service and presentations on behalf of the BRS National Program Office, at health care facilities, Federal, State, municipal and private organizations.

(8) Assisting VA medical facilities by providing support from the national BRS program office in recruitment efforts. This includes, but is not limited to, participating with direct supervisors in the selection of blind rehabilitation specialists within the Continuum of Care (e.g., BRC Service Chief, VISOR Chief, VIST Coordinator, BROS).

(9) Collaborating with and supporting BRS Continuum of Care programs to continually improve BRS practices and outcomes for Veterans with visual impairment. Areas of collaboration include, but not limited to:

(a) Providing or assisting BRS staff in gathering and tracking data as it relates to BRS program goals and objectives (e.g., access to care, wait times, productivity, patient experience, modernization efforts and performance measures).

(b) Assisting BRS staff with problem-solving strategies when issues arise and keeping local, regional and national BRS staff informed throughout the process.

(c) Developing strategies with all involved BRS staff to address pertinent issues in a timely and efficient manner.

k. **Blind Rehabilitation Center Service Chief.** The BRC Service Chief is a Blind Rehabilitation Specialist who has operational and programmatic responsibilities that include managing the budget, ensuring workload productivity, staffing and coordinating supporting services. In addition, the BRC Service Chief is responsible for:

(1) Assuring that inpatient care at the BRC is of the highest caliber through reviews and updates of evidence-based best practices and evaluation of Veterans' rehabilitation goals and treatment outcomes.

(2) Successfully attaining and maintaining rehabilitation program accreditation (e.g., CARF) and assuring that applicable regulatory standards (e.g., The Joint Commission) are being met. For additional information, see VHA Office of Quality and Patient Safety, Office of Quality Management, Office of External Accreditation Services and Programs at <https://vawww.qps.med.va.gov/divisions/qm/ea/carf.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

(3) Determining, in partnership with the Veteran's interdisciplinary team, the appropriateness of the Veteran's BRS care and the dates of admissions and discharges from the program and ensuring appropriate length of stay (LOS) based on individual needs. **NOTE:** *While this is a collaborative process, the BRC Service Chief is the final authority over admissions to and discharges from BRC programs.*

(4) Partnering with Human Resources to assure that BRC blind rehabilitation staff is appropriately credentialed, onboarded and that continuing education is available to assure staff members are practicing at their full scope. **NOTE:** *See VA Handbook 5005/109 Staffing, dated March 13, 2019 and VA Handbook 5005/110 Staffing, dated May 14, 2019.*

(5) Ensuring that clinician core competencies are reviewed annually by the employee's supervisor or designee. For more information on competencies and licenses, see paragraph 15.

(6) Ensuring that all rehabilitation care listed in this directive is provided at the VA medical facility, including outpatient services. Care can be provided on an outpatient

basis by BRS specialists, VIST Coordinators or by BROS. **NOTE:** All BRS staff engaged in provision of care in a patient home must adhere to The Joint Commission standards in the Home Care manual located at <https://vawww.qps.med.va.gov/divisions/qm/ea/carf.aspx>. This is an internal VA website that is not available to the public.

(7) Arranging and providing VA medical facility internships and traineeships for students enrolled in blind rehabilitation university-based programs, in collaboration with the VA medical facility's Designated Education Officer.

(8) Ensuring that the VA medical facility where blind rehabilitation services are provided is physically safe, secure, comfortable, accessible and conducive to the rehabilitation care of Veterans with visual impairment. For more information, see Appendix K.

(9) Communicating and partnering with the VA medical facility Director, the VISN Director and the National Director, BRS to determine the most appropriate number of beds and bed occupancy rates for the BRC. BRC Service Chiefs must adhere to processes in VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, dated December 22, 2010. Any proposed modification to authorized and operating beds must be reported to the National Director, BRS prior to processing the change in count.

(10) Developing, managing and sending budget requests, as needed, to the VA medical facility Director.

(11) Supervising scheduling of Veterans with visual impairment and workflow of the BRC to ensure access to care, including scheduling appointments, admissions and discharges in inpatient and outpatient programs.

(12) Ensuring partnership between Blind Rehabilitation Service (BRS) and Prosthetics and Sensory Aids Service (PSAS) staff to improve service delivery. **NOTE:** In VA medical facilities without a Blind Rehabilitation Center Service Chief, the VA medical facility Director will be delegated to fulfill this responsibility. See paragraph 5.g.(9).

(a) Ensuring Blind Rehabilitation Specialists follow national clinical practice recommendations and PSAS guidance pertaining to evaluation and management, including recommending ordering and issuing devices. (See paragraph 12.b.(6).).

(b) Ensuring adequate supply of devices issued for therapeutic instruction. (See Appendix K).

(c) Ensuring BRS providers evaluate various aids, devices, appliances and technologies to determine their clinical effectiveness for Veterans with visual impairment and recommend inclusion and exclusion criteria for use. **NOTE:** For further information on evaluation of emerging technology, see Appendix F. Depending on the VA medical facility, a BRS Supervisor may be delegated to fulfill this responsibility.

(13) Ensuring partnership between BRS and Logistics Management Services staff to improve access, record-keeping and logistical processes for stocking devices. **NOTE:** *In VA medical facilities without a Blind Rehabilitation Center Service Chief, the VA medical facility Director will be delegated to fulfill this responsibility. (See paragraph 5.g.(9).)*

(14) Implementing a process to ensure that Veterans with visual impairment are assigned to a visual impairment admissions review team with appropriate medical, nursing, counseling, care coordination and any other required expertise to assist and make admission recommendations to the BRC Service Chief. **NOTE:** *For BRC, the admission review standard is 7 calendar days and the outpatient clinical review standard is 3 business days.*

(15) Managing effective communication of information and education of VA medical facility staff about the care and abilities of Veterans with visual impairment. This extends to NPCs and VIST Coordinators in assigned geographic areas, as well as the BRS National Program Office staff. In addition, BRC Service Chiefs are responsible for supporting outreach efforts to inform internal and external stakeholders about the benefits of blind and vision rehabilitation.

(16) Ensuring and supporting BRC staff involvement in applied research and cooperative studies, development and deployment of best practices in blind and vision rehabilitation care and evaluation of new and emerging assistive technology.

(17) Ensuring that designated management and admissions staff at all BRC programs use the BR National Database to modify and complete referrals to the local BRC program as detailed in Appendix B.

(18) Ensuring Blind Rehabilitation telehealth care is aligned with the VA medical facility's clinical, business and technical processes in accordance with VHA Office of Telehealth Services standards.

I. **Blind Rehabilitation Center Supervisor.** BRC Supervisors are responsible for:

(1) Assisting in managing the BRS program by providing administrative, management and technical supervision, compliance with rehabilitation program accreditation standards, strategic direction and leadership for blind rehabilitation professional staff at their respective VA medical facilities.

(2) Managing staff education and performance improvement including establishing local operating procedures on obtaining and using patient outcomes data to continually improve the quality of care to patients and their families.

(3) Ensuring BRS staff competencies and quality of clinical practice for each supervised staff member adhere to evidence-based practices. Core competencies are reviewed annually by the employee's supervisor or designee. **NOTE:** *For further information on competencies, certification and licenses, see paragraph 15.*

(4) Ensuring that practice credentials, certifications and/or licenses of the blind

rehabilitation professionals for whom they supervise are current **NOTE: For further information on competencies, certification and licenses, see paragraph 15.**

(5) Ensuring that Blind Rehabilitation Specialists recommend prosthetic devices within their scope of practice (or demonstrated discipline-specific competencies) and that the Veterans ability to use devices to successfully reach their goals is documented.

(6) Ensuring BRS providers evaluate various aids, devices, appliances and technologies to determine their clinical effectiveness for Veterans with visual impairment and recommending inclusion and exclusion criteria for use, if delegated by the BRC Service Chief.

(7) Supporting outreach efforts to inform internal and external stakeholders about the benefits of blind and vision rehabilitation.

m. **Blind Rehabilitation Specialists and Blind Rehabilitation Outpatient Specialists.** Blind Rehabilitation Specialists (BRS) and Blind Rehabilitation Outpatient Specialists (BROS) are responsible for ensuring that practice credentials and certifications for respective disciplines and skill areas are current. **NOTE: BRS, VIST coordinators and BROS may provide care in an outpatient setting, inpatient setting and in a home environment as deemed appropriate for clinical care.** They are also responsible for practicing their full scope, including:

(1) **Adjustment Counseling.** This includes enabling Veterans with visual impairment to gain a better understanding of their visual diagnoses and resulting problems; discussing the Veteran's adjustment to sight loss; and assessing the Veteran's mental health status including signs of depression and screening for suicide risk. **NOTE: Blind Rehabilitation Specialists and Blind Rehabilitation Outpatient Specialists must have local established procedures for referring Veterans who report mental health conditions to licensed independent providers or licensed independent mental health providers for follow up, further evaluation and supporting engagement in mental health services as needed. For suicide risk screening resources, see the Risk ID SharePoint site: <https://dva.gov.sharepoint.com/sites/ECH/srsa/SitePages/Home.aspx>.** **NOTE: This is an internal VA website that is not available to the public.**

(2) **Assessment.** This includes assessing functional capabilities in the use of visual motor and visual perceptual skills, in areas such as reading, writing, self-care, safe independent travel and comprehensively and accurately assessing and identifying the blind rehabilitation needs and goals of Veterans while taking into consideration all other factors affecting the Veteran with visual impairment. These include, level of visual function, physical health, medical conditions, mental health, cognitive function, level of motivation, age, social and cultural elements and other factors that influence the needs and goals of the Veteran with visual impairment. The specialist will utilize department specific assessment techniques and intake forms.

(3) **Goal Development and Treatment Plan.** In partnership with the Veteran, developing and modifying, as needed, an individualized rehabilitation treatment plan.

This includes developing Veterans goals and rehabilitation plans in an interdisciplinary team and evaluating outcomes of therapeutic interventions.

(4) **Therapeutic Instruction.** This includes instructing in rehabilitation techniques and assistive technology to support Veterans in reaching their rehabilitation goals; instructing Veterans in effective use of their remaining vision through techniques that improve visual perceptual and visual motor function for daily tasks; providing information and education about visual impairment for family members and significant others, where needed, to support Veterans with visual impairment in incorporating practice of training techniques and use of assistive technology in the home and their surrounding environments.

(5) **Coordinating Care.** This includes maintaining effective communication and team cohesion within the BRS CoC to maximize Veterans' blind rehabilitation outcomes by:

(a) Establishing a peer support environment to foster the following for Veterans with visual impairment: health, skills of independence and adjustment to sight loss with the goal of successfully reintegrating within the family and community environment.

(b) Collaborating with the VIST Coordinator and/or other BRS clinical programs to provide outreach and education to VA medical facility and non-VA agencies and personnel.

(c) Collaborating with NPCs and Supervisor for administrative and clinical support, quality improvement processes and best practices.

(d) Contributing subject matter expertise in support of BRS program goals and objectives by maintaining their professional development and updating their knowledge, skills and abilities in a changing health care system, as well as adjusting to the changing needs, techniques and technologies for Veterans with visual impairment.

(e) Determining if additional intervention by other providers will be needed in order to develop a Veteran's individualized treatment plan. In such instances, the BRS clinician is expected to refer, consult, educate and/or cotreat with other providers in order to support the Veteran in addressing individualized goals (e.g., assessment for supplementary adaptive interventions, issuance criteria and core competencies for prosthetic recommendation).

(6) **Documenting Care.** This includes understanding the importance of recording and maintaining clear, accurate and concise documents that pertain to Veteran's profiles. Documentation includes:

(a) Documenting Veterans with visual impairment assessments, treatment plans, progress notes and discharge summaries which must be consistent with VHA requirements as well as the requirements of rehabilitation program accreditation standards (e.g., CARF) and applicable regulatory standards (e.g., The Joint Commission). This includes, but not limited to:

1. Specific, Measurable, Achievable, Relevant and Time-bound (SMART) goal(s) for each therapeutic intervention(s) recommended in the treatment plan (e.g., training, education, prosthetic device).

2. Administrative Consults for devices submitted to PSAS, which specify the type of device, specifications and other relevant information along with the clinical justification for need (e.g., documented capability of Veteran to meet issuance criteria and core competencies). Refer to local VA medical facility PSAS guidance on required elements of administrative consult for procurement of devices.

3. For BROS or designated BRS, initiating and tracking referrals in all aspects of BRS CoC on behalf of Veterans with visual impairment in accordance with the BR National Database guidelines as detailed in Appendix B.

(7) Adhering to The Joint Commission standards in the Home Care manual located at <https://vaww.qps.med.va.gov/divisions/qm/ea/carf.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

n. Visual Impairment Services Team Coordinator. The VIST Coordinator is responsible for:

(1) Following a model of lifetime care coordination offered to all Veterans with visual impairment who are eligible to receive services. The model requires varying degrees of intervention based on the clinical and psychosocial needs of each Veteran. (See Appendix D.)

(2) Providing care coordination services to eligible Veterans with visual impairment by assessing (at least annually), coordinating and reviewing the Veteran's rehabilitation and adjustment needs and determining and referring the type and intensity of services needed, based upon clinical judgment and the Veteran's goals. **NOTE:** *For further information on the VIST review, see paragraph 7.*

(3) Determining if additional intervention by other providers will be needed in order to develop a Veteran's individualized treatment plan. In such instances, the BRS clinician is expected to refer, consult, educate and/or cotreat with other providers in order to support the Veteran in addressing individualized goals (e.g., assessment for supplementary adaptive interventions, issuance criteria and core competencies for prosthetic recommendation).

(4) Ensuring the update and maintenance of the VIST roster including all legally blind and low vision Veterans enrolled at a given VA medical facility.

(5) Providing outreach and education to VA medical facility and non-VA agencies and personnel through brochures and other educational materials about Veteran counseling and family information. Regardless of the level of care coordination, VIST Coordinators counsel Veterans with visual impairment about their health needs and refer them annually for medical examinations to include, but not limited to, ocular health examinations, physical examinations and audiological examinations.

(6) Conducting monthly VIST support groups for Veterans on various topics to enhance outreach, education, adjustment to sight loss, and peer-to-peer engagement.

(7) Ensuring the recommended prosthetic devices and rehabilitation interventions are in alignment with the Veteran's goals and individualized rehabilitation plan. **NOTE:** *This is a VIST Coordinator responsibility if a contracted vendor is utilized for therapeutic interventions.*

(8) Promoting awareness of the needs of Veterans with visual impairments to the VA medical facility staff through identifying eligible Veterans with visual impairment in EHR.

(9) Coordinating community care and VHA care to assist Veterans with visual impairment in receiving the best services in both the BRS CoC and from community providers.

(10) Ensuring seamless coordination of BRS-related care for traveling Veterans with visual impairment who are away from their primary residence and preferred VA medical facility. This includes leading the Veteran's care coordination and contacting the Veteran's primary VIST Coordinator, if necessary. As defined in VHA Handbook 1101.11(3), Coordinated Care for Traveling Veterans, dated April 22, 2015, a traveling Veteran is one who is registered at a VA medical facility and who is preparing to embark on or has embarked upon extended travel away from their primary residence and preferred VA medical facility. **NOTE:** *For further information, see VHA Handbook 1101.11(3).*

(11) Ensuring adherence to best practices by conducting VIST Reviews via in-person contact or telehealth (see paragraph 7). **NOTE:** *Telephone encounters are acceptable after exhausting all other avenues for face-to-face encounters.*

(12) Entering the initial application for the Veteran with visual impairment admission into BRC care in accordance with the Veteran's choice of date for admission. The VIST Coordinators must refer Veterans with visual impairment to BRCs via the Blind Rehabilitation (BR) National Database guidelines detailed in Appendix B.

(13) Monitoring and assisting in developing and updating service agreements and assisting in developing VA medical facility operating procedures pertinent to blindness and visual impairment.

(14) **Documenting Care.** This includes understanding the importance of recording and maintaining clear, accurate and concise documents that pertain to Veteran's profiles. Documentation includes:

(a) Documenting Veterans with visual impairment assessments, treatment plans, progress notes and discharge summaries which must be consistent with VHA requirements as well as the requirements of rehabilitation program accreditation standards (e.g., CARF) and applicable regulatory standards (e.g., The Joint Commission). This includes, but not limited to:

1. Specific, Measurable, Achievable, Relevant and Time-bound (SMART) goal(s) for each therapeutic intervention(s) recommended in the treatment plan (e.g., training, education, prosthetic device).

2. Administrative Consults for devices submitted to PSAS, which specify the type of device, specifications and other relevant information along with the clinical justification for need (e.g., documented capability of Veteran to meet issuance criteria and core competencies). Refer to local VA medical facility PSAS guidance on required elements of administrative consult for procurement of devices.

(15) **Guide Dogs.** The VIST Coordinator will work with the Veteran to obtain the necessary information and documents to request the VA Veterinary Health Insurance on behalf of the Veteran through coordination with the local PSAS.

(16) Initiating and tracking referrals in all aspects of BRS CoC on behalf of Veterans with visual impairment in accordance with the BR National Database guidelines detailed in Appendix B.

(17) **Visual Impairment Services Team (VIST) Committee.** The Visual Impairment Services Team (VIST) Coordinator is the chairperson of the VIST Committee. The VIST Committee convenes annually to review VIST program performance, develop strategic plans, advocacy, education, outreach and assure that access and compliance concerns of Veterans with visual impairment are addressed. Additional meetings may be called as necessary by team members and may be held by audio or video conferencing.

(a) Notable VIST developments and needs are reported to the VA medical facility's leadership, to promote awareness of VIST and facilitate intra-service line collaboration, as needed.

(b) VIST Committee Representatives. VIST Representatives represent services that impact the care of Veterans with visual impairment and serve as consultants to the VIST in their areas of expertise. Specialties may include, but are not limited to: BRS Professionals, Social Work, Ophthalmology, Optometry, Prosthetics Sensory Aids Service, Primary Care, Patient Aligned Care Teams, Physical Therapy, Occupational Therapy, Recreational Therapy, Speech Therapy and Kinesiotherapy, Pharmacy, Nursing, Audiology, Speech and Language Pathology, Podiatry, Nutrition, Psychology, Patient Administration, Telehealth, Chaplain Service.

(18) Adhering to The Joint Commission standards in the Home Care manual located at <https://vaww.qps.med.va.gov/divisions/qm/ea/carf.aspx>. **NOTE:** *This is an internal VA website that is not available to the public. Rehabilitative care can be provided on an outpatient basis by BRS specialists, VIST Coordinators or by BROS.*

o. Outpatient Low Vision Clinic Supervisor and the Visual Impairment Services Outpatient Rehabilitation Chief. The Outpatient Low Vision Clinic Supervisor and the Visual Impairment Services Outpatient Rehabilitation (VISOR) Chief, are responsible for:

(1) Partnering with the BRS National Program Office to ensure that effective, efficient blind and visual impairment rehabilitation care coordination is provided to eligible Veterans with visual impairment.

(2) Ensuring that BRS staff provide evidence-based, patient-centered care by developing, managing, supervising and implementing VHA policy and requirements pertaining to the provision of care for Veterans with visual impairment.

(3) Managing staff education and performance improvement including establishing local operating procedures on obtaining and using Veteran outcomes data to continually improve the quality of care to Veterans and their families.

(4) Supporting outreach efforts to inform internal and external stakeholders about the benefits of blind and vision rehabilitation.

(5) Attaining and maintaining rehabilitation program accreditation and assuring applicable accreditation standards are being met. For additional information, see VHA Office of Quality and Patient Safety, Office of Quality Management, Office of External Accreditation Services and Programs at <https://vaww.qps.med.va.gov/divisions/gm/ea/carf.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

(6) All BRS staff engaged in provision of care in a patient home must adhere to The Joint Commission standards in the Home Care manual located at <https://vaww.qps.med.va.gov/divisions/gm/ea/carf.aspx>. This is an internal VA website that is not available to the public. **NOTE:** *Rehabilitative care can be provided on an outpatient basis by BRS specialists, VIST Coordinators or by BROS.*

(7) Ensuring BRS staff utilize the BR National Database to initiate and track referrals in all aspects of BRS CoC on behalf of Veterans with visual impairment in accordance with the BR National Database guidelines detailed in Appendix B.

(8) Partnering with Human Resources to assure blind rehabilitation staff are appropriately credentialed, onboarded and that continuing education is available to assure staff members are practicing at their full scope. **NOTE:** *See VA Handbook 5005/109 Staffing, dated March 13, 2019 and VA Handbook 5005/110 Staffing, dated May 14, 2019.*

(9) Ensuring clinician core competencies are reviewed annually by the employee's supervisor or designee (see paragraph 15).

(10) Ensuring partnership between Blind Rehabilitation Service (BRS) and Prosthetics and Sensory Aids Service (PSAS) staff to improve service delivery. **NOTE:** *In VA medical facilities without an Outpatient Low Vision Clinic Supervisor or the Visual Impairment Services Outpatient Rehabilitation Chief, the VA medical facility Director will be delegated to fulfill this responsibility, see paragraph 5.g.(9).*

(11) Ensuring Blind Rehabilitation Specialists follow national clinical practice recommendations and PSAS policies pertaining to evaluation and management, including recommending ordering and issuing devices. For more information on issuance of devices, see paragraph 12.b.(6).

(a) Ensuring adequate supply of devices issued for therapeutic instruction (see Appendix K).

(b) Ensuring BRS providers evaluate various aids, devices, appliances and technologies to determine their clinical effectiveness for Veterans with visual impairment and recommend inclusion and exclusion criteria for use. For more information on Evaluation of Emerging Technology, see Appendix F.

(12) Ensuring partnership between BRS and Logistics Management Services staff to improve access, record-keeping and logistical processes for stocking devices. **NOTE:** *In VA medical facilities without an Outpatient Low Vision Clinic Supervisor or the Visual Impairment Services Outpatient Rehabilitation Chief, the VA medical facility Director will be delegated to fulfill this responsibility, see paragraph 5.g.(9).*

6. BLIND REHABILITATION SERVICE CONTINUUM OF CARE

a. The BRS CoC refers to blind and visual impairment rehabilitation services ranging across multiple levels of care. (See paragraph 3.f.)

b. The VIST Coordinator conducts a comprehensive evaluation of needs for all identified Veterans experiencing functional difficulty due to visual impairment. (See paragraph 7.) Based on individual needs, the Veteran is then referred to the most beneficial level of the BRS CoC, as outlined below:

(1) **Basic Low Vision Care.** Basic Low Vision Care by an eye care provider (optometrist or ophthalmologist) includes evaluation for optical devices (see paragraph 3 for definition of optical low vision devices) and basic environmental adaptations (for example, lighting and contrast adjustments).

(2) **Intermediate Low Vision Clinic.** Intermediate Low Vision Clinic (ILVC) services are provided by an eye care provider and low vision therapist working together in an interdisciplinary team to provide low vision care. There is a spectrum of low vision devices available for the Veteran's rehabilitation treatment plan (see paragraph 3 for definition of Optical Low Vision Devices).

(3) **Advanced Low Vision Clinic.** Advanced Low Vision Clinic (ALVC) services are provided by an eye care provider as well as blind rehabilitation specialists and other support services working together in an interdisciplinary team to provide low vision care. In addition to low vision care orientation & Mobility (O&M), Computer Assistive Technology (CAT) and Activities of Daily Living/Instrumental Activities of Daily Living (ADL/IADL) assessment and training are also available.

(4) **Vision Impairment Services in Outpatient Rehabilitation Programs.** VISOR is an outpatient clinic in which an eye care provider as well as blind rehabilitation specialists and other support services work together in an interdisciplinary team to provide low vision care. In addition to low vision care orientation & Mobility (O&M), Computer Assistive Technology (CAT) and Activities of Daily Living/Instrumental Activities of Daily Living (ADL/IADL) assessment and training are also available. While a Veteran or active duty Servicemember is undergoing an episode of care at a VISOR Program, the VA medical facility may provide temporary lodging at either a VA Fisher House or other temporary lodging facility, as appropriate. Those who use temporary lodging to participate in the VISOR program must be able to perform basic activities of daily living independently, including the ability to self-medicate. Veterans who are visually impaired are eligible for this program that may last up to nine days.

(5) **Blind Rehabilitation Centers.** BRCs provide intensive interdisciplinary rehabilitation to Veterans with visual impairment in a VA medical facility support system. Each Veteran with visual impairment receives an individualized treatment plan and therapeutic instruction is provided on a one-on-one basis. **NOTE:** *Veterans admitted to BRC are considered inpatients of the VA medical facility.*

(6) **Blind Rehabilitation Outpatient Services.** Blind Rehabilitation Outpatient Services provide a wide array of blind rehabilitation including assessments and therapeutic training in low vision, ADL/IADL, computer assistive technology and orientation and mobility. Not all Veterans with visual impairments are capable of receiving rehabilitation training in an inpatient setting because of inability to perform ADL, medical instability or family situation. Vision and blind rehabilitation services are provided in outpatient clinics hospital, residential, community, workplace and education settings. **NOTE:** *Blind Rehabilitation Specialists may provide these services where appropriate.*

(7) The BRS CoC offers direct rehabilitative care at the sites listed in Appendix J, Blind Rehabilitation Service Regional Distribution of Care. Veterans with visual impairment may receive coordinated BRS care at more than one VA medical facility.

7. VISUAL IMPAIRMENT SERVICES TEAM COORDINATOR REVIEW

a. The VIST Coordinator conducts a comprehensive evaluation of needs for all identified Veterans experiencing functional difficulty due to visual impairment.

b. VIST Reviews are offered at a minimum at least annually; and, as best practice, should be offered whenever the VIST Coordinator becomes aware of a significant change in visual, physical or mental functioning; a significant change in established support systems (i.e., death of a spouse); a significant change in finances (i.e., loss of employment); or Veteran relocation. **NOTE:** *For further information, on BRS Levels of Care, see Appendix D.*

c. VIST Reviews via face-to-face or utilizing telehealth. VIST Reviews conducted by telephone are acceptable after exhausting all avenues for face-to-face encounters.

d. The VIST Review consists of the following components:

(1) **Medical Care Review.** The VIST Coordinator ensures that the Veteran has had a comprehensive physical examination and audiological examination (as necessary) within the previous 12-month period. Examinations may be provided by VA and/or non-VA providers. The VIST Coordinator will assist the Veteran in obtaining examinations as needed. Notation is made in EHR of any medical conditions that may affect Veteran's rehabilitation plan/goals.

(2) **Ocular Care Review.** The VIST Coordinator ensures that the Veteran has a comprehensive ocular health examination within the previous 12-month period. Examinations may be provided by VA and/or non-VA providers. VIST Coordinator will assist Veteran in obtaining examinations as needed.

(3) **Personal History.** This includes domestic/housing arrangements and established support systems, functional capabilities and limitations.

(4) **Rehabilitation History.** This includes rehabilitation addressing Veteran's functional difficulty due to visual impairment including BRS Continuum of Care programs, non-VA rehabilitation services, adjustment to vision changes, prosthetics review (ensures previously issued prosthetics are in good working condition and Veteran is able to use them effectively).

(5) **Benefits/Services Review.** The VIST Coordinator screens the Veteran for appropriateness for available benefits and services, both VA and non-VA; and places consults to resources to assist with obtaining appropriate benefits/services.

(6) **Assessment and Therapeutic Treatment Planning.** This includes prior year goals reviewed and adjusted as needed and new goals established as ascertained by a problem-based needs assessment, consults/referrals. For more information, see paragraph 11.

8. CRITERIA FOR BLIND REHABILITATION SERVICES CARE

NOTE: *Qualifications for BRS care are based on clinical conditions and rehabilitative needs, see Appendix A for a Step-by-Step Decision-Making Process for Veterans Served in the BRS CoC. Successful enrollment in VA health benefits satisfies criteria one.*

BRS care is determined by the review of three key criteria: whether the Veteran is enrolled for VA health benefits (or is an active duty Service member), whether the Veteran possesses a visual impairment and whether the Veteran has received a designation of excess disability. The following describes the review of the three criteria and how BRS establishes care. After it has been established that the first criterion has been satisfied, the Veteran must then satisfy either criterion two or criterion three to qualify for rehabilitative care within the BRS CoC.

a. **Criterion One: Eligible for VA Health Benefits or Active Duty Status.** All Veterans are reviewed for eligibility for VA health benefits or an active duty status.

b. **Criterion Two: Visual Impairment.** A Veteran who has met the first criterion may qualify for rehabilitative care within the BRS CoC if they also receive an ocular health examination and a visual impairment is identified. **NOTE:** *This includes low vision, legal blindness and statutory blindness. For further information see paragraph 3.*

(1) **Review Standards.** This criterion is satisfied if a licensed eye care provider determines that the Veteran has a visual impairment, as revealed by an ocular health examination. All VA and community care ocular health examinations and evaluations are accepted by VA BRS. The ocular health examination must be conducted within the last 12 months (see paragraph 3 for ocular health examination definition.)

(2) **Qualification.** BRS care will be provided if the Veteran qualifies for both criterion one and criterion two. At that point, the Veteran may be referred to the appropriate level of care.

c. **Criterion Three: Excess Disability.** Excess disability is the third criterion for blind rehabilitation services qualification. Excess disability is determined by a BRS provider's clinical judgment and refers to functional limitations that are greater than those warranted by the objective degree of impairment. Excess disability refers to problems and task performance difficulties related to vision loss that impact the Veteran's functional independence or personal safety and that are out of proportion to the degree of visual impairment as measured by visual acuities or visual fields.

(1) **Review Standards.** This criterion is satisfied if a BRS provider determines, based on their clinical judgment, that the Veteran has excess disability and that their rehabilitation needs represent a substantial (or significant) impact on the person's functional independence or personal safety.

(a) Veterans whose vision is better than legal blindness may have excess disability due to:

1. Disabling comorbidities (e.g., hearing impairment, mobility impairment) as well as visual impairment.

2. Systemic diseases that cause fluctuating visual impairment (e.g., multiple sclerosis).

3. Combined losses of vision functions (e.g., visual acuity, contrast sensitivity, visual field loss that is less than legal blindness, stereopsis).

4. Sudden changes in caregiver status.

5. Other reasons. **NOTE:** *The BRS provider determines a Veteran has excess disability after a complete review of the Veteran's functioning and problem-based needs assessment, with input from the VA medical facility as needed. Excess disability*

designation is based on a Veteran's functional losses and difficulties that require BRS care.

(b) Any BRS provider has authority to categorize a Veteran as having excess disability based on interviews, problem-based needs assessment and information in the Veteran's medical record. A categorization of excess disability in most cases will require input from other medical, eye care, nursing, rehabilitation and care coordination practitioners.

(c) The BRS provider must understand the severity, impact and possibly temporal nature of conditions that contribute to excess disability. The categorization cannot be based solely on clinical vision functions, including acuity, visual field or contrast sensitivity function.

(d) A categorization of excess disability must be decided based on each individual Veteran's function, as well as adjustment and training needs related to visual impairment.

(2) **Qualification.** The Veteran is deemed qualified for BRS CoC care if both criterion one and criterion three are satisfied. At that point, the Veteran may be referred to the appropriate level of care.

9. REFERRALS TO BLIND REHABILITATION SERVICES

a. After a Veteran has been deemed eligible for BRS care, a BRS provider creates an initial referral to the appropriate level of care within the CoC, based on the clinical examinations and determinations in the eligibility stage (see paragraph 8). **NOTE:** *The Veteran's preference will be honored when possible and warranted (e.g., specialty programs, emergent needs, bed capacity or access to dialysis bed).* (For more information on the step by step decision-making process for Veterans in the Blind Rehabilitation Service Continuum of Care, see Appendix A.

b. Following the initial referral to BRS and corresponding episode of care (see paragraph 11), Veterans with visual impairment can be referred to varied levels of care in the CoC. Those subsequent referrals within the CoC are based on the Veteran's individual needs, as determined by ocular health examination and low vision exam, as deemed appropriate and clinical judgment of BRS providers, in coordination with the Veteran's care team. For more information on Blind Rehabilitation Services Levels of Care Coordination, see Appendix D.

c. To enable consistent and effective BRS care for all Veterans with visual impairment, BRS maintains mandatory referral procedures for all eligible Veterans. These mandatory standards are detailed in Appendix B.

d. VA and non-VA providers refer to the appropriate BRS CoC program based on Veteran's individualized needs and availability of BRS resources at local station. (Refer to <https://www.rehab.va.gov/blindrehab> for BRS CoC program locations and contact information).

10. STANDARDS OF DOCUMENTATION AND APPLICATION MANAGEMENT

a. **Health Information Management System.** BRS CoC adheres to VA-mandated HIMMS scheduling and consult requirements within EHR, as well as mandatory BR documentation. All BRS CoC programs must use consults within EHR to monitor clinical access and improve accountability.

b. **Electronic Health Records.** The documentation of patient assessments, treatment plans, progress notes and discharge summaries and consult management must be consistent with VHA requirements as well as rehabilitation program accreditation standards (e.g., CARF) and applicable regulatory standards (e.g., The Joint Commission). See VHA Office of Quality and Patient Safety, Office of Quality Management, Office of External Accreditation Services & Programs at <https://vaww.qps.med.va.gov/divisions/qm/ea/eaDefault.aspx>. **NOTE:** *This is an internal VA website and is not available to the public.*

c. **Electronic Encounter Form.** All BRS programs must use the BRS Electronic Encounter Form (EEF) to record patient treatment, as per VHA Directive 1082 Patient Care Data Capture, dated March 24, 2015.

d. **Blind Rehabilitation National Database.** To enable consistent and effective BRS care for all Veterans with visual impairment, BRS maintains mandatory application management procedures for all Veterans. These mandatory standards are detailed in Appendix B.

11. BLIND REHABILITATION SERVICES EPISODES OF CARE

The following elements represent the standardized components within a single Veteran-centered episode of care (EoC).

a. **Intake.** Each Veteran's EoC begins at the first contact to educate the Veteran (and HIPAA authorized representative, as needed) about BRS services, to discuss their questions and develop an action plan based on intake results (e.g., submit BRS CoC referral, schedule appointment).

b. **Assessments and Evaluations.** All BRS Veterans receive a problem-based needs assessment and evaluation to determine their level of need and develop their specific rehabilitation care plan. **NOTE:** *BRS providers can initiate evaluation/intake assessment prior to receiving ocular examination. To avoid fragmented care, continuous communication, interdisciplinary collaboration and coordination is critical.*

(1) The intake is followed by full interdisciplinary assessments and evaluations of the use of vision and other learning modalities related to the Veteran's concerns and goals.

(2) Assessment and evaluation include both standardized assessments using formal, evidence-based assessment instruments, as well as informal assessments. Assessment and evaluation address the Veteran's strengths, needs, preferences and desired outcomes.

(3) Assessments and evaluation include questions about the Veteran's lifestyle, culture, age, medical condition, cognitive ability, previous training and future plans. The assessment and evaluation process are continuously updated to ensure best practices and evidence-based rehabilitation care.

c. Interdisciplinary Rehabilitation Treatment Plan.

(1) Based on the assessments described, each Veteran receives a coordinated and integrated interdisciplinary plan of care that includes all required disciplines and reflects the goals of the Veteran, with family input where appropriate.

(2) The plan specifies the problems and rehabilitation goals of the Veteran, including family or caregiver (if needed), a description of the planned therapeutic interventions that the Veteran is to receive to achieve the goal(s), the Veteran or family responsibilities in rehabilitation (if needed), an approximation of the time the plan requires for completion and a description of the anticipated outcomes.

(3) The length of the Veteran's program is determined according to their individualized treatment plan, at which point the Veteran must verbally express understanding of an agreement with the rehabilitation treatment plans and projected completion date before proceeding to the provision of care.

d. Provision of Rehabilitative Care. In accordance with each Veteran's treatment plan, the Blind Rehabilitation Specialists provide or coordinate care, in the least restrictive environment available, to ensure the Veteran's whole well-being, particularly through the provision of skill area therapeutic instruction, prosthetic usage, adjustment counseling, health and wellness care, family training and specialty programs (see paragraph 12).

e. Documentation of Rehabilitation Goals and Outcomes. Throughout the entire episode of care, the Veteran's progress in achieving their established rehabilitation goals is documented in EHR to promote desired Veteran outcomes.

f. Discharge Planning and Implementation. When the provision of care is nearing completion, the BRS treatment team (in partnership with the Veteran) plans for discharge, coordinates follow-up appointments as necessary and implements Lifetime Care Coordination. See Appendix D for more information. Discharge planning includes information about any further services needed that will be required to maintain the Veteran's rehabilitation at home. Discharge planning considers the unique assets and barriers in the Veteran's environment (community and home) and prepares the Veteran for a successful transition.

12. BLIND REHABILITATION SERVICES AND ACTIVITIES

This paragraph describes the care and services offered across the BRS CoC. VA medical facilities operate inpatient BRCs that facilitate the learning of new skills and promotes emotional adjustment to a Veteran's disability by housing the Veteran in a self-contained physical facility that is architecturally accessible, conducive for safe

training practices and free of attitudinal barriers. Similarly, each outpatient setting (ILVC, ALVC, VISOR, VIST, BROS) provides comprehensive and individualized adjustment programs in a therapeutic atmosphere where privacy, dignity, personal values and emotional needs of the Veteran and their families are recognized and respected.

a. **Therapeutic Interventions, Interdisciplinary Teams, Services and Activities.**

Blind rehabilitation services are delivered through interdisciplinary blind rehabilitation teams, whose members have a variety of disciplines and who work together to assess, plan and implement the Veteran's treatment goals.

(1) Interdisciplinary teams avoid fragmented care, are in continuous communication, collaboration and coordination, critical to assisting Veterans with visual impairment in achieving their goals and supporting maximum patient and family outcomes. Interdisciplinary treatment plans are a collaborative effort based on active involvement of the Veteran, family/caregivers and discipline-specific assessments of each Veteran.

(2) The treatment plan addresses the Veteran's individual needs and goals, relevant to lifestyle, stamina, level of capability and future plans. Treatment plans identify problems and needs; define realistic and measurable goals; interventions to be applied to achieve the goals; and the disciplines responsible for implementation. BRS staff continually evaluate performance results during the Veteran's rehabilitation program, as they relate to expected outcomes, in order to determine the appropriateness of the training being provided and to adjust as needed. Any revisions to the treatment plan are made with the Veteran's involvement and are based on demonstrated strengths, changing needs and expected outcomes in order to ensure that goals remain achievable and meaningful to the Veteran.

(3) The BRS provider determines if additional intervention by other providers will be needed in order to develop a Veteran's individualized treatment plan. In such instances, the BRS clinician is expected to refer, consult, educate and/or cotreat with other providers in order to support the Veteran in addressing individualized goals (e.g., assessment for supplementary adaptive interventions, issuance criteria and core competencies for prosthetic recommendation).

(4) See Appendix H for more information on programs offered.

b. **Supporting Blind Rehabilitation Services and Activities.** To supplement the core of BRS care, VHA offers additional supporting services and activities. These include training programs and counseling services for Veterans and their family member or caregiver, including:

(1) **Family Training Program.** The family training program promotes the continued personal development of Veteran's with visual impairment after returning to the home environment. Participants gain a greater understanding of the Veteran's visual impairment and obtain information on how BRS training has impacted the Veteran's adjustment to sight loss and independent function. **NOTE:** *When recommended by the*

rehabilitation team at a BRC, local VA medical facility provides funding for travel and lodging.

(2) **Adjustment Counseling.** BRS provides evaluation, counseling, psychotherapy and consultation for Veterans with visual impairment and provide information and education for family members. These services help promote a healthier emotional state, increased social participation and provide the ability to talk about and understand feelings in a safe and confidential environment.

(3) **Whole Health Education and Counseling.** BRS takes a whole health approach to ensure that Veterans with visual impairment are empowered to take charge of their health and wellness. Veterans are provided with health education and counseling, as appropriate. An interdisciplinary team works together to assure that Veterans with visual impairment are taught health literacy, how to manage and take medications, obtain needed and appropriate exercise and are introduced to and follow healthy eating plans.

c. **Specialized Recreation Therapy Programs.** Recreation therapy provides specialized designed adapted programs such as but not limited to adaptive sports, therapeutic expression, virtual technology, leisure education, lifestyle and community transition and wellness and prevention. Recreation Therapists incorporate patient directed therapy goals to maximize rehabilitation potential, increase independence and sustain a healthy leisure lifestyle integrating the skills learned in treatment settings into the community settings.

d. **Consumer Education.** Veterans are counseled regarding their rights and responsibilities, VA and non-VA benefits and resources for which they may be eligible due to visual impairment. Self-advocacy is promoted to achieve positive outcomes in community reintegration.

e. **Community and Professional Education.** BRS sites serve as a resource to VISNs, VA medical facilities and staff within their catchment area, offering in-service education for professionals, laypersons and internal and external stakeholders to provide a greater understanding of the complexities of visual impairment, the rehabilitation process and achievements of people who are blind.

f. **Issuance of Devices.** Blind Rehabilitation Specialists and Prosthetics and Sensory Aids Service (PSAS) staff collaborate closely to ensure timely processing and issuance of administrative consults. Blind Rehabilitation Specialists may recommend devices within their scopes of practice (or demonstrated discipline-specific competencies) to meet one or more goals for blind/vision rehabilitation care. Veterans with visual impairment must adequately demonstrate the ability to use and care for the device to meet the goal(s) for which the device was recommended.

(1) **Prosthetics Consult.** When requesting device(s), BRS providers are required to provide information to the PSAS staff in the form of an administrative consult via EHR.

(2) **Medical devices.** Medical devices prescribed for a physical/medical condition, unrelated to visual impairment, assessments conducted by the appropriate specialty

clinic or provider (i.e., Cardiology, Audiology, Physical Medicine & Rehab, Respiratory Therapy, etc.) should be documented in the medical record, to include BRS review and selection of the appropriate assistive device. An administrative consult is submitted to PSAS via EHR.

(3) **Optical Low Vision devices.** Optical low vision devices must be prescribed by a licensed eye care provider. **NOTE:** For further information, see paragraph 3.

(4) **Issuance by BRS CoC Program.** For Veterans referred to a BRS Continuum of Care Program, all devices recommended by that CoC program for issuance to the Veteran upon completion of training will be provided by PSAS at the VA institution where the training was provided.

(5) **Returning devices.** Computer assistive technology devices issued to the Veteran becomes the property of the Veteran. Due to the possibility of private and personal information being stored on this device, VA does not recover this device for re-issuance or disposal. Prosthetics devices issued by BRS providers that are no longer beneficial in addressing functional deficits caused by a visual impairment will not be accepted by BRS Continuum of Care programs for re-issuance or disposal.

(6) **Replacement devices.** Devices may be replaced after the BRS clinician determines that it is no longer serviceable due to fair wear and tear, no longer meets the Veteran's stated needs or has been replaced with a new device with advanced technological capabilities.

(7) **Duplicate devices.** Veterans who are issued devices may be authorized duplicate devices when it contributes to the Veteran's individualized treatment plan (i.e., it is required for vocational or avocational activities) as determined by the BRS clinician.

(8) **Repairing devices.** Refer to local VA medical facility PSAS guidance on submitting consults for repairing devices.

(9) **Device set-up.** In instances where a community partner, vendor or third-party assistance is needed to support the home set-up of special electronic devices, cost of set-up and delivery can be arranged and funded by PSAS. Refer to local VA medical facility PSAS guidance on required elements of administrative consult for procurement of devices.

g. **Eye Care Services.** Eye and vision care comprise a spectrum of needs including primary, specialty and surgical eye and vision care services. The VHA National Eye Care Program is the combination of the national divisions of optometry and ophthalmology and is jointly led by the national directors of optometry and ophthalmology within Specialty Care Services (SCS). Patients seen by either optometry or ophthalmology who meet the requirements of low vision or legal blindness need to be referred for low-vision care. A consult is required to optometry at VA medical facilities where ophthalmology is not able to provide this care. In cases where a patient can be referred to a BRS intermediate and low vision clinic, the referral process should follow the guidelines established for the BRS CoC. Veterans with visual impairment and those

with excess disability are to be referred to and enrolled with, a Visual Impairment Services Team (VIST) Coordinator for blind rehabilitation services. Veterans who are legally blind, but retain vision, can benefit from a low-vision evaluation/low vision clinical examination and prescription of low vision devices while waiting to be seen at a VA BRS program. For more guidance, see VHA Directive 1121, VHA Eye and Vision Care, dated October 2, 2019.

h. **VA Medical Facility Logistics and Management Service**. The VA medical facility Logistics and Management Service coordinates with BRS CoC programs to ensure access and availability of stock items. (Refer to local VA medical facility Logistics and Management service for further guidance and processes).

13. BLIND REHABILITATION SERVICES ACADEMIC AFFILIATIONS

BRS is authorized to establish affiliations with colleges and university programs for the advanced training of practicum students and interns in the various professions serving in the field of blind and vision rehabilitation. Branches of learning may include (but are not limited to): O&M, Vision Rehabilitation Therapy, Low Vision Therapy and Computer Assistive Technology. For more information on academic affiliations, see VHA Directive 1400, Office of Academic Affiliations, dated November 9, 2018.

14. RESEARCH

In collaboration with the VA medical facility's Designated Education Officer, the BRS program may conduct significant research that addresses the needs of Veterans with visual impairment and improves clinical programs for blind and visual impairment rehabilitation.

a. BRS promotes rehabilitation research activities and appropriately applies research findings within the clinical setting. This includes participation in research activities directed towards producing relevant, reliable data and best practices.

b. BRS research is always conducted under the auspices of the local Research Service subject to pertinent regulations and guidelines.

c. BRS research, including the preparation and publication of professional papers, is accomplished with policies and procedures as detailed by the VHA Office of Research and Development, available at:

<https://www.research.va.gov/resources/policies/default.cfm>.

15. COMPETENCIES, CERTIFICATIONS AND LICENSES

a. Functional Statement.

(1) The BRS supervisory staff develops discipline-specific and program-specific competencies based on BRS staff members' functional statements as described in Hybrid 38 qualification standards (see VA Handbook 5005 Part II Appendix G109 Blind Rehabilitation Specialist GS-0601 Qualification Standard and VA Handbook 5005 PART

II, G110, Blind Rehab Outpatient Specialist GS-0601 Qualification Standard, Blind Rehabilitation Specialist GS-0601 Qualification Standard) and core competencies that are in accordance with rehabilitation program accreditation guidelines (e.g., CARF) and applicable regulatory standards (e.g., The Joint Commission).

b. Certifications and Licensure.

(1) The Academy for Certification of Vision Rehabilitation & Education Professionals (ACVREP) administers four certifications: Certified Low Vision Therapist (CLVT), Certified Orientation and Mobility Specialist (COMS), Certified Assistive Technology Instructional Specialist (CATIS) and Certified Vision Rehabilitation Therapist (CVRT), (for more information, see: <https://www.acvrep.org>).

(2) Once certified, all Blind Rehabilitation Specialists and Blind Rehabilitation Outpatient Specialists must maintain their full, valid and unrestricted independent certification or license to remain qualified for employment. Loss of certification or license will result in removal from the BRS occupation and may result in termination of employment.

(3) A Blind Rehabilitation Specialist and Blind Rehabilitation Outpatient Specialist who has or has ever had their certification or license revoked, suspended, denied, restricted, limited or issued/placed in a probationary status may be appointed only in accordance with the provisions in VA Handbook 5005, Part II, Chapter 3, Section B, Paragraph 16 of this part.

(4) Individuals appointed on the basis of being licensed as a Social Worker must be licensed or certified by a State to independently practice social work at the master's degree level. **NOTE:** For more information, see *VHA Directive 1110.02 Social Work Professional Practice, dated July 26, 2019*. If appointed as a VIST Coordinator, Social Workers are appointed to the GS-0601 series, but must still maintain a full, valid and unrestricted independent license or certification to remain qualified for employment.

(5) Individuals appointed on the basis of being licensed in other health care occupations must be licensed or certified by a State to independently practice in their field. If appointed as a VIST Coordinator, such individuals would be appointed to the GS-0601 series, but must still maintain their full, valid and unrestricted independent license or certification in their occupation to remain qualified for employment.

c. Competency Based Training and Cross-Training.

(1) Blind Rehabilitation Continuum of Care programs may require additional orientation and training to develop and enhance clinical core competencies.

(2) Competency based training is the on-going acquisition or refinement of skills and knowledge, including job mastery and professional development. The overarching goal is to provide staff with the tools and resources to create and implement comprehensive blind and visual impairment treatment programs which will ensure service delivery excellence to Veterans with a visual impairment.

(3) Cross-training into different skill areas may be provided to BRS staff within professional standards. Blind Rehabilitation programs must assure that staff who are cross-trained are practicing within scope as defined by the profession's credentialing organization.

(4) Clinician core competencies must be reviewed annually by the employee's supervisor.

16. TRAINING

There is no national training required. Local field offices will determine trainings for specific roles that comply with Human Resources requirements.

17. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer. The VA medical facility Logistics Management Services Staff must maintain records of logistics following relevant VA medical facility record-keeping processes.

18. REFERENCES

- a. 38 U.S.C. §§ 1706, 1710.
- b. 42 U.S.C. §§ 416(i), 1382c(a)(2).
- c. 38 C.F.R. §§ 17.36, 17.38, 17.148, 17.149, 17.3200-3250, 17.154
- d. VA Handbook 5005, Staffing, Part II, Appendix G41, Blind Rehabilitation Specialist Qualification Standard GS-0601, dated March 13, 2019.
- e. VA Handbook 5005, Staffing, Part II, Appendix G42 Blind Rehabilitation Outpatient Specialist Qualification Standard GS-0601, dated May 14, 2019.
- f. VHA Directive 1011, Department of Veterans Affairs Liaison for Healthcare Serving Military Treatment Facilities and Public-Private Partnerships, dated May 9, 2022.
- g. VHA Directive 1034, Prescribing and Providing Eyeglasses, Contact Lenses and Hearing Aids, dated October 24, 2019.
- h. VHA Directive 1082, Patient Care Data Capture, dated March 24, 2015.
- i. VHA Directive 1107 VA Fisher Houses & Other Temporary Housing, dated March 10, 2017.

- j. VHA Directive 1110.02 Social Work Professional Practice, dated July 26, 2019.
- k. VHA Directive 1110.04(1), Integrated Case Management Standards of Practice, dated September 6, 2019.
- l. VHA Directive 1121(2), VHA Eye and Vision Care, dated October 2, 2019.
- m. VHA Directive 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs, dated September 23, 2022.
- n. VHA Directive 1172.01, Polytrauma System of Care, dated January 24, 2019.
- o. VHA Directive 1173.06, Wheeled Mobility Devices, dated December 13, 2021.
- p. VHA Directive 1230, Outpatient Scheduling Processes and Procedures, June 1, 2022.
- q. VHA Directive 1400, Office of Academic Affiliations, dated November 9, 2018.
- r. VHA Directive 1400.03, Educational Relationships, dated February 23, 2022.
- s. VHA Directive 1914 Telehealth Clinical Resource Sharing between VA Facilities and Telehealth from Approved Alternative Worksites, dated April 27, 2020.
- t. VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, dated December 22, 2010.
- u. VHA Handbook 1006.02 VHA Site Classifications and Definitions, dated December 30, 2013.
- v. VHA Handbook 1101.11(4), Coordinated Care for Traveling Veterans, dated April 22, 2015.
- w. VHA Handbook 1601B.05, Beneficiary Travel, dated January 20, 2022.
- x. Academy for Certification of Vision Rehabilitation & Educational Professionals at <https://www.acvrep.org/>.
- y. Blind Rehabilitation Product Evaluation form for Applications (Apps) and Blind Rehabilitation Product Evaluation Forms at <https://dvagov.sharepoint.com/sites/VHARehab/brs/1174appendixf/SitePages/Home.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*
- z. Blind Rehabilitation Services SharePoint at <https://dvagov.sharepoint.com/sites/VHARehab/brs/references%20for%20vha%20d%201174%20blind%20and%20visual%20impairm/forms/allitems.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

aa. BRS CVT Stop Code Clinic Guidance at <https://dvagov.sharepoint.com/sites/VHARehab/brs/telehealthvtel/forms/allitems.aspx?rooffolder=%2Fsites%2Frehab%2Fbrs%2Ftelehealthvtel%2Fclinic%20set%2Dup%20and%20coding&folderctid=0x0120009410c59a3c600e45b3e9ff71ed060870&view=%7B335d06c0%2D1f07%2D47c4%2D8c90%2Dc0087a85f6d0%7D>. **NOTE:** This is an internal VA website that is not available to the public.

bb. Commission on Accreditation of Rehabilitation Facilities (CARF) at <https://vaww.qps.med.va.gov/divisions/qm/ea/carf.aspx>. **NOTE:** This is an internal VA website that is not accessible to the general public.

cc. Optometric Clinical Practice Guideline: Care of the Patient with Visual Impairment (Low Vision Rehabilitation) at <https://www.aoa.org/AOA/Documents/Practice%20Management/Clinical%20Guidelines/Consensus-based%20guidelines/Care%20of%20Patient%20with%20Visual%20Impairment%20%28Low%20Vision%20Rehab%29.pdf>.

dd. Telehealth Service Agreement example per Telehealth Services SharePoint at https://dvagov.sharepoint.com/:w:/r/sites/VHA-Telehealth/layouts/15/Doc.aspx?sourcedoc=%7BCF1532AB-963D-4C98-9741-B01497B5CF4D%7D&file=th-sagr_June%202020.docx&wdLOR=cA31F0159-5E8E-4C4C-888C-0AE189942033&action=default&mobileredirect=true. **NOTE:** This is an internal VA website that is not available to the public.

ee. VA Telehealth (See <http://www.telehealth.va.gov> and <http://vaww.telehealth.va.gov>). **NOTE:** The VHA Telehealth Services website is an internal VA website that is not available to the public.

ff. VHA Office of Quality, Safety & Value and Division of External Accreditation Services & Programs at <https://vaww.qps.med.va.gov/divisions/qm/ea/carf.aspx>. **NOTE:** This is an internal VA website that is not accessible to the general public.

gg. VHA Office of Research and Development Policies and Guidance Documents at <https://www.research.va.gov/resources/policies/default.cfm>. **NOTE:** This is an internal VA website that is not accessible to the general public.

STEP BY STEP DECISION MAKING PROCESS FOR VETERANS IN THE BLIND REHABILITATION SERVICE CONTINUUM OF CARE

1. BACKGROUND

a. The Blind Rehabilitation Service (BRS) Lifetime Case Management process models described in this document, depict the business processes followed by members of the Blind Rehabilitation Services staff, as they do case management and provide assessment, training, devices and services to Veterans with a visual impairment.

b. The use of the word business, as in business process or business information, is meant to differentiate these processes from information technology processes and workflows. The BRS processes described in this document, show what a Visual Impairment Services Team (VIST) Coordinator does to assess and refer a Veteran or what a specialist does when training a Veteran or what a provider does to determine the degree of visual impairment.

c. There is a total of five BRS diagrams, each of which depicts a different workflow and may involve multiple providers, in the execution of the business process. These diagrams depict the providers, activities, decisions and the flow of information throughout the processes.

2. THE FIVE BLIND REHABILITATION SERVICES LIFETIME CASE MANAGEMENT PROCESS MODELS

The five Blind Rehabilitation Service Continuum of Care process models are listed below:

a. **Number one.** Provide Blind Rehabilitation Services to Visually Impaired Veterans, High-Level.

b. **Number two.** Refer to the Department of Veterans Affairs (VA) Intermediate Low Vision Clinic (ILVC) or Advanced Low Vision Clinic (ALVC), Visual Impairment Center to Optimize Remaining Sight (VICTORS).

c. **Number three.** Refer to VA Visual Impairment Services in Outpatient Rehabilitation, Visual Impairment Services Outpatient Rehabilitation (VISOR) Program.

d. **Number four.** Refer to VA Blind Rehabilitation Outpatient Services Program.

e. **Number five.** Refer to VA Inpatient Blind Rehabilitation Center.

For a detailed overview of the five processes, see
<https://dvagov.sharepoint.com/sites/VHAREhab/brs/references%20for%20vha%20d%20>

April 19, 2021

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APPENDIX A

[1174%20blind%20and%20visual%20impairm/forms/allitems.aspx](#). **NOTE:** *This is an internal VA website that is not available to the public.*

BLIND REHABILITATION NATIONAL DATABASE

1. DESCRIPTION

The Blind Rehabilitation (BR) National Database is a tool for identification, care coordination, referral and reporting services provided to Veterans with a visual impairment served by Department of Veteran Affairs (VA) Blind Rehabilitation Service (BRS). The database enables program managers and staff to monitor and report on referral and wait times for various BRS programs.

2. REQUIRED USE

The BR National Database is mandated for use by all BRS program types including Visual Impairment Services Team (VIST) Coordinators, Blind Rehabilitation Centers (BRC), Blind Rehabilitation Outpatient Specialists (BROS), Intermediate Low Vision Clinics (ILVC), Advanced Low Vision Clinics (ALVC), Visual Impairment Center to Optimize Remaining Sight (VICTORS) and Visual Impairment Services Outpatient Rehabilitation (VISOR) programs. Failure to properly utilize BR National Database may result in local disciplinary action.

3. BRS PROGRAM REFERRALS

All BRS program types must utilize the BR National Database to create, modify and complete referrals to VA BRS programs as well as non-VA blind rehabilitation programs for which VA is providing funding or assistance. The referral status must be modified to completed once a Veteran is discharged from a BRC or training is completed for all other referral types. A new BRS referral must be entered for each new episode of care.

a. **Blind Rehabilitation Center Referrals.** Primarily created by the local VIST Coordinator but can be created by any BRS program staff to a BRC, including the BRC referring to the local BRC program.

b. **Blind Rehabilitation Outpatient Services Referrals.** Primarily created by the local VIST Coordinator or the BROS but can be created by any BRS program staff to a BROS program, including the BROS staff member referring to their local BROS program.

c. **Non-VA Referrals.** Primarily created by local VIST Coordinator or BROS but can be created by any BRS program staff to a non-VA program.

d. **Intermediate Low Vision Clinic Referrals.** Primarily created by local ILVC staff and VIST Coordinator but can be created by any BRS program staff to an Intermediate Low Vision Clinic program.

e. **Advanced Low Vision Clinic Referrals.** Primarily created by local ALVC staff and VIST Coordinator but can be created by any BRS program staff to an Advanced Low Vision Clinic program.

f. **Visual Impairment Services Outpatient Rehabilitation Referrals.** Primarily created by VISOR staff and VIST Coordinator but can be created by any BRS program staff to a VISOR program.

4. RESPONSIBLE STAFF

a. **Visual Impairment Services Team Coordinators.** In addition to referrals, all VIST Coordinators must utilize the BR National Database to identify and manage cases for all Veterans who are legally blind, visually impaired, have low vision or have excess disability needing comprehensive blind rehabilitation using the BR Patient option in the BR National Database. Newly identified Veterans with visual impairment will be added to the local VIST Roster and complete an initial VIST Review. Veterans with visual impairment on the VIST Roster will be offered a VIST Review, at a minimum annually, and will be updated to reflect overall current status. The VIST Review findings and all referrals for blind rehabilitation/low vision training will be documented in BR National Database.

b. **Blind Rehabilitation Outpatient Services.** All BROS must utilize the BR National Database to create, modify and complete referrals to the local BROS program.

c. **Blind Rehabilitation Centers.** Designated management and admissions staff at all BRC programs must utilize the BR National Database to effectively manage BRC referrals for all Veterans. When appropriate, the BRC staff may create referrals to the BRC or another BRC. Veterans with visual impairment admitted to a BRC program will receive coordinated care by designated staff at the BRC program until successful case handoff upon discharge to another BRS program.

d. **Outpatient BRS Programs (Intermediate Low Vision Clinic, Advanced Low Vision Clinic and Visual Impairment Services Outpatient Rehabilitation Program).** All Outpatient BRS Continuum of Care programs must utilize the BR National Database to create, modify and complete referrals to the local low vision clinic program. BRS CoC program staff will serve all VIST Roster patients, determined to need blind rehabilitation services. Veterans with visual impairment participating in a BRS CoC program will receive coordinated care by designated staff at the BRS CoC program until successful case handoff upon discharge to another BRS program.

5. DOCUMENTATION

The BR referral option must be utilized to document and track all referrals, waiting times for service and VIST Reviews. The official VA patient's electronic health record will be used to document all patient encounters (Refer to Paragraph 11 Blind Rehabilitation Services Episodes of Care).

6. BLIND REHABILITATION REFERRAL OPTIONS

<u>Referral Type</u>	Description
BRC CAT	Veteran needs Computer Assistive Technology (CAT) instruction only.
BRC DUAL Program	Veteran needs both REGULAR and CAT instruction during the same admission period.
BRC OTHER Programs	Veteran needs a special or focused program (e.g., power mobility, GPS, tandem biking) at the BRC that is not considered a regular or CAT type program.
BRC REGULAR Program	Veteran needs a full regular program of instruction in all skill areas, not including CAT.
BROS Follow-up	Veteran needs follow-up services from BROS following post-discharge from a BRS program.
BROS-Local	Veteran needs evaluation and training in their home area or as an outpatient at a VA medical facility.
BROS Prep	Veteran needs evaluation and/or training services from BROS in preparation for admission to a BRS program.
Non-VA Blindness Agency	Veteran needs evaluation and/or training services from a non-VA blindness agency or provider. These only need to be tracked if VA is providing funding or if the agency is providing services as part of a specific VA treatment plan, but without VA funding (i.e. guide dog training).
Non-VA Local CAT	Veteran needs CAT from a non-VA agency or provider that VA is providing funding to cover cost.
VA Outpatient LV Clinic	Veteran needs low vision services from the regional Intermediate Low Vision Clinic.
VICTORS	Veteran needs comprehensive low vision services from the regional Advanced Low Vision Clinic and/or VICTORS.
VISOR	Veteran needs comprehensive low vision and/or rehabilitation services from a regional VISOR program.

<u>Referral Type</u>	Description
VIST Coordinator	Used for care coordination transfer or warm hand-off from another provider.
<u>Definitions</u>	
1st Experience	Use 1 st Experience referral type if this is Veteran's first experience with that program type. For example, Veteran has never participated in a BRC program in the past.
Additional Training	Use Additional Training referral type if Veteran has participated in 1 or more of that referral type in the past. For example, Veteran was seen by a BROS in a prior year, for a new BROS referral use the Additional Training option.

7. LEGEND FOR BLIND REHABILITATION CENTER APPLICATION (REFERRAL) STATUS

Status	Description
<u>Pending</u>	No action taken on BRC application. NOTE: The BRC application must determine acceptance within 7 calendar days.
<u>In Review</u>	Compiling information for determination of acceptance.
<u>Accepted</u>	The patient medically approved and accepted for admission to the BRC. NOTE: The BRC application must determine acceptance within 7 calendar days.
<u>Offered</u>	BRC contacts patient and offers next available admission date. If patient accepts the future admission date, the offered date is recorded and the status indicated as YES. If patient declines the next available admission date, the declined status and date are recorded and the status will remain Offered. The patient is then offered another future admission date and the process repeats. BRCs may cancel the application of any Veteran who declines three offers of admission to the BRC within a 28 day calendar period. In certain circumstances, this window may be expanded to 60 calendar days to address Veteran preference.
<u>Scheduled</u>	Agreed upon, scheduled future date of patient's arrival for care. NOTE: Admission to the BRC is expected within a 28 calendar day period. In certain circumstances, this window may be expanded to 60 calendar days to address Veteran preference.

Status	Description
<u>Admitted</u>	Date the patient is admitted to BRC for service.
<u>Discharged</u>	Date the patient discharged from BRC. NOTE: Discharge status must be updated in BR 5 National Database within 3 business days.
<u>Cancelled</u>	Referral was cancelled by BRC.
<u>Withdrawn</u>	Veteran unable to attend, application withdrawn.

8. LEGEND FOR BLIND REHABILITATION OUTPATIENT CLINICS APPLICATION (REFERRAL) STATUS

Status	Description
<u>Pending</u>	No action taken on referral. NOTE: <i>Outpatient scheduling requires action within 3 business days.</i>
<u>In Review</u>	Awaiting acceptance of referral.
<u>Accepted</u>	The Veteran is approved and accepted for evaluation/training.
<u>Offered</u>	First date of service offered.
<u>Scheduled</u>	Actual care scheduled date. NOTE: <i>The scheduled in-training is expected within a 28 calendar day period. In certain circumstances, this window may be expanded to 60 calendar days to address Veteran preference.</i>
<u>In Training</u>	Actual date of 1 st appointment in clinic.
<u>Completed</u>	Date that all care and training was completed.
<u>Cancelled</u>	Referral was cancelled by clinic.
<u>Withdrawn</u>	Veteran unable to attend, application withdrawn.

BLIND REHABILITATION CENTER ADMISSION GUIDELINES

Blind Rehabilitation Service (BRS) typically generates referrals for Veterans with visual impairment for admission to Blind Rehabilitation Centers (BRC) based on the date the approved application was received. However, in response to Veterans' safety considerations and other emergent needs, each BRC has the authority to accept applicants to BRC and offer admission as deemed appropriate.

1. BLIND REHABILITATION CENTER STANDARD ADMISSION GUIDELINES

a. Pre-Admission BRC Referral Documentation.

(1) The Blind Rehabilitation (BR) National Database is used to calculate and report BRC wait times for admission to BRC inpatient training programs.

(2) If the Veteran or Servicemember has been evaluated or trained by a Blind Rehabilitation Outpatient Specialists (BROS) or other specialist in preparation for admission to the BRC, any pre-admission evaluations, assessments and training reports are documented in the BR National Database for the admitting BRC program to review.

(3) A completed BRC application must include a comprehensive Visual Impairment Services Team (VIST) Review and physical examination from the applicant's primary care physician (within the last 12 months) and an ocular health exam (within the last 12 months).

(4) Referrals of Service members are submitted by program care coordinators at military treatment facilities or polytrauma rehabilitation centers and follow the procedures outlined in the current Memorandum of Agreement established by the Department of Veterans Affairs (VA) and Department of Defense (DoD).

b. Admission Review.

(1) The presence of complicating medical or mental conditions does not preclude Veterans or Service members from participating in BRCs. To maximize benefit from the program, specific conditions that may adversely affect Veterans involvement (e.g., acute medical conditions, post-stroke rehabilitation, current alcohol or drug abuse, amputation with planned prosthesis, need for assistive listening devices) can be addressed by the referring VA medical facility before admission to the BRC.

(2) Veterans with visual impairment cannot be denied admission to a BRC based solely upon residential status, homelessness status, length of current abstinence from alcohol or non-prescribed controlled substances, the number of previous treatment episodes, the time interval since the last residential admission, the use of prescribed controlled substances or legal history. The screening process must consider each of

these special circumstances and determine whether the program can meet the individual Veteran's needs while maintaining the program's safety, security and integrity.

(3) Referral to the most appropriate BRC setting may be considered in consultation with the affected BRCs. The VIST Coordinator is responsible for notifying the BRC Service Chief of the referral and documenting it in the electronic health record and BR National Database as a historical note.

(4) Veterans with visual impairment who are hospitalized may be transferred directly to a BRC when medical transfer is indicated and when the Veteran or Servicemember is able to participate in the BRC Program.

(5) The BRC notifies the referring VIST Coordinator when additional information is needed in order to confirm the appropriateness of the Veteran or Servicemember for the program. If information is not provided in the designated timeframe, the application is considered incomplete and returned to the VIST Coordinator. (**NOTE: Admission to the BRC is expected within a 28 calendar day period. In certain circumstances, this window may be expanded to 60 calendar days to address Veteran preference.**)

(6) **BRC Independence Levels.** The BRC Independence levels are categorized as follows:

(a) Minimum Assistance. Application by a caregiver of support or assistance at a single point of contact to enable a Veteran to perform an activity safely. The Veteran with visual impairment expends at least 75% of the effort; the caregiver, 25% or less. Verbal prompting and help with set-up such as assisting with meals (tray set up), limited assistance with dressing such as buttoning a shirt, standby while transferring is included in this category.

(b) Moderate Assistance. Application of support or assistance at two points of contact by one or more people to enable a Veteran with visual impairment to perform a desired activity safely; caregivers supply 25-75% of needed effort. Stand by assist with meal preparation, assisting more with dressing, help with bathing, physical help transferring from bed to chair is included in this category.

(c) Maximum Assistance. Total care for a Veteran with visual impairment where the Veteran contributes less than 25% or is unable to complete the task and requires complete assistance. Hands on assistance with eating, grooming, bathing, dressing, toileting and setting up Continuous Positive Airway Pressure (CPAP)/O2 (changing tanks), ostomy care and physical help transferring from bed/chair/wheelchair/toilet/ambulance, etc. is included in this category.

c. Accepted Applications.

(1) Applications that have been accepted to a BRC require an update in BR National Database to reflect accepted status. Adding each accepted application to the BRC waiting list and informing the Veteran of this decision by letter and in their preferred

format. The letter must include an estimated waiting time for admission, as well as any cost that may be incurred by the Veteran. A courtesy copy of this letter must be forwarded to the Veteran's VIST Coordinator. This includes providing information regarding the Veteran's program and estimated duration of training.

(2) Forwarding required documents to the Eligibility Coordinator at the VA medical facility where the program is located.

(3) The BRC must provide the Veteran or Servicemember and their Health Insurance Portability and Accountability Act (HIPAA)-authorized representatives (e.g., significant other, caretakers), as appropriate, scheduled for admission with appropriate information concerning program expectations, Veteran's stay and rehabilitation care, what to bring, patient advocacy process and any pertinent local information/policies.

(4) The applicant and the BRC must mutually agree upon the reporting date and travel arrangements. The referring VIST Coordinator (and BROS where applicable) must be notified of these arrangements. **NOTE:** For more information on Veteran travel benefits, refer to VHA Handbook 1601B.05, *Beneficiary Travel*, dated July 23, 2010.

d. Admission.

(1) At any point during a BRC admission, if the admitted Veteran experiences an emergent disruption in their ability to fully engage in the rehabilitation plan, the Veteran's treatment team will apply clinical judgment in determining whether to continue the treatment plan or to discharge the Veteran for treatment of the emergent disruption.

(2) Veterans cannot, while admitted to a BRC program, be under the influence of alcohol, narcotics, amphetamine or any un-prescribed substance. Utilization of contraband can put the Veteran's safety at risk and interferes with their ability to benefit from a rehabilitation program. In such cases, the Veteran will be discharged from the BRC, but may reapply for a future BRC admission.

e. Cancellations.

(1) Cancelled applications require notification from the BRC to the Veteran or Servicemember, with a courtesy copy to the referring VIST Coordinator. This notification must provide the rationale for the cancellation along with a recommendation to consult the VIST Coordinator regarding alternative services.

(2) BRCs may cancel the application of any Veteran who declines three offers of admission to the BRC within a 28 calendar day period. In certain circumstances, this window may be expanded to 60 calendar days to address Veteran preference. The applicant must be advised to reapply through the VIST Coordinator when ready to attend.

(3) If the BRC is unable to contact the Veteran within the 28-calendar day scheduling period, the BRC admission coordinator must attempt to establish contact with the

Veteran via official letter. If the Veteran is still unresponsive in 14 calendar days, the BRC will then cancel the application.

2. PRIORITY OF CARE ADMISSION

a. **Urgent Need Considerations.** BRS staff may also consider the following issues when determining whether to refer a Veteran to a BRC and in determining the Veteran's priority for admission to BRC.

(1) **Safety and medical issues.** If prompt blind rehabilitation is needed to address health or safety issues, the BRC must expedite admission.

(2) Lack of or sudden loss of, a caregiver.

(3) Vocational needs (e.g., attending school, obtaining or keeping employment).

(4) Direct patient transfer.

b. **Blind Rehabilitation Outpatient Services.** When priority of care admission is requested, the BRC refers the applicant to the referring VIST Coordinator to make every effort to arrange for BROS or other local blind rehabilitation services to address the Veteran's pressing needs. The application stays on the waiting list during this period.

c. **Bed Census.** If admission to a BRC is needed in order to maintain bed census, the BRC may give priority to Veterans with visual impairment who are willing to be admitted on short notice.

d. **Calculation of BRC Wait Times.** The waiting time for admission to a BRC is defined as the number of days between the date a referral is received at a BRC and the actual admission date of the applicant. The Blind Rehabilitation Service (BRS) National database is used to calculate the number of days waiting.

BLIND REHABILITATION SERVICES LEVELS OF CARE COORDINATION

The Blind Rehabilitation Service (BRS) Continuum of Care (CoC) offers cascading levels of care coordination to all Veterans with visual impairment enrolled in the BRS CoC. BRS Care Coordination provides structured systems support to complement the blind and visual impairment rehabilitation care offered in BRS. Before, during and after the episode(s) of care to the eligible Veteran or Servicemember, the Visual Impairment Services Team (VIST) Coordinator is responsible for determining and implementing one of four levels of BRS Care Coordination – Complex, Moderate, Basic or Lifetime. Each model requires varying degrees of intervention based on the clinical and psychosocial needs of each Veteran and is not based solely on visual acuity.

1. COMPLEX LEVEL OF CARE COORDINATION

It is suggested for Complex Level of Care Coordination management to occur at a minimum of a monthly basis. Veterans with visual impairment are often referred to VIST Coordinators because they experience a problem that impedes their ability to manage and accomplish functional tasks and because they are facing a daunting adjustment to living with visual impairment. VIST Coordinators provide a thorough assessment to plan the intervention and rehabilitation goals with Veteran and family. Education and support for the Veteran's family and significant others is critical during this phase. Veterans placed in Complex Level of Care Coordination may be experiencing circumstances to include, but not limited to, the following:

- a. Transfer of care to a different Department of Veterans Affairs (VA) medical facility.
- b. Veteran or family/caregiver relocation.
- c. Referrals to specialty programs (e.g., Day Treatment, Compensated Work, Therapy, community re-entry program).
- d. Change in social support system (e.g., caregiver stress, divorce, decline in support system, death of an important person in the Veteran's life, loss of job, new employment).
- e. Newly identified health problems (e.g., depression, post-traumatic stress, substance abuse, wound care, metabolic disease) or behavioral changes.
- f. Significant change in medical status and functional decline.
- g. Change in living arrangements, such as admission to assisted living or a skilled nursing facility.
- h. Transfer to another facility for blind or low vision services (inpatient Blind Rehabilitation Center (BRC) or outpatient blind/vision rehabilitation clinic).

2. MODERATE LEVEL OF CARE COORDINATION

It is suggested for Moderate Level of Care Coordination to occur on a quarterly basis. This level of care is implemented when a Veteran with visual impairment no longer requires Complex Level of Care Coordination and transition is to a quarterly follow-up, at a minimum. Education and support for the Veteran's family and significant others remains essential during this phase. Examples of issues that may require care coordination during this phase include:

- a. Ensuring access and coordination of care by monitoring progress on referrals for benefits review, vocational rehabilitation and community agencies and resources.
- b. Facilitating community re-integration.
- c. Applying for home modifications and adaptive automobile equipment.
- d. Counseling for adjustment issues.

3. BASIC LEVEL OF CARE COORDINATION

Basic Level of Care Coordination should occur on a semi-annual basis. This level of care is implemented at the point the individual no longer requires Moderate Level of Care Coordination. This phase may consist of an in-person or telephone follow-up with Veteran and family. Examples of circumstances that may require care coordination during this phase include:

- a. Veterans well established in the BRS CoC with stable medical, psychosocial and visual impairment issues.
- b. Ongoing issues related to BRS, such as replacement and repair of prosthetic device(s).
- c. Monitoring progress toward goals established in earlier phases of rehabilitation, evaluating of goals for completion or adjusting goals.

4. LIFETIME CARE COORDINATION

Lifetime Care Coordination should occur on annual basis, at a minimum. This level of care provides ongoing follow-up and review that may be completed annually or bi-annually depending upon the Veteran's goals. This level of care must be implemented at the point that the individual no longer requires Basic Level of Care Coordination and may extend for the remainder of the Veteran's life if the Veteran continues to benefit and is agreeable to receiving VIST services. Care coordination during this phase requires a VIST Review (Refer to Paragraph 7 Visual Impairment Services Team Coordinator Review).

- 5.** It is a best practice to conduct VIST Reviews via face-to-face or utilizing telehealth. VIST Reviews conducted by telephone are acceptable after exhausting all avenues for face-to-face encounters.
- 6.** At all levels of care coordination, the Veteran's case is reviewed and documented in the Blind Rehabilitation National Database and electronic health record (EHR) to include a VIST Review summary.
- 7.** Depending on the circumstances, the length of time the Veteran is kept in a specific level of care varies and is dependent upon the goals and objectives established by the Veteran (and significant others, when appropriate).

HIRING AND PROMOTION OF BLIND REHABILITATION SPECIALISTS

1. Blind Rehabilitation Specialists are Hybrid Title 38 GS-0601 series professionals. The hiring and promotion of these employees are in accordance with VHA Hybrid Title 38 qualification standards. These standards may be found at:

http://vawww.va.gov/ohrm/Directives-Handbooks/Direct_Hand.htm. **NOTE:** *This is an internal VA website that is not available to the public.*

2. Accurate classification of an individual provider based on the person class code is required in order to ensure correct workload and productivity. Blind Rehabilitation Specialists, including Visual Impairment Services Team (VIST) Coordinators, are assigned the following:

- a. Person Class: V130206.
- b. Person Class Description: Specialist/Technologist Rehabilitation, Blind.
- c. NUCC Taxonomy Code X12Code: 2255R0406X.

BLIND REHABILITATION SERVICE GUIDELINES FOR EVALUATION OF EMERGING TECHNOLOGY

1. It is the responsibility of each Blind Rehabilitation Services (BRS) provider and program to evaluate various aids, devices, appliances and technologies to determine their clinical effectiveness for Veterans with visual impairment and recommend inclusion and exclusion criteria for use. Veterans with visual impairment must be provided the most appropriate prosthetic devices to assist in the rehabilitation process to compensate for the sensory loss of vision.

2. While each BRS Continuum of Care (CoC) program will have established policy and procedures for evaluating new and upgraded technology, the following components of product evaluations must be implemented by BRS staff:

a. Staff will continuously monitor the prosthetic devices in the areas in which they provide treatment to ensure that the prosthetic devices that are being issued are current and appropriate in relation to the prosthetic devices that are commercially available. BRS providers will monitor any upgrades to or a new model of currently stocked devices, similar device from a different manufacturer or a brand-new device identified as having potential for incorporation into any of the treatment areas.

b. The National BRS Product Evaluation website will be reviewed to see if there has been any information entered on the device.

c. If the device is an upgraded version of a device currently in stock, a product evaluation form is completed only if the device is significantly different from the current device in inventory.

d. BRS providers who will be providing therapeutic instruction on the device will receive appropriate training to include issuance criteria, core competencies and pertinent protocols.

e. Training materials developed by the manufacturer may be utilized by the BRS Continuum of Care program with appropriate additions, deletions or modifications of training to meet the individualized needs of the Veteran.

f. New or upgraded devices that are being evaluated will not be shown to Veterans without the express permission of the supervisor.

g. If the device is not going to be established as a prosthetic, the evaluation form is completed and filed without any further action required.

3. For Blind Rehabilitation Product Evaluation form for Applications (Apps) and Blind Rehabilitation Product Evaluation Forms, see <https://dvagov.sharepoint.com/sites/VHAREhab/brs/1174appendixf/SitePages/Home.aspx>. **NOTE:** This is an internal VA website that is not accessible to the general public.

4. The BRS Continuum of Care (CoC) providers develop best practices that strengthen and enhance therapeutic instructional programs. BRS CoC providers partner with BRS National Program Office, PSAS National Program Office and other supporting services, as appropriate, to develop training programs and clinical protocols for issuance and training of devices.

TELEHEALTH SERVICES WITHIN THE BLIND AND VISUAL IMPAIRMENT REHABILITATION CONTINUUM OF CARE

This appendix provides guidance and general information on the application of Telehealth Services as part of the Blind and Visual Impairment Rehabilitation Continuum of Care (CoC).

1. TELEHEALTH DEFINITIONS

The following definitions are not an exhaustive resource on the Department of Veterans Affairs (VA) Telehealth and are only meant to serve as key definitions.

a. **Telehealth.** Telehealth (telemedicine) is the use of electronic information or telecommunications technologies to support clinical health care, patient and professional health-related education, public health or health administration at a distance.

b. **The Telehealth Conditions of Participation.** The Telehealth Conditions of Participation (COP) are the VA's nationally defined quality standards for the clinical, business and technology components of telehealth services. **NOTE:** *The conditions of participation can be accessed on the VHA telehealth website, located at <https://vawww.infoshare.va.gov/sites/telehealth/docs/sop-std-sa.docx>. NOTE: This is an internal VA website that is not available to the public.*

c. **Telehealth Health Care Professional.** For the purposes of this directive, telehealth health care professionals include all health care providers who provide patient care and related health care services via telehealth.

d. **Home Telehealth.** Home Telehealth (HT) is a remote patient monitoring program into which beneficiaries are enrolled that provides ongoing assessment, monitoring and case management of beneficiaries in their residential environment (or their environment of choice).

e. **Secure Messaging.** Secure Messaging is a web-based, encrypted, secure communication tool available through MyHealthVet. Secure messaging allows participating patients and BRS professionals to communicate non-urgent, health related information through a private and secure electronic environment. **NOTE:** *To participate in secure messaging, users need to have a MyHealthVet account; see www.myhealth.va.gov.*

f. **Telehealth Service Agreement.** Telehealth Service Agreement (TSA) defines the clinical, technical and business requirements for a telehealth clinical service. TSAs include the contingency and emergency plans for the clinical service. **NOTE:** *An example TSA can be found on the Telehealth Services website at https://dvagov.sharepoint.com/sites/VHA-Telehealth/docs/th-sagr_June%202020.docx?d=wcf1532ab963d4c989741b01497b5cf4d. This is an*

internal VA website that is not available to the public. A TSA is distinctly different from and in addition to, the Telework Agreement requirements outlined in VA Handbook 5011/26, Hours of Duty and Leave, part 2, Chapter 4, dated August 9, 2013.

2. BLIND REHABILITATION SERVICES TELEHEALTH

a. VA strives to provide “the right care, in the right place, at the right time,” through effective, cost-effective and appropriate use of health information and telecommunications technologies. Blind Rehabilitation Services (BRS) telehealth expands access to care by providing rehabilitation service in or near the Veteran’s home (e.g., community-based outpatient clinics). For Veterans with visual impairment, BRS telehealth provides a supplement to face-to-face care, enhancing support to the Veteran and creating an overall positive experience.

b. BRS Telehealth program requirements and eligibility criteria are determined by local program staff with VA medical facility/Veterans Integrated Service Network (VISN)/BRS National Program Office oversight and are outlined in the Facility Telehealth Service Agreement. A BRS professional may determine to use Telehealth to provide assessment, intervention, consultation, care coordination, advocacy and educational interventions. Ultimately, the BRS professional is responsible for determining whether the Veteran and/or intervention is appropriate for BRS Telehealth services.

c. **Prior to the encounter.** All VA Video Connect encounters require that certain resources and information be obtained prior to the encounters. These resources include the Veteran’s phone number, the Veteran’s present location and address, the name and phone number of the Veteran’s emergency contact and contact information for emergency services local to the Veteran. It must also be verified that the Veteran is in a private and safe location.

(1) BRS telehealth encounters are conducted using real-time videoconferencing, termed Clinical Video Telehealth (CVT). A BRS Primary Stop code supplemented with a Telehealth stop code, must be used for an BRS Telehealth clinic. BRS and Telehealth codes will vary depending on BRS clinics and if the visit is in the home, within the VA medical facility/station or outside the VA medical facility/station. Additional information on clinic set up and coding can be found on BRS SharePoint site: BRS CVT Stop Code Clinic Guidance, available at <https://dvagov.sharepoint.com/sites/VHARehab/brs/telehealthvtel/forms/allitems.aspx?rootfolder=%2Fsites%2Frehab%2Fbrs%2Ftelehealthvtel%2Fclinic%20set%2Dup%20and%20coding&folderctid=0x0120009410c59a3c600e45b3e9ff71ed060870&view=%7B335d06c0%2D1f07%2D47c4%2D8c90%2Dc0087a85f6d0%7D>. **NOTE:** *This is an internal VA website that is not available to the public.*

d. **BRS Programs Primary Stop Codes.**

(1) Blind Rehabilitation Centers: 218.

(2) VIST Coordinators: 209.

(3) Blind Rehabilitation Outpatient Specialist: 217.

(4) Outpatient Clinics.

(a) Intermediate Low Vision: 438.

(b) Advanced Low Vision: 437.

(c) VISOR: 220.

e. Telehealth Secondary Stop Codes.

(1) Patient site: 690.

(2) Provider site: 692, same VA station number.

(3) Provider site: 693, different VA station numbers.

(4) CVT into the home: 179.

(5) CVT to non-VA providers (vendors/community providers): 648.

Table 1: VA Video Connect Business Rules

Clinical Pathway	Clinical Use Case	Definition of Visit	Documentation	Telehealth Stop Code	Agreements
Mobile/ Home	VVC On Demand	On Demand* post scheduled face-to-face visit or Scheduled Video Visit	Addendum to scheduled face-to-face or video visit note. Uses template for security verification	None	No Telehealth Service Agreement (TSA)
	VCC On Demand	On Demand Video Visit only	TeleClinic; use template for verification	179	No TSA a one-time visit for follow up of walk-in or other same day use case.
	VVC Scheduled	Scheduled Visit	TeleClinic** with complete note, use template for security	179	TSA needed and sent to Administration (ADM) for notification all

Clinical Pathway	Clinical Use Case	Definition of Visit	Documentation	Telehealth Stop Code	Agreements
			verification documentation		managed by Telehealth Management Platform (TMP)
Clinic Based	VVC connecting from clinic to clinic	Scheduled Visit in TMP	TeleClinic** with complete note	690/692, 693, 699	TSA with approval. Emergency Contact all managed by TMP
VVC Site to Site	VVC connection from site to site. Example: VA to non-VA; Provider to ER; Provider to Acute Care	Non-scheduled and scheduled visits using TMP Phone book	TeleClinic with complete note	690/ 692, 693, 699, 648	TSA with approval for non-urgent visits. Emergency Contact all managed by TMP

f. Following the encounter, Provider Current Procedural Terminology (CPT) codes are the same as face to face codes and are based on evaluation/treatment provided.

g. When two appointments are needed; Interfacility and Intrafacility (using 692/690 and 693/690) encounters includes provider using face to face CPT code(s) and patient site using Healthcare Common Procedure Coding System (HCPCS) code for telehealth facility fee Q3014 as the procedure code.

h. The primary diagnosis code must match that of the provider site.

(1) Additional Telehealth coding and billing guidance available online at: https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/content/554400000050170/Section-A-Telehealth-Reasonable-Charges-and-Billing#3.%20Telehealth%20Coding%20and%20Billing.

NOTE: This is an internal VA website that is not available to the public.

(2) Additional information on Telehealth Business Rules for VA Video Connect is available at: <https://dvagov.sharepoint.com/sites/VHARehab/brs/1174appendixg/SitePages/Home.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

i. **Additional Telehealth Resources.**

(1) VHA Directive 1914, Telehealth Clinical Resource Sharing Between VA Facilities and Telehealth from Approved Alternative Worksites, dated April 27, 2020.

(2) Connected Care/Telehealth Manual, available at: <https://dvagov.sharepoint.com/sites/VHA-Telehealth/docs/th-mnl.pdf>. **NOTE:** *This is an internal VA website that is not available to the public.*

(3) TeleRehabilitation Supplement, available at: <https://dvagov.sharepoint.com/sites/VHA-Telehealth/docs/tblnd-spp.pdf>. **NOTE:** *This is an internal VA website that is not available to the public.*

(4) Master Document Library, available at: <https://dvagov.sharepoint.com/sites/vha-telehealth/docs/forms/allitems.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

(5) TeleRehabilitation Documents, available at: <https://dvagov.sharepoint.com/sites/vha-telehealth/docs/forms/trehb.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

(6) TeleRehabilitation Contacts, available at <https://dvagov.sharepoint.com/sites/vha-telehealth/lists/leads/trh.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

(7) Blind TeleRehabilitation Contacts, available at <https://dvagov.sharepoint.com/sites/vha-telehealth/lists/leads/tblnd.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

BLIND REHABILITATION CENTER PROGRAMS

BRS programs provide a model of care that extends from the Veteran's home to the local Department of Veterans Affairs (VA) care site, regional low vision clinics and inpatient training programs. A Blind Rehabilitation program is designed to provide Veteran's specialized rehabilitation and adjustment skills to enable them to return to an independent, safe and successful lifestyle. **NOTE:** *Programs mentioned in this appendix may be offered on an outpatient basis, where deemed appropriate.*

1. BLIND REHABILITATION INPATIENT PROGRAM

Blind and Visual Impairment rehabilitation is patient-centered and interdisciplinary, developing and deploying integrated plans of care that address the Veterans' needs and goals to guide service delivery. The setting of the Blind Rehabilitation Center (BRC) maximizes the opportunity for Veterans with visual impairment to interact and support one another in an atmosphere free from attitudinal judgment and isolation. This peer interaction, along with the comprehensive training program, allows participants to envision a positive future, function effectively and comfortably and strive to achieve their best level of independence. Family members, included as members of the team, are provided with education and training that allows them to understand visual impairment and provide support for goal achievement. BRS personnel evaluate and determine best practices for selecting, training and providing Veterans with cutting-edge technology. Veterans participate in a comprehensive treatment plan based on Veteran's expressed goals and clinical assessments, which includes: Orientation & Mobility (O&M), Activities of daily living/instrumental activities of daily living (ADL/IADL), Assistive Technology, Low Vision, Manual Skills, Rehabilitation Nursing, Recreational Therapy and other supportive clinical services as deemed appropriate. The Veteran receives intense individualized training; program length will vary depending on the Veteran's needs. Training can be done as individual or group classes.

a. **Assistive Technology Training.** Assistive Technology programs focus on training participants to effectively and efficiently operate a computer or mobile electronic devices. Assistive technology can be incorporated in all areas of rehabilitation training. Examples of assistive technology programs:

(1) **Computer Assistive Technology training.** Computer Assistive Technology (CAT) training includes using specialized access software and device to meet individualized goals. This includes assessing the ability of the person served to use large print, synthetic speech, voice recognition or Braille access devices in order to perform word processing functions and other computer-related activities. Veterans participating in a computer or mobile computing programs can be consulted to other skill areas or services as deemed appropriate, including iOS training.

(2) **Portable Electronic Devices.** This technology program addresses the basic functions of mobile computing needs of the Veteran by providing training on the built-in

accessibility programs for a smartphone or tablet computer. Both Android and iOS devices can be utilized depending upon the Veterans goals.

(3) **Simplified Communication Devices.** Training can occur with less complex technology devices that are used to transmit or receive messages; such aids range from speech generating devices to simple cellular phones.

2. SPECIALTY PROGRAMS

a. **Computer Assistive Technology Training and Guide Dog Program.** The Computer Assistive Technology (CAT) and Guide Dog program allows a Veteran to work with a partnered Guide Dog training program while admitted to a Blind Rehabilitation Center. The Veteran participates in training provided by Blind Rehabilitation Specialists typically focused on CAT while concurrently working with an instructor from a Guide Dog Training Programs that are members of Assistance Dogs International accredited agencies or International Guide Dog Federation accredited agencies.

b. **Independent Living Program.** The Independent Living Program (ILP) is designed for Veterans with visual impairment who live alone, have plans to live alone independently or have had a change in their living situation requiring a greater need for independence. This program involves staying in an independent living apartment at a center, which is equipped with a kitchen. Veterans that participate in the ILP have completed therapeutic instruction in all disciplines and practice using the devices and skills learned to live independently in an apartment setting.

c. **Voice Activated Standalone Personal Assistant.** Veterans with visual impairment learn how Voice Activated Standalone Personal Assistant (VASPA) devices and applications help in achieving common goals through voice command. The program provides training utilizing VASPA devices for goals such as organization, time keeping, communication, general inquiry, leisure and increased automation in the home.

d. **Specialized Medical Devices.** BRCs partner with rehabilitation nursing to provide training on accessible medical devices. The goal of the program is to provide training on specific medical devices which enable the Veteran to independently manage their medical conditions.

e. **Specialized Mobility Training.** There are several specialized mobility trainings:

(1) **Power Mobility.** The Power Mobility (PM) training program is designed for Veterans with visual impairment in which a power mobility device has been clinically indicated by a provider with wheeled mobility expertise. The PM program is designed to maximize safe, independent and efficient travel ability for appropriate Veterans with visual impairment. PM is an O&M specialty program for Veterans with visual impairment candidates who meet specific issuance criteria and would benefit from a power mobility device such as a 3-wheel scooter or power wheelchair. For more details, see VHA Handbook 1173.06, Wheelchairs and Mobility Aids, dated January 15, 2008.

(2) **Global Positioning System.** These programs use devices with digital maps to provide outdoor orientation information and navigation and may be taught in conjunction with a mobility device.

(3) **Specific Travel Conditions.** This component of O&M Training, Night Travel Training (if indicated) includes an assessment and primary skill training that allows the Veteran to achieve their night travel goals. Lessons may include traveling in a dimly lit environment such as a theater, navigating a dark room or outdoor night-time travel.

(4) **Electronic Travel Aids.** Electronic Travel Aids (ETA) is an O&M specialty program utilizing sonar technology to help Veterans with visual impairment locate and navigate potential hazards at a greater distance with greater efficiency and confidence. Selection of the ETA is based on the candidate's functional assessment and goals. ETA devices are only intended as an accessory to the more traditional mobility devices such as the 4-Wheeled Walker (4WW), white cane and guide dog.

f. **Specialized Optical Aids.** Several programs exist to address individualized needs and goals via training with electronic optical aids such as: head mounted devices; stand-alone optical character readers; and portable closed-circuit televisions (CCTVs) devices.

g. **Traumatic Brain Injury.** Traumatic Brain Injury (TBI) programs include:

(1) **Comprehensive Neurological Vision Rehabilitation Program.** Comprehensive Neurological Vision Rehabilitation (CNVR) Program specifically addresses neurological visual impairment as a result of brain injury. Causes of neurological visual impairment includes stroke, motor vehicle accidents, gunshot wounds, blast related trauma, falls, brain tumors and toxic exposure. Clinical evaluation and treatment are planned with consideration to the individual Veteran's mental and physical endurance, capabilities and interests. Emphasis is placed on realistic, success-oriented therapy goals.

(2) **Vision Rehabilitation after Acquired Brain Injury/ Traumatic Brain Injury, Binocular Vision Therapy.** Partnering with the Low Vision/TBI Eye Care Specialist, functional evaluations and treatments are provided for a variety of low vision skills including eye movements and control, focus change, depth perception, using peripheral vision appropriately, binocularity, scanning, visualization, visual perception and visual-spatial reasoning.

h. **Specialized Recreation Therapy Programs.** Recreation Therapy provides specialized designed adapted programs such as but not limited to adaptive sports, therapeutic expression, virtual technology, leisure education, lifestyle and community transition and wellness and prevention. Recreation Therapists incorporate patient directed therapy goals to maximize rehabilitation potential, increase independence and sustain a healthy leisure lifestyle integrating the skills learned in treatment settings into the community settings

VISUAL IMPAIRMENT SERVICES TEAM ROSTER STAFFING GUIDELINES

Each Department of Veterans Affairs (VA) medical facility Chief of Staff/VA medical facility Associate Director of Patient Care Services (ADPCS) supports the Visual Impairment Services Team (VIST) program by ensuring sufficient staffing to meet caseload demand. Local VIST roster staffing guidelines are as follows:

1. ROSTER SIZE

Determine if the VA medical facility requires a full time or a part time VIST Coordinator. Part-time VIST Coordinators must devote 50% time to a VIST caseload and responsibilities to fully perform all duties required for care coordination for a Veteran with visual impairment caseload.

a. **Rosters of 150 Veterans or Less.** Establish a part-time VIST Coordinator for facilities with less than 150 Veterans on the VIST roster. A minimum of half time is required for VIST duties.

b. **Rosters of 150-500 Veterans.** Establish a full-time VIST Coordinator in a Hybrid Title 38 (HT 38) 0601 series position in facilities with greater than 150 Veterans on the national and VA medical facility VIST roster. This ensures dedicated time to serve Veterans with visual impairment.

c. **Rosters Greater than 500 Veterans.** Assess whether one full-time VIST Coordinator can adequately provide the services described in this directive in facilities with VIST rosters greater than 500 Veterans. This is a local staffing decision that requires input from the BRS national office and may consider:

(1) Shared resources as an interim measure.

(2) Expected vs. actual workloads.

(3) Adequacy of care. ***NOTE: If care coordination services at the VA health care system for Veterans with visual impairment are not adequate, establishing an additional HT 38 VIST Coordinator position is in the best interest of Veterans with visual impairment and the VA medical facility. VIST rosters that include 500 or more Veterans with visual impairment are strongly encouraged to be provided a second VIST Coordinator.***

(4) Dedicated administrative support is strongly encouraged to assist in the daily operations of the VIST program and VIST Coordinator (e.g., Medical Support Assistants (MSAs), Program Support Assistants (PSAs), Volunteers).

**BLIND REHABILITATION SERVICE CONTINUUM OF CARE REGIONAL
DISTRIBUTION**

The following chart describes the regional distribution of Blind Rehabilitation Service clinical programs, not including Visual Impairment Services Team (VIST) and Blind Rehabilitation Outpatient Services (BROS).

CoC Type	VA Medical Facility Name and Location	District / VISN	VA medical Facility STA_NO
ILVC	White River Junction VA Medical Center White River Junction, VT	1V01	405
ILVC	Albany Stratton VA Medical Center Albany, NY	1V02	528A8
ILVC	VA Hudson Valley Health Care System Montrose, NY	1V02	620
ILVC	VA Pittsburgh Healthcare System Pittsburgh, PA	1V04	646
ILVC	Martinsburg VA Medical Center Martinsburg, WV	1V05	613
ILVC	Hampton VA Medical Center Hampton, VA	1V06	590
ILVC	Columbia VA Health Care System Columbia, SC	2V07	544
ILVC	North Florida/South Georgia Veterans Health System Ocala, FL	2V08	573DG
ILVC	Memphis VA Medical Center	2V09	614

CoC Type	VA Medical Facility Name and Location	District / VISN	VA medical Facility STA_NO
	Memphis, TN		
ILVC	John D. Dingell VA Medical Center Detroit, MI	3V10	553
ILVC	Cincinnati VA Medical Center Cincinnati, OH	3V10	539
ILVC	William S. Middleton Memorial Veteran Hospital Madison, WI	3V12	607
ILVC	VA St. Louis Health Care System St. Louis, MO	3V15	657
ILVC	Kansas City VA Medical Center Kansas City, MO	3V15	589
ILVC	Central Texas Veterans Health Care System Austin, TX	4V17	674
ILVC	VA Montana Health Care System Fort Harrison, MT	4V19	436
ILVC	Oklahoma City VA Health Care System Oklahoma City, OK	4V19	635
ILVC	VA Southern Nevada Healthcare System Las Vegas, NV	5V21	593
ILVC	New Mexico VA Health Care System Albuquerque, NM	5V22	501
ILVC	VA Loma Linda Healthcare System Loma Linda, CA	5V22	605

CoC Type	VA Medical Facility Name and Location	District / VISN	VA medical Facility STA_NO
ILVC	Sioux Falls VA Health Care System Sioux Falls, SD	3V23	438
ALVC	VA Boston Healthcare System Boston, MA	1V01	523
ALVC	Syracuse VA Medical Center Syracuse, NY	1V02	528A7
ALVC	VA NY Harbor Healthcare System Brooklyn, NY	1V02	630
ALVC	Corporal Michael J. Crescenz VA Medical Center Philadelphia, PA	1V04	642
ALVC	VA Maryland Health Care System Baltimore, MD	1V05	512
ALVC	W.G. (Bill) Hefner VA Medical Center Salisbury, NC	1V06	659
ALVC	Atlanta VA Health Care System Atlanta, GA	2V07	508
ALVC	James A. Haley Veterans Hospital Tampa, FL	2V08	673
ALVC	Tennessee Valley Healthcare System Nashville, TN	2V09	626
ALVC	Dayton VA Medical Center Dayton, OH	3V10	552

CoC Type	VA Medical Facility Name and Location	District / VISN	VA medical Facility STA_NO
ALVC	Aleda E. Lutz VA Medical Center Saginaw, MI	3V10	655
ALVC	Clement J. Zablocki VA Medical Center Milwaukee, WI	3V12	695
ALVC	Robert J. Dole VA Medical Center Wichita, KS	3V15	589A7
ALVC	Central Arkansas Veterans Healthcare System Little Rock, AR	4V16	598
ALVC	VA North Texas Health Care System Dallas, TX	4V17	549
ALVC	George E. Wahlen VA Medical Center Salt Lake City, UT	4V19	660
ALVC	VA Portland Health Care System Portland or	5V20	648
ALVC	VA Northern California Health Care System Martinez, CA	5V21	612A4
ALVC	Phoenix VA Health Care System Phoenix, AZ	5V22	644
ALVC	VA Greater Los Angeles Healthcare System Los Angeles, CA	5V22	691
ALVC	VA San Diego Healthcare System San Diego, CA	5V22	664

CoC Type	VA Medical Facility Name and Location	District / VISN	VA medical Facility STA_NO
ALVC	VA Central Iowa Health Care System Des Moines, IA	3V23	636A6
VISOR	VA Western New York Healthcare System Buffalo, NY	1V02	528
VISOR	VA New Jersey Health Care System Lyons, NJ	1V02	561
VISOR	Lebanon VA Medical Center Lebanon, PA	1V04	595
VISOR	Washington D.C. VA Medical Center Washington, DC	1V05	688
VISOR	Hunter Holmes McGuire VA Medical Center Richmond, VA	1V06	652
VISOR	Battle Creek VA Medical Center Battle Creek, MI	3V10	515
VISOR	Michael E. DeBakey VA Medical Center Houston, TX	4V16	580
VISOR	VA Eastern Colorado Health Care System Denver, CO	4V19	554
VISOR	Minneapolis VA Health Care System Minneapolis, MN	3V23	618
BRC	VA Connecticut Healthcare System West Haven, CT	1V01	689

CoC Type	VA Medical Facility Name and Location	District / VISN	VA medical Facility STA_NO
BRC	Charlie Norwood VA Medical Center Augusta, GA	2V07	509
BRC	Birmingham VA Medical Center Birmingham, AL	2V07	521
BRC	VA Caribbean Healthcare System San Juan, PR	2V08	672
BRC	West Palm Beach VA Medical Center West Palm Beach, FL	2V08	548
BRC	Louis Stokes Cleveland VA Medical Center Cleveland, OH	3V10	541
BRC	Edward Hines, Jr. VA Hospital Hines, IL	3V12	578
BRC	Gulf Coast Veterans Health Care System Biloxi, MS	4V16	520
BRC	Central Texas Veterans Health Care System Waco, TX	4V17	674A4
BRC	VA Puget Sound Health Care System Tacoma, WA	5V20	663
BRC	VA Palo Alto Health Care System Palo Alto, CA	5V21	640
BRC	VA Long Beach Healthcare System Long Beach, CA	5V22	600

CoC Type	VA Medical Facility Name and Location	District / VISN	VA medical Facility STA_NO
BRC	Southern Arizona VA Health Care System Tucson, AZ	5V22	678

BLIND REHABILITATION SERVICES RESOURCE REQUIREMENTS

This appendix explains the requirements for successful Blind Rehabilitation Services (BRS) implementation in terms of budget, staffing, space, equipment and transportation.

1. BUDGET

a. Budget levels vary and are modified when advances in the field of blind and visual impairment rehabilitation, such as new technology and innovative programs, create a demand.

b. Budget planning at the Department of Veteran Affairs (VA) medical facility housing a blind or vision rehabilitation clinic must take into account the regional scope of the clinic within the Veterans Integrated Service Network (VISN). A coordinated budgetary decision process requires input from the VISN, as well as the Director, BRS, VA Central Office.

c. All BRS locations are strongly advised to develop local budgets, in alignment with their local VA medical facility, for the purchase of adaptive devices for Veteran’s needs.

2. FULL-TIME EQUIVALENT

a. **Intermediate Low vision Clinics.** Clinics are staffed by a minimum of 1.0 Full-time Equivalent (FTE) Blind Rehabilitation Specialist (low-vision therapist), 0.5 FTE eye care provider and 0.5 FTE program assistant.

b. **Advanced Low vision Clinics.** Clinics are staffed by a minimum of 2.0 FTE Blind Rehabilitation Specialists (low-vision therapy and Orientation and Mobility (O&M)), 0.5 FTE eye care provider and 0.5 FTE program assistant.

c. **Visual Impairment Services Outpatient Rehabilitation.** Clinics are staffed by a minimum of 1 FTE VISOR Chief, 4.0 FTE Blind Rehabilitation Specialists, 0.5 FTE eye care provider and 0.5 FTE program assistant.

d. **Blind Rehabilitation Centers.**

(1) **Blind Rehabilitation Centers Service Staffing Matrix.** The minimum FTE for Blind Rehabilitation Centers (BRC) are described in the matrix below.

BRS Position	FTE: BRCs with 1-15 beds	FTE: BRCs with 16 or more beds
BRC Chief	1	1
BRC Assistant Chief	0	1

BRS Position	FTE: BRCs with 1-15 beds	FTE: BRCs with 16 or more beds
Admission Coordinator	1	1
Supervisory Blind Rehabilitation Specialists	2	4
Blind Rehabilitation Specialists	1:1 Ratio	1:1 Ratio
Psychologist	0.5	1
Social Worker	0.5	1
Recreational Therapist	0.5	1

(a) Sufficient therapeutic instructional personnel must be allocated so the majority of training and adjustment efforts can be accomplished on a one-to-one basis. This is required for Veteran safety and to ensure the highest quality of care with an optimal length of stay (LOS).

(b) Group training (peer support, specialty training) is appropriate when clinically indicated.

(2) To ensure effective and efficient delivery of Veteran care, each BRC must have:

(a) An adequate number of qualified Blind Rehabilitation Specialists to serve as supervisors.

(b) One FTE Blind Rehabilitation Specialist who serves as an Admission Coordinator. Responsibilities may include management of applications and coordination of Veteran admissions and discharges. Duties may include quality improvement activities, management of applicable regulatory standards compliance (e.g., The Joint Commission) and rehabilitation program accreditation activities (e.g., Commission on Accreditation of Rehabilitation Services (CARF)) and coordination of new product evaluations.

(c) Core members of the interdisciplinary team must be assigned to each BRC to enable the attainment of the program mission to include a Physician or extender, Nurses, Psychologist, Social Worker, Optometrist, Recreation Therapist, Chaplain and Dietitian.

(3) Medical Support Services.

(a) Physician or extender and Nursing staff are critical to ensure health maintenance and Veteran safety. Qualifications and staffing matrix must be sufficient to enable the

BRC to fulfill its commitment to serve all Veterans with visual impairment who could benefit from the BRC program regardless of the presence of complicating medical conditions.

(b) An essential element in vision rehabilitation is the active participation by Low Vision Optometrists. Inpatient BRCs having 16 or more operating beds will have a 1.0 FTE residency trained Low Vision Optometrist or an Optometrist with equivalent experience serving those Veterans. Those inpatient BRCs having fifteen or fewer operating beds must be assigned a 0.5 FTE residency trained Low Vision Optometrist or an Optometrist with equivalent experience. **NOTE:** *When outpatient BRS care is provided in addition to inpatient BRC care, an additional 0.5 FTE residency trained Low Vision Optometrist or an Optometrist with equivalent experience, must be available to serve those Veterans.*

3. SPACE

a. Intermediate Low Vision Clinic.

Space Type	Size (feet)	Size (square feet)
Clinical Exam Room	12x16	192
Therapy Room (and Office: ADL, LVDs, Visual Skills)	20x20	400
Temporary Lodging beds (Two Beds, Shared Room)	15x20	300
	TOTAL	892

b. Advanced Low Vision Clinic.

Space Type	Size (feet)	Size (square feet)
Clinical Exam Room	12x16	192
Therapy Room (and office): ADL, LVDs, Visual Skills	20x20	400
Therapy Room 1 (Office): ADL, Near and Inter. LVDs, Visual Skills	20x20	400
Therapy Room 2 (office): Distance LVDs, O&M, Visual Skills	20x20	400
Temporary Lodging beds (Two Beds, Shared Room)	15x20	300
	TOTAL	1432

c. Visual Impairment Services Outpatient Rehabilitation.

Space Type	Size (feet)	Size (square feet)
Clinical Exam Room	12x16	192
Intake/Adjustment Counseling (Office)	10x14	140
2 Therapy Rooms (Office): ADL, Near and Inter. LVDs, Visual Skills	20x20	800
2 Therapy Rooms (Office): Distance LVDs, O&M, Visual Skills	20x20	800
Computer Assistive Technology Training Room	20x20	400
Temporary Lodging beds (Four Beds, Shared Rooms)	15x20	600
	TOTAL	2932

d. Outpatient.

(1) Assigned clinical space must be sufficient to allow efficient and safe (including compliance with Veterans Health Administration (VHA) Privacy and Confidentiality policies) operation of the program and to enable Veterans with visual impairment to maximize their rehabilitation potential.

(2) Clinical areas need to complement and enhance the rehabilitation process. Care needs to be taken to ensure that environmental lighting, color, contrast, signage and tactile environment support the learning, safety and wayfinding needs of Veterans who are visually impaired.

(3) Storage space needs to be sufficient to secure assessment and training devices, any recreational equipment and the prosthetic devices issued.

(4) All Blind Rehabilitation Outpatient Specialists require adequate office and clinical space to evaluate and assess Veterans, demonstrate adaptive devices and provide training in multiple skill specialty areas to Veterans with visual impairment (e.g., visual skills and O&M assessment/training space, space for closed-circuit televisions (CCTVs), adapted computer systems and other technology). The assigned space must be a minimum of 300 square feet and located in an area that is accessible and convenient for Veterans with visual impairment.

(5) All Visual Impairment Services Team (VIST) Coordinators require adequate office and clinical space to evaluate and assess Veterans, facilitate clinical care, demonstrate adaptive devices and provide adjustment to sight loss counseling

coordination (for Veterans with visual impairment and caregivers/family, as necessary). The assigned space must be a minimum of 300 square feet and located in an area that is accessible and convenient for Veterans with visual impairment.

e. **Blind Rehabilitation Centers.**

(1) BRCs are inpatient units where Veterans with visual impairment from multi-state areas reside for an extended period of time in order to immerse themselves in the rehabilitation process. Because of the unique needs of a blind rehabilitation center, special accommodations for space that promote a therapeutic, safe and home-like atmosphere are required. **NOTE: BRC requires inpatient rehabilitation beds as defined in paragraph 3.**

(a) In order to achieve this, the BRC treatment and living areas must be dedicated to the BRC and must not be shared with other hospital functions.

(b) To ensure a therapeutic atmosphere, pedestrian traffic unrelated to the BRC needs to be kept to a minimum, especially in BRC living areas.

(2) Assigned BRC space must be sufficient to allow efficient and safe operation of the program (clinical treatment areas for all services offered) and to enable Veterans with visual impairment to maximize their rehabilitation potential. To support safety and developing independence, each Veteran needs to have control of their private space (i.e., a private bedroom and bath).

(3) BRC treatment and living areas must ensure that environmental lighting, color, contrast and appropriate signage support the visual needs of Veterans.

(4) The BRC unit must:

(a) Contain a laundry room that contains two washers, two dryers, an ironing board and racks to hang up ironed clothing with easy access for Veterans.

(b) Have dining facilities of sufficient size to accommodate all Veterans at one sitting.

(c) Contain a multipurpose room that is adequate for Veteran's recreational and leisure activities when not participating in direct therapeutic instruction and training.

(d) Have access to an exercise room.

(e) Have adequate storage space sufficient for training devices, recreational equipment and the prosthetic devices issued by therapeutic instructors in the disciplines of O&M, Low Vision, ADL/IADL, Manual Skills and Computer Assistive Technology training (CAT).

(5) Clinical areas need to complement and enhance the rehabilitation process. A nursing communication center needs to be located so that it controls entry to the BRC,

in addition to providing oversight of the dining room and activity areas that are used after hours.

4. STOCK DEVICES

A supply of devices (see paragraph 3 for definition) that are designed to ensure Veterans safety and/or utilized to address ADL/IADL needs must be maintained at the VA medical facility BRS locations for immediate issuance to eligible Veterans.

5. TRANSPORTATION

a. Blind rehabilitation care may be conducted in areas that are specific to the individual needs of Veterans with visual impairment, including their home residence. This requires frequent travel by government vehicle and public transportation, if available to Veterans with visual impairment.

b. Immediate access to vehicles is critical to ensure an efficient rehabilitation process. The VA medical facility must provide access to government vehicles, to BRS, for this reason.

c. Public transportation rail/bus passes may also be required and must be provided by the VA medical facility where BRS is located.

d. For BRS providing care in rural areas, overnight travel may promote the most efficient use of BRS face-to-face assessment and therapeutic instruction time. BRS providers work with National Program Consultant (NPC) for the region and the VA medical facility Chief of Staff office to determine whether and how overnight travel should be planned and funded.

6. REHABILITATION PROGRAM ACCREDITATION

Applicable standards must be met in order to attain and maintain rehabilitation program accreditation (e.g., CARF). For more information, see VHA Office of Quality and Patient Safety, Office of Quality Management, Office of External Accreditation Services and Programs at <https://vaww.qps.med.va.gov/divisions/qm/ea/carf.aspx>.

NOTE: *This is an internal VA website that is not available to the public.*