U.S. DEPARTMENT OF VETERANS AFFAIRS

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PUBLIC LAW 114-256

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PUBLIC MEETING

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TUESDAY
JUNE 13, 2017

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The Meeting convened in the U.S. Department of Veterans Affairs, Room C-7, 810 Vermont Avenue, N.W., Washington, D.C., at 9:00 a.m., Penny Nechanicky, Moderator, presiding.

PRESENT

PENNY NECHANICKY, National Director for Prosthetic and Sensory Aid Services, Moderator
LUCILLE BECK, Acting Deputy Under Secretary for Health for Policy & Services
DANNY DEVINE, Deputy Director of Policy and Procedure, VBA Compensation Service
SHAYLA MITCHELL, VHA
BILL WENNINGER, VHA
STEPHANIE JONES, VHA
KEITH HANCOCK, VBA
LISANDRA GARAY-VEGA, NHTSA

C-O-N-T-E-N-T-S

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1 P-R-O-C-E-E-D-I-N-G-S

2 (9:03 a.m.)

3 MS. NECHANICKY: Good morning,
4 everyone. I'm Penny Nechanicky. I'm the
5 Director of Prosthetics and Sensory Aides, and I
6 want to thank all of you for attending our public
7 meeting today, in which we're seeking consultative
8 advice in implementing Section 3 of Veterans
9 Mobility Safety Act of 2016.

10 On your agenda you will see the proposed
11 topics of Public Law 114-256, Section 3, that your
12 comments will contribute to. At this time, I'd
13 like to invite our first five speakers, Speakers
14 1 through 5, to the reserve front row, and our
15 timekeeper will collect your speaker cards at this
16 time.

17 Each registered speaker will have 15
18 minutes. The timer is on the screen to your right
19 and once you've exhausted your time, we ask that
20 you complete your sentence and provide any
21 additional remarks in the form of written comments
22 as noted on Page 2 of the agenda.

1 I ask that everyone silence their
2 mobile phones, that you treat everyone with
3 respect, and that if you must take a break, you may
4 quietly visit the back of the room to access the
5 water and refreshments.
6 The restrooms are outside the
7 conference room to the -- the women's to the left
8 of the elevator and the men's on the right side of
9 the elevator.
10 Please stay within the designated area
11 of the meeting on this C level floor, unless you
12 are exiting the building. The VA Police have asked
13 that you not wander in other areas of the building
14 and you may be escorted from the building if you're
15 found in those areas.
16 You may access additional meeting
17 etiquette outlined on Page 2 of your agenda for
18 guidance and information.
19 At this time, we have two VA leaders
20 that will bring you opening remarks. The first is
21 Dr. Lucille Beck. She's the Acting Deputy
22 Undersecretary for Health for Policy and Services

1 for VHA. Following her, Mr. Danny Devine, Deputy
2 Director of Policy and Procedure for Veterans
3 Benefits Administration Compensation Service.
4 Dr. Beck.
5 DR. BECK: Good morning. On behalf of
6 Secretary Shulkin, our Secretary for Veterans
7 Affairs, I welcome you to this meeting and thank
8 you for attending. Automobile adaptive equipment
9 is critically important for disabled veterans.
10 The VA's AAE Program, as we call it, is
11 a benefit under the department's Veterans Benefits
12 Administration that is administered in partnership
13 with the Veterans Health Administration, VHA.
14 We appreciate the partnership between
15 VHA and VBA in providing this benefit to veterans
16 and my colleague from VBA, Mr. Dan Devine, will
17 follow me to offer his remarks on behalf of VBA and
18 also welcome you to this meeting.
19 The Department of Veterans Affairs is
20 seeking consultative advice in developing its
21 comprehensive policy regarding quality standards
22 for providers of services to veterans under VA's

1 Automobile Adaptive Equipment Program.
2 In planning this meeting, VA previously
3 sought input from the public through the Federal
4 Register in February of 2017 to identify
5 stakeholder groups, organizations, and
6 individuals, and receive their comments regarding
7 AAE.
8 As we had planned and hoped for, those
9 of you participating in this meeting represent a
10 broad, diverse group of stakeholders, including
11 veterans and their caregivers, Veterans Service
12 Organizations, automobile adaptive equipment
13 dealers, modifiers, and manufacturers, state
14 rehabilitation engineers, AAE trade
15 organizations, such as NMEDA, professional
16 organizations, Association for Driver Rehab
17 Specialists, American Occupational Therapy
18 Association, and other federal agencies, the
19 National Highway Traffic Safety Administration.
20 Your input that you collectively share
21 today is vital to VA as we plan, develop, and
22 implement the policy for quality standards for

1 providers of AAE services to veterans through this
2 benefit.
3 Further, your collaboration is
4 important to Secretary Shulkin and his goals and
5 priorities for the department in order to ensure
6 that veterans have easy access to benefits, care,
7 and services they earned and need, no matter where
8 the veteran may be, veterans receive integrated
9 care and support that emphasizes their well-being
10 and independence throughout their life.
11 VA is accountable for delivering the
12 best possible outcomes in the most efficient,
13 effective, and compassionate manner possible. We
14 appreciate your desire to partner with VA, as
15 together, we seek to meet these goals with regard
16 to providing the highest quality AAE services to
17 America's veterans.
18 We look forward to receiving your
19 input, and again, thank you for your participation
20 in this important meeting. Thank you.
21 MR. DEVINE: Good morning. How are
22 you? I'm Danny Devine, Deputy Director of VBA's

1 Compensation Service. It's really an honor to be
2 here. I want to personally thank you for your
3 participation. These are important comments that
4 we're going to get from you today.
5 Your input is very instrumental. We
6 love to have that public input and it's important
7 for us to develop the policies for the automobile
8 and the adaptive equipment quality standards. The
9 program is important because it serves our most
10 important veterans. And we owe it to these
11 veterans to continue this program.
12 VBA has two primary responsibilities,
13 first, our adjudicators across the 56 regional
14 offices review veterans' claims and determine
15 eligibility for financial assistance in purchasing
16 a new or used automobile or providing adaptive
17 equipment.
18 Second, once a veteran purchases or
19 receives services for his automobile, VBA pays the
20 provider directly for the services rendered. We
21 understand the importance of providing timely
22 payments to the providers and we're currently

1 working with our VHA partners in making those
2 payment services better.
3 Thank you again for being here. We
4 look forward to your comments. My colleague will
5 be here all day to listen to your comments and we
6 appreciate you being here. Thank you.
7 MS. NECHANICKY: Thank you for those
8 opening remarks. I think you can see from those
9 remarks, how important this is and how our top
10 leadership is committed to making this work for us
11 all.
12 I'd like to now ask our panel members
13 to introduce themselves.
14 DR. MITCHELL: Hi. My name is Shayla
15 Mitchell. I am a Program Analyst with the
16 Rehabilitation and Prosthetics Service. I manage
17 three of the benefit programs. First, the
18 Automobile Adaptive Equipment Program, Clothing
19 Allowance, as well as our Home Improvement and
20 Structural Alterations Programs.
21 And thanks to everyone for taking your
22 time to spend the day with us.

1 MR. WENNINGER: Good morning. I'm
2 Bill Wenninger. I'm a physical therapist by
3 background. I was a driver's trainer in the early
4 '80s, primarily in spinal cord injury. About
5 eight or nine years ago I was fortunate to come into
6 central office in one the programs that I'm
7 responsible for clinically, is the Driver
8 Relocation Program, so I'm in the Physical Medicine
9 Rehab Program Office here in the central office.
10 MS. JONES: Good morning. I'm
11 Stephanie Jones. I work in our Regulatory and
12 Administrative Affairs Office within VHA and I work
13 on regulations.
14 MR. HANCOCK: Good morning. I'm Keith
15 Hancock. I'm a Legislative Policy Analyst for
16 Compensation Service. I have served out in the
17 regional offices and now it's an honor to be here
18 and to set policy for the regional offices here at
19 headquarters. Thank you.
20 DR. GARAY-VEGA: Good morning. My
21 name is Dr. Lisandra Garay-Vega with the National
22 Highway Traffic Safety Administration, an agency

1 with the U.S. Department of Transportation. You
2 might be familiar, our mission is to save lives,
3 prevent injuries, reduce economic costs from road
4 crashes.
5 We do this through education, our
6 research, safety standards, and fortunately, the
7 activities. We are happy to be joining you today.
8 MS. NECHANICKY: Thank you, all. Now,
9 we'd like to begin to listen to your comments,
10 testimonies, and technical remarks. Speaker 1,
11 are you ready? Please approach the podium,
12 announce your name and affiliation when you are
13 here at the podium, and your 15 minutes may now
14 start.
15 MR. SAVICKI: Thank you, good morning.
16 My name is Mike Savicki, I'm a disabled veteran.
17 Thank you for affording me the opportunity to
18 speak. It's an honor to speak and I hope my
19 comments will help shape policy that puts the
20 safety and interest of my fellow veterans first and
21 foremost.
22 So who am I? I'm a former Navy officer

1 who had just begun flight training when I sustained
2 a spinal cord injury on active duty in 1990. I'm
3 a service-connected veteran enrolled in the VA's
4 AAE Program since 1991. That's more than half my
5 life.
6 I'm a member of the Military Officers
7 of America Association, DAV, United Spinal, a life
8 member of PVA, and I know NMEDA mostly through its
9 National Mobility Awareness Month Program.
10 I'm a husband, a father, an athlete, an
11 advocate, and a small business owner. I put tens
12 of thousands of miles on my vehicle every year.
13 The first vehicle I received from you through the
14 program took me to grad school and I haven't slowed
15 down since. Thank you.
16 So why am I here? I want to see more
17 veterans do what I've done and go where I've gone.
18 I want to see them do more. I'm here because I
19 appreciate value and live the work that you do at
20 VA every day. It's hard work. And I'm here
21 because I bring a perspective that no dealer,
22 manufacturer, vendor, organization, association,

1 or anyone else can bring.
2 I have more years in this program, I
3 would argue, than most people in this room. The
4 AAE Program has literally helped me every single
5 day become the person that I am. When I saw the
6 VMSA Bill was introduced into Congress, I became
7 excited.
8 I could see that the VA's AAE Program
9 could change, improve, and become safer for
10 veterans, and that's why I'm here. In my 27 years,
11 I've driven everything from a full-size van to a
12 minivan, to a car equipped with manual hand
13 controls, I've had my chair carried in car toppers,
14 plus swing-around and hitch-mounted lifts.
15 And I'd like to share a few points with
16 you from those years. First my full-size vehicle
17 was a full-size van. It took six months to
18 deliver. I knew nothing about adaptive vehicles
19 at the time and I assumed they were all the same.
20 I put total trust in the VA, assuming that the VA
21 had trained and vetted the people who were working
22 on my vehicle, but I was wrong.

1 Flaws became evidence quite quickly.
2 My vehicle was unbalanced because there was so much
3 equipment on the right side of the vehicle. I was
4 wearing through tires like a NASCAR driver in the
5 Daytona 500.
6 I learned that steering was impacted as
7 well. Weight in vehicles, no matter what they are,
8 matters. I went for comfort on my next van, and
9 as an example, I chose a full-size, soft-leather,
10 Captain's chair for my swing-around seat.
11 It was too large to fit close enough,
12 even in a Ford full-size van. The VA-approved
13 vendor, he said, had put it where I wanted. The
14 VA approved the vehicle and throughout the life of
15 that vehicle, I drove reaching out, steering and
16 using the seatbelt as a way to maintain balance.
17 It would have been helpful if a driver
18 rehab specialist had been involved, if the mobility
19 industry had a dealer, had someone there to work
20 with my discomfort once I received the vehicle.
21 If you think hand controls are simple,
22 easy, cookie-cutter pieces of adaptive equipment,

1 I'm here to say they aren't. Years ago, you put
2 your choice in one or two different manual hand
3 controls. That's not the case now.
4 Some are all manual, some are manual
5 with electronic, some are all electronic.
6 Combined with a poor install, especially for a
7 quadriplegic like myself, driving can be tiring,
8 draining, and an unpleasant activity.
9 And now, even in my most recent minivan
10 that I received, it took myself, working with the
11 dealer, three times to get the hand controls
12 correct. Resistance, placement, steering, where
13 buttons are placed, all that matters. It isn't and
14 wasn't plug-and-play. There is no easy solution.
15 Before coming today, I reached out to
16 veterans I knew who have had adaptive equipment
17 issues. I asked them if they would share their
18 stories with me. Wiring failures, steering
19 problems, power chairs bouncing off the back of
20 hitch-mounted lifts, rear-vehicle lifts bending
21 and dragging, veterans trapped in vehicles alone
22 for hours waiting for people to come, and the

1 response I got was, no.
2 So I'd like to share one example with
3 you. Several years ago I was flying to Denver for
4 a wheelchair rugby tournament. A teammate of mine
5 was driving from the West Coast. I made it and he
6 did not. The wiring in his van, which had been
7 quickly repaired by a VA-approved vendor prior to
8 his leaving, caught fire.
9 It engulfed his van and trapped him.
10 He was rushed to a hospital. He was afraid of what
11 might happen if he spoke up. He kept the incident
12 quiet, but all of us knew. We veterans wonder what
13 would happen to us if we speak up too.
14 I'll share one small example from what
15 happened to me recently. Last summer on family
16 vacation, if you think a ramp is a simple install
17 in a vehicle, I'm here to say it's not. My minivan
18 ramp broke off the housing, which it was attached
19 to, and the van would not move, the lift would not
20 move, the ramp would not move. I could not get out.
21 I used the 1-800 to call NMEDA, because
22 I knew there was a hotline for me, much like AAA,

1 for able-bodied folks, but specific to adaptive
2 equipment. They found a dealer about an hour away
3 from me, and I had the van fixed, I'm glad I was
4 not alone -- I'm glad I was alone and not with my
5 wife or 4-year-old daughter.
6 Finally, I want to state what many in
7 this room already know, veterans like me rely on
8 our vehicles to live, to get to our jobs, transport
9 our families, to travel, and yes, to feel whole.
10 What many in this room do not know is that when
11 issues arise, we veterans tend to close our mouths
12 because we don't want to cause a problem. We don't
13 want to be a burden. We don't want the VA to think
14 it is us, not poor quality equipment or unsafe
15 installs, and pull us off the road for even a short
16 period of time or take away our benefits entirely.
17 We keep our mouths shut and just go on.
18 This is sad and disheartening, and this tendency
19 is encouraged by the fact that current AAE policy
20 has no clear path for corrective action or
21 complaint resolution. This needs to change.
22 So what to do? From my experience, and

1 this is what I believe, if the VA pays for a piece
2 of adaptive automobile equipment, any piece, every
3 piece, it needs to be a quality piece of equipment
4 and the VA needs to do everything it can to ensure
5 that equipment is installed safely by a competent
6 vendor. No exceptions, no waivers, nothing.
7 Every veteran has earned the assurance
8 that his or her vehicle is quality tested and safe,
9 for us, for our families, and because we are on the
10 road with others. And if a vendor will not or
11 cannot abide by your standards, that vendor should
12 not be permitted to work with veterans.
13 Not all vehicles are the same and a
14 veteran needs to know his or her vehicle has met
15 meaningful quality safety standards. For years,
16 I just assumed that every vendor vetted by the VA
17 was approved. I was wrong.
18 Equipment, and that includes lowered
19 floors, hand controls, swivel seats, electronic
20 driving aides, all the lifts, even steering pins,
21 need to be quality checked.
22 There's a cost issue too. Right now,

1 VA is paying for final products that are dangerous,
2 substandard, partly because of product, partly
3 because of installation, and partly because a
4 veteran who has to pay for some of his own
5 equipment, is seeing a cheaper price tag and going
6 there, because it may be the only way he or she can
7 get on the road.
8 You know as well as I do that sometimes
9 the VA pays two and three times for something when
10 it is done incorrectly. There's an issue of
11 wasteful spending that needs to be eliminated. A
12 sticker, a certification, something. I don't want
13 to create more work for the VA, but the VA needs
14 to give the veterans the assurance that the VA has
15 his or her back.
16 And lastly, the Veterans Mobility
17 Safety Act directs the VA to come up with standards.
18 That's a challenging task. But I encourage you not
19 to try to recreate the wheel. Look at what
20 organizations like NMEDA have in place. Look at
21 what they are developing. Look at how the industry
22 is progressing.

1 The industry is advancing faster than
2 you can imagine because we veterans are pushing it.
3 We want vehicles, not just to get us around, but
4 to give us a quality of life and a standard that
5 we deserve.
6 Develop a policy, not a system, where
7 you remain out in front, not playing catchup. Talk
8 to veteran service organizations and get their
9 input. Ask your own driver rehab specialists to
10 give their input. Work with the national
11 association that has dedicated more years than
12 you can imagine to this very issue.
13 And yes, I say this from experience, and
14 I volunteer to help, ask the veteran as well.
15 Thank you.
16 MS. NECHANICKY: Thank you, Speaker
17 Number 1. While Speaker Number 2 comes up to the
18 podium, I'd like to ask, there are our partners on
19 the VANTS Line, on the conference call, to please
20 mute your phone. We can hear some background noise
21 and it is disruptive, so if you could please mute
22 your phone, that would be helpful. Thank you.

1 You may begin.
2 MR. DAWSON: Thank you. Good morning.
3 My name is Steve Dawson and I'm the CEO of Harmar.
4 Okay. Is that any better? Okay. Great. My
5 name is Steve Dawson. I'm the CEO of Harmar, just
6 in case you didn't hear it the first time.
7 I appreciate the opportunity to present our
8 thoughts to you today. Harmar is a proud supplier
9 of auto lifts, stair lifts, and porch lifts to the
10 VA. We were the first lift manufacturer with an
11 FSS contract. We started in 2008.
12 We estimate that we have sold over
13 100,000 lifts to the VA for veterans. We sell more
14 auto lifts to the VA than all other auto lift
15 manufacturers combined and we've had an exemplary
16 safety record.
17 I give these data points in our history,
18 not to brag or impress you, but rather, to talk to
19 you about our experience and our history with the
20 VA.
21 Let me start by saying that the Veterans
22 Mobility Safety Act, enacted by Congress last year,

1 has a commendable objective, that is to establish
2 safety standards for accessibility modifications
3 for veterans' vehicles, paid for by the VA, and we
4 support that wholeheartedly.
5 And we were glad to see that it
6 preserved some very important elements, such as
7 preserving manufacturer certifications, installs
8 performed at the veteran's home, and seeking to
9 avoid financial conflicts of interest with
10 third-party certifying agencies.
11 Our goal in presenting today is to
12 ensure these valuable services and the means in
13 which they are provided are not inadvertently
14 eliminated or reduced by the new regulations.
15 We believe the key standards that
16 should be addressed are related to manufacturers
17 and installers, and these should be incorporated
18 into your handbook. I'm just going to jump right
19 into it.
20 On the manufacturer's side, we believe
21 that installers should have personal
22 certifications, individuals certifications, for

1 the product they are installing. So each
2 manufacturer will provide a badge or a certificate
3 for that person to identify them as a certified
4 installer for that business.
5 The manufacturer shall retain the
6 installation training records for a minimum of five
7 years to evidence the installation if you ever want
8 to go back and look at the records.
9 Each manufacturer shall have a
10 documented quality system and each manufacturer
11 should have a system to evaluate product
12 compatibility for the product the AAE is being
13 installed on, so that they work together.
14 For the installer, we think, again,
15 each installer shall follow the manufacturer's
16 guidelines for product selection. In our case, we
17 have a compatibility calculator that matches the
18 lift to the vehicle and the adapters and such that
19 are required for it, and of course, the scooter or
20 wheelchair, so it all kind of mixes together.
21 The equipment shall be installed to
22 manufacturer's standards. Each installer is

1 responsible for getting certified. They must be
2 certified by the manufacturer. Each installation
3 must be overseen and performed by a certified
4 installer. We think that's critical.
5 So you could have two guys on an
6 install, or two people on an install, but one of
7 them has to be certified.
8 An installer shall only install if the
9 working conditions and location are acceptable and
10 safe. So on a hill, in the middle of a snowstorm,
11 probably not a great idea to put on an auto lift.
12 The installer must retain the veteran's
13 signature of approval on the install, either that,
14 or the caregiver. And the installer shall also
15 retain documents for five years.
16 We also think it's important to discuss
17 the veteran themselves. Each veteran shall be
18 trained as to how to load and secure the mobility
19 device and safely operate the equipment. Each
20 veteran shall be provided with operating and
21 maintenance instructions for the equipment, shall
22 be given warranty registration, owner's manual,

1 and installer's and manufacturer's contact
2 information, and an 800 number to contact the
3 manufacture in case there's an issue.
4 And that veteran or caregiver, again,
5 should sign the installation certificate when
6 they're done. The veteran's a key part of this
7 process. It's not just the manufacturer and it's
8 not just the installer, but it's a three-way effort
9 to bring it all together.
10 And we ask when implementing these new
11 rules, we think there should be a phase-in period
12 because it's going to take, I think, a lot of
13 organizations to get ready and handle whatever
14 changes come through, there's going to be some work
15 involved, so I would consider a phase-in period for
16 whatever new regulatory scheme we come up with.
17 We think it's essential that new
18 standards and implementing regulations not limit
19 the locations where one can add a lift, since
20 there's no evidence that such a restriction would
21 improve safety.
22 The VA should not try to regulate which

1 product or lift should go on the vehicle. The
2 number of possible combinations would be way too
3 burdensome. For example, in our particular
4 situation, we have 7.5 million combinations of
5 lifts, vehicles, scooters, and other equipment.
6 That's significant.
7 Instead, the VA should rely upon the
8 manufacturers of these AAEs, who are the subject
9 matter experts. It is also important that VA
10 regulations and standards follow the VMSA
11 requirement, that the agency considers the
12 differentiation and complexity, simple or complex
13 problems.
14 We think substantially altering a
15 vehicle and its operating controls versus
16 attaching an exterior lift, which is more like a
17 bicycle rack, that's a good example of difference
18 in complexity.
19 Also, consider that there's different
20 types of business models that serve the VA today,
21 including work done in a shop or garage, field
22 service, home install, and several others,

1 something you might not even think about, and
2 you'll probably hear from other folks today.
3 We think that the key criteria judging
4 these services is to determine if the product can
5 be provided safely, and in a cost-effective manner,
6 and in such a way to give the veteran the best
7 overall experience, because we honestly believe
8 that's what this is all about. It's the end user
9 that's critical in this process.
10 We're not trying to stop a garage-based
11 install, in fact, we work many NMEDA dealers today,
12 and that's part of our organization, but we also
13 think that at-home or in a more convenient location
14 for the veteran is critically important. Some
15 veterans have to travel significant distances -
16 four, six hours - to get to a garage, so that's just
17 not appropriate in most situations.
18 The VA should consider the VMSA
19 requirement as it develops and implements
20 financial conflict of interest procedures when
21 considering any third-party association to serve
22 in a certifying role.

1 Ultimately, this legislation and the
2 handbook that you're developing is about safety and
3 providing our veterans with a quality experience.
4 So moving on, I want to talk a little bit about some
5 of the standards, and in particular, some proposed
6 standards by NMEDA and QAP.
7 I'll start with some facts --
8 (Audio difficulties)
9 MS. NECHANICKY: Sorry about this.
10 Amber's going to go get the gentleman to come back
11 and fix it. Thank you. That was giving me a
12 headache. That's okay.
13 MR. DAWSON: Can you hear me? Still
14 works.
15 MS. NECHANICKY: Okay. Let's just do
16 one check before we get started. Hang on a minute.
17 You good? Okay. You all good? Ready?
18 MR. DAWSON: I'm ready.
19 MS. NECHANICKY: Okay. Start the time
20 again.
21 MR. DAWSON: Thank you.
22 MS. NECHANICKY: Thank you.

1 MR. DAWSON: First of all, Harmar is a
2 member of the NMEDA organization, in good standing,
3 and I personally have a good working relationship
4 with the CEO of NMEDA, which may be surprising to
5 some, who I don't think was here during the initial
6 part of this legislative process.
7 The NMEDA trade organization is run by
8 van modification businesses and their dealer
9 networks, which, in my world of auto lifts, that's
10 a small portion of our business and our customer
11 base.
12 In fact, auto lift installs in NMEDA
13 shops represent only a fraction of our overall
14 lifts installed. It's a very small part of who we
15 work with in our organization. We have thousands
16 of installers across the country and only a small
17 percentage of those are NMEDA.
18 And it's also a fact that NMEDA wants
19 the VA to accept its proprietary standards, which
20 we understand, and some of which we think are good,
21 which are called QAP, but they reflect the biases
22 and competing financial interests of the

1 controlling members of the organization.
2 We were part of working on some of the
3 standards. One of my guys in my organization
4 actually sat on committees for some of these trying
5 to steer it in a more reasonable direction, but was
6 unsuccessful.
7 And I'll tell you in their own words,
8 something that I thought was interesting, and this
9 comes from the NMEDA spring 2015 newsletter,
10 "Getting the VA to adapt selection criteria based
11 on a NMEDA quality assurance program, QAP, is the
12 single most important thing we could do to support
13 sales growth." And that was highlighted in their
14 newsletter.
15 So when we're talking about safety,
16 that doesn't sound to me like a safety driver. QAP
17 standards include some unnecessary things, in our
18 opinion, such as four-corner scales, two
19 installers on each lift. I'll say that most lifts
20 installed today are done by one person.
21 If you've ever put a bike rack in the
22 back of a car, you don't need two people for that.

1 Bike rack, and a wire, many installs are done within
2 an hour, hour and a half.
3 Other QAP standards dictate which lifts
4 are applicable for which vehicle. And who knows
5 better which lifts are appropriate, the
6 manufacturer or this trade organization?
7 We're concerned if QAP were
8 implemented, non-members would be forced to
9 increase costs and overhead to meet these
10 standards, thereby, leveling the playing field for
11 its association members.
12 NMEDA requires payment of membership
13 fees and only represents quality standards of
14 manufacturers who are members of NMEDA. Not all
15 industry participants choose to belong to NMEDA and
16 should not be forced to in order to conduct business
17 with the VA.
18 Given the financial conflicts with paid
19 memberships, we do not believe that NMEDA qualifies
20 as an independent third-party organization that
21 can be a certifying agency and we don't think
22 they're a safety organization either.

1 And most importantly, this is about the
2 standards that are going to be proposed in the
3 rulebook and so we want to just recap the important
4 points. We think the manufacturer should bear the
5 responsibility for certifying their products.
6 That's very, very important.
7 Installers need to be individually
8 certified. We think veterans need to be properly
9 trained. Michael made some really good points.
10 And sign-off on their install.
11 And basically, let's not
12 over-complicate the process. Let's not hurt the
13 small businesses and the veteran-owned businesses
14 serving the veterans at their homes today. Thank
15 you.
16 MS. NECHANICKY: Thank you. Speaker
17 Number 3? Let us get the time ready and then we'll
18 get to you.
19 MR. RENBERG: I don't have Steve's
20 magnetic personality so there should be as much
21 feedback.
22 MS. NECHANICKY: That was good.

1 MR. RENBERG: My name is Dan Renberg.
2 I work at the Arent Fox law firm here in Washington.
3 I have the privilege of representing Harmar and I
4 also worked with many of the stakeholders who will
5 be here today.
6 I've got a different task at hand, I'm
7 going to try to focus on some of the statutory and
8 regulatory issues, focusing on the statute itself,
9 the legislative history, et cetera, to try to give
10 you some thoughts as you put together this set of
11 regulations.
12 It's difficult to follow someone like
13 Mike, who has an impassioned approach to this and
14 who has lived through so much, and who gives you
15 a singularly unique perspective of the three of us,
16 and I'm so glad he was able to be the first speaker,
17 because it reminds us that this is about veterans,
18 this is about safety, and this is about making sure
19 that people who give so much to us as Americans get
20 the best that they can out of their government, out
21 of your agency, and thank you for all that you do.
22 It goes unsaid on most days, that the

1 people here in this building are doing so much for
2 us. I used to work at Ex-Im Bank, and so we came
3 over for your cafeteria, but we also grew to have
4 a healthy respect for our neighbors on the first
5 four floors.
6 I think that all the stakeholders today
7 are going to agree on the end goal of what you're
8 doing with VMSA implementation, but there may be
9 some differences in how we actually suggest you get
10 there.
11 I think that today, you're going to hear
12 from some dealers, small business people, many of
13 who are veterans themselves, who can offer
14 particularly relevant insight from the trenches.
15 I'm going to focus on three or four main points and
16 then yield the floor to far more important folks.
17 I want to talk first about the need for
18 preserving what we call at-home or driveway
19 installations. It's really important that the
20 quality and safety standards you adopt will bear
21 in mind the congressional exhortation in the law
22 that the new regulatory regime should preserve the

1 ability of veterans, "to receive modifications at
2 their residence of location of choice."
3 We believe implicit in this legislation
4 was assumption of creating a reasonable standard
5 that allowed the home installation of something,
6 like an external lift for a motorized scooter of
7 wheelchair, without placing unnecessary
8 requirements on the installer.
9 Congress intended that the VMSA will
10 not inadvertently reduce home service for
11 veterans, which has worked, historically, quite
12 well, because veterans don't have to contend with
13 weather, traffic, parking, and wait times, as they
14 might if they have to go to a brick-and-mortar
15 commercial establishment.
16 It's important that the standards
17 promulgated by you under this legislation won't
18 impose new limitations on where one can add a lift
19 or provide other modifications, with no
20 corresponding evidence that such a restriction
21 would improve safety.
22 Nothing the VMSA was intended to choke

1 off the ability of veterans to choose to receive
2 a wheelchair, scooter lift, or converted van at
3 their homes, provided that it is installed or
4 modified by a certified provider.
5 In fact, the House committee report
6 accompanying the VMSA stated, "The committee is
7 aware that many veterans receive installations
8 and/or modifications through the AAE Program at
9 their place of residence. The committee intends
10 for the VA to preserve access to residential
11 installations and service, where appropriate, when
12 developing and implementing standards pursuant to
13 this section."
14 In order to preserve these at-home
15 services, we urge the VA not to adopt any standard
16 regulation that requires the use of four-corner
17 scales or other equipment it would be infeasible
18 to use for installation of equipment at the
19 customer's house.
20 To reduce the chance that some
21 companies will not let veterans know of their right
22 to receive modification services at their

1 residence of choice, which is reflected in Section
2 3(b)(8), we supported the addition of language in
3 the VMSA requiring the VA to develop standards,
4 "that ensure such receipt and notification to
5 veterans of the availability of such receipt."
6 We suggested that veterans receive a
7 notice from the VA during their assessment in a VA
8 wheelchair clinic and that the notice makes clear
9 that the veteran may be eligible for this kind of
10 at-home service, installation, or other
11 modifications.
12 Another key point is the
13 differentiation in complexity, which is addressed
14 in the law. We believe it's very important that
15 when you put out the regulations, you're going to
16 differentiate between simple and complex
17 modifications to vehicles, and to implement
18 standards that will reflect that differentiation.
19 This approach is borne out by the
20 direction to the VA in Section 3(b)(2) of the law.
21 Failure to differentiate successfully is going to
22 create new, unnecessary, and costly regulatory

1 hurdles for our companies, and will adversely
2 impact veteran customers, and add costs for the VA.
3 The law requires the VA to develop
4 standards for safety and quality of equipment and
5 installation through the AAE Program, "including
6 with respect to the defined differentiations in
7 levels of modification complexity." This
8 reflects Congressional recognition that it's
9 inefficient and unnecessary to impose the same
10 standards on simple modifications as for more
11 complex modifications to a vehicle.
12 Support for this interpretation comes
13 from the House Committee report, which states that
14 the committee would also support VA
15 differentiating between complex vehicle
16 modifications that involve changes to the
17 structure or controls of a vehicle and less complex
18 modifications.
19 We believe that you could define
20 complex and simple modifications fairly easily and
21 we have suggested in our answer to the RFI that a
22 complex modification is one that interfaces with

1 the vehicle control functions or driving controls
2 that operate through the design logic system, or
3 that interfaces with the electronic system of the
4 vehicle, systems or devices that alter the
5 structural integrity of the vehicle would be
6 installed as complex modifications.
7 On the other hand, a simple
8 modification can be something that doesn't meet the
9 definition of complex. This would generally
10 include items that are easily installed, simply
11 changing the location of a driving control, or a
12 manual or relocated pedals, or adding an external
13 unoccupied scooter or wheelchair lift.
14 In terms of the standards that you're
15 going to be selecting, in formulating the
16 standards, we think it's important that the agency
17 refrain from attempting to regulate which type of
18 product goes with which vehicle, which is a
19 decision most appropriately left to the
20 manufacturer.
21 If the VA attempts to create rules which
22 will dictate the specific exterior wheelchair or

1 scooter lift that can be put on a specific vehicle,
2 it would be incredibly burdensome on your agency
3 to implement, because the number of types of
4 vehicles and lifts on the market would make the
5 number of combinations immense.
6 I think Steve said 7.5 million. That's
7 a fairly large number. Because the manufacturers
8 of AAE are subject matter experts, we strongly
9 recommend you adopt an approach whereby you
10 leverage the experience of trained and certified
11 providers to achieve the goals of the law and leave
12 the question of engineering guidelines to the
13 manufacturers.
14 There are analogous situations
15 elsewhere in federal law, such as the regulatory
16 approach favored by the U.S. Food and Drug
17 Administration. FDA employs a qualitative
18 minimum safety and effectiveness threshold that
19 was interpretable by manufacturers of products
20 already on the market as well as those yet to be
21 developed, which the agency could not have
22 conceived of during development of that threshold.

1 Still, these new products are expected
2 to, and indeed satisfy, the safety and
3 effectiveness threshold established by FDA that
4 benefit individual patients. By not
5 over-regulating, the agency facilitates
6 innovation and competition to help continuously
7 bring to market products that build upon previous
8 iterations and are always improving to meet patient
9 needs.
10 The FDA accomplishes this goal by
11 leveraging healthcare professionals who are
12 trained and certified to determine the appropriate
13 solution for the individual.
14 For example, the FDA regulates the
15 general safety associated with products using a
16 knee or hip replacement, but it doesn't mandate
17 that a physician must use a particular brand of knee
18 or hip replacement product or how that product has
19 to be designed.
20 This cooperative and dynamic ecosystem
21 takes advantage of the strength of each player,
22 regulator, manufacturer, and provider to promote

1 a safe and effective innovative product for the
2 benefit of patients and their individual needs.
3 In a similar approach, the VA should not
4 seek to develop regulations with specific
5 standards related to each and every AAE product and
6 installation because, as I said earlier, it would
7 be extremely burdensome.
8 Set a more simple standard that AAE
9 products must be safe for their intended use and
10 safely installed. That would allow industry
11 experts to exercise discretion-based knowledge and
12 training, and to avoid unnecessary
13 over-regulation.
14 The stakeholders I've been working with
15 have concerns with specific elements of NMEDA's QAP
16 guidelines and also remained concerned about the
17 notion of the VA adopting a set of quality and
18 safety standards, in whole, offered by a trade
19 association whose members may have competing
20 financial interests of the very companies who would
21 have to implement those standards.
22 On certification, it's essential that

1 your agency ensure that manufacturers can continue
2 to certify providers and installers as they do
3 under the existing program. Manufacturers who are
4 closest to their programs are best suited to
5 certify compliance with the quality and safety
6 standards.
7 Another critical aspect of the VMSA is
8 a set of provisions aimed at reducing the potential
9 for an unfair conflict of interest if third-party
10 organizations act both as certifying bodies for the
11 members who -- I'm sorry, certifying bodies for the
12 installers who perform modification services and
13 also as trade associations requiring membership.
14 Recognizing the potential for
15 misconduct in Section 3(c)(2), Congress provided
16 that there must always be two third-party
17 non-profit certification organizations if any are
18 to be playing a role in this program.
19 That should help reduce the likelihood
20 of monopolistic activities by any one
21 certification organization. In terms of
22 manufacturer certifications, we think it's

1 important that you develop standards that provide
2 for manufacturers to continue to be certifiers.
3 They have the most detailed knowledge
4 of the products and are thus the best qualified
5 entities to certify affiliated dealers and
6 installers.
7 One advantage of a robust manufacturer
8 program is that they often charge nothing to
9 certify installers. By contrast, third-party
10 certification organizations could charge
11 unlimited rates for certification. It's not
12 limited in any way in the statute.
13 Manufacturers will be able to continue
14 certifying installers more efficiently than any
15 third-party organization and there will not be
16 conflict of interest or prioritization of some
17 dealers over others.
18 Lastly, you should know that if dealers
19 must pay a third-party certifying non-profit for
20 this process, dealers can be expected to pass along
21 higher costs to the VA, meaning that veterans are
22 not necessarily safer, but the benefits will cost

1 more for taxpayers.
2 Accordingly we believe that
3 manufacturer certification standards that you'll
4 be developing will empower manufacturers and
5 dealers to maximize their efficiency and keep
6 program costs lower than might be otherwise the
7 case.
8 We also want to point out that
9 manufacturers, installers, modifiers, and others
10 in the supply chain would benefit from the
11 reasonable phase-in period that Steve has
12 mentioned. It's going to take time to develop the
13 certification procedures to account for the new
14 quality and safety standards that you're going to
15 be implementing.
16 In terms of third-party certification
17 organizations, I would like to quote from the House
18 Committee report accompanying the VMSA, stated
19 that the Committee expects the VA to take all
20 appropriate steps to minimize the potential for
21 conflicts of interest, particularly if a
22 third-party organization who stands to

1 unreasonably gain from designated quality
2 standards, high enough so that only the
3 organization itself can provide certification of
4 modification equipment is selected as a certifying
5 body.
6 In the interest of time, I'm going to
7 jump to the concluding paragraph. Congress
8 routinely imposes conflict of interest
9 requirements in detail, and inserts a level of
10 accountability to a federal agency and to Congress
11 when permitting third-party organizations to be
12 involved with development of standards and
13 certification of industry actors.
14 The Food Safety Modernization Act
15 requires FDA to ensure competence and independence
16 of third-party auditors and certification bodies
17 that conduct foreign food safety audits.
18 It ensures the reliability of food and
19 facility certifications issued by third-party
20 auditors and certification bodies that the FDA will
21 use in making certain decisions related to imported
22 food, including pet food and animal food.

1 The law provides an accredited
2 third-party auditor shall not be owned, managed,
3 or controlled by any person that owns or operates
4 an eligible entity be certified by such auditor.
5 Similarly, the VMSA requires you to
6 establish procedures that ensure against the use
7 of a certifying organization that has a financial
8 conflict of interest regarding certification of an
9 eligible provider.
10 We urge you to adopt appropriate
11 standards and procedures under this section and to
12 enforce it vigilantly once implemented. With
13 that, I thank you.
14 MS. NECHANICKY: Thank you. Speaker
15 Number 4, please approach the podium.
16 MS. KEMPF: Thank you. My name is
17 Martine Kempf, founder and CEO of Kempf, Inc. We
18 design, manufacture, and install digital hand
19 controls for drivers who cannot use their legs, but
20 who still have full dexterity of their hands, like
21 paraplegics.
22 We are a NMEDA member and QAP certified.

1 Let's remind us who the heroes are we have the
2 privilege to serve, like Mike, but I will give you
3 another example. Mark, a Marine Staff Sergeant,
4 was a bomb technician, responsible for taking apart
5 the countless numbers of homemade explosive
6 devices hidden in Iraq and Afghanistan.
7 He had already been injured four times,
8 but still insisted to go back. The fifth time, he
9 stepped on an IED and lost both of his legs. Thanks
10 to great VA medical care, and his strong will, he
11 managed, just 18 months later, to climb Mount
12 Kilimanjaro as a double amputee.
13 He also decided to drive again and the
14 VA paid for his digital hand controls. In the last
15 five years, he drove 150,000, criss-crossing the
16 continent from Alaska to Baja, from California to
17 Florida. We are very honored to be able to serve
18 Mark and many other veterans.
19 Now, let's just imagine what would
20 happen if, God forbid, Mark had an accident that
21 was linked to his car adaptation. Who would be
22 responsible? The VA, NMEDA, the QAP certifier?

1 Of course not. None of them. Only the installer,
2 and ultimately, we, the manufacturer, would be
3 responsible.
4 Fortunately, this has never happened,
5 but I mentioned it to illustrate who is taking the
6 risk. It is always the manufacturer, no matter if
7 he's QAP certified or not, he will be responsible.
8 So what minimum standards should the VA
9 set for manufacturers and installers to be
10 providers of the Auto Adaptive Equipment Program?
11 The VA could require, from the manufacturers, to
12 show proof of liability insurance, to offer
13 sufficient warranty, for example, a minimum of two
14 years covering parts and labor, and a require that
15 the products be installed by well-trained
16 technicians.
17 This is just common sense. No
18 manufacturer wants its products to be poorly
19 installed, but only the manufacturer can determine
20 how much training is required. For some simple
21 products, it might just be a few hours, but for some
22 complex installations, it might require more than

1 two weeks of training.
2 So I suggest the VA should rely on the
3 manufacturers to make sure that every technician
4 who installed their products is well-trained.
5 From the installers, the VA could require to show
6 proof of liability insurance and to offer 24/7
7 answering service to respond to emergencies.
8 This would be, in my view, the minimum
9 requirement. Now, I'd like to tell you why the QAP
10 standards from NMEDA are not the solution for every
11 AAE provider. The QAP standards are tailored to
12 mobility dealers with a particular business model.
13 The brick-and-mortar dealership with equipment,
14 staff, and a well-defined sales and service area.
15 There are at least two groups of
16 manufacturers and installers whose business models
17 are incompatible with the QAP standards. The
18 first group includes manufacturers who sell their
19 products mainly online, deliver them nationwide to
20 the veteran's homes, and provide training and
21 service through the employees or trained
22 representatives at the customer's homes.

1 Even with excellent products and
2 services, most cannot be QAP certified, mainly due
3 to the restrictions in paragraph "out of area sales
4 of the QAP standards," because remember, they sell
5 nationwide.
6 The second group includes small dealers
7 who mainly install products which could be
8 described as simple, scooter lifts, at the
9 veteran's homes. These installers are
10 well-trained by the manufacturers, but often don't
11 have a large enough facility to comply with all the
12 QAP requirements.
13 Today, these two groups of manufactures
14 and dealers are providing an excellent service to
15 many veterans and I ask the VA to keep them in mind
16 when setting new standards for the AAE program.
17 I'd like to conclude by sharing an idea.
18 The VA could implement a customer satisfaction
19 system, available exclusively to AAE
20 beneficiaries, asking them to rate the products and
21 services just after they receive them, and maybe
22 one year later again.

1 This could provide the VA with real data
2 on how each manufacturer and each dealer is
3 performing in the eyes of the veterans. The VA
4 could then ask the providers with unsatisfactory
5 ratings to either improve or risk to be
6 disqualified from participating in the AAE
7 program.
8 This could ensure the Mark and all the
9 other veterans would continue to receive safe and
10 reliable products and services through the Auto
11 Adaptive Equipment Program, which, I think you'll
12 agree, is the common goal which unites all of us
13 in this room.
14 Thank you very much for giving me the
15 opportunity to contribute.
16 MS. NECHANICKY: Thank you so much.
17 Speaker Number 5, please approach the podium. You
18 may begin.
19 MR. DRESDNER: Thank you. Good
20 morning. Thanks for allowing me time to present
21 our organization's thoughts regarding the
22 implementation of the Veterans Mobility Safety

1 Act.

2 I'm Michael Dresdner and I'm president

3 of the Adaptive Driving Alliance, also referred to

4 as the ADA. I'm here today with my colleague, Matt

5 Jones. The ADA is business services organization

6 serving mobility equipment providers with a

7 network of 253 mobility equipment dealer locations

8 throughout the United States.

9 As a point of information, over the last

10 27 years, I've been a mobility equipment installer,

11 I've been a licensed state driver trainer, and I've

12 operated several mobility equipment dealerships.

13 Within that scope, I've manned the afterhours

14 pager, or now referred to as the cell phone, and

15 I've fielded calls on virtually every kind of

16 product and installation failure that you can

17 imagine.

18 The ADA has been in business for over

19 20 years and we currently hold a federal supply

20 schedule contract for automotive adaptive

21 equipment, including wheelchair and scooter lifts,

22 automotive transfer seats, and wheelchair

1 accessible conversions.
2 Our contracted products cover the full
3 spectrum of vehicular mobility. While performing
4 our duties under the FSS contract, we rely on our
5 local mobility equipment dealers to properly
6 evaluate the veteran as well as install and service
7 the adaptive equipment.
8 Rightfully, the veteran expects that
9 they're being provided the correct product for
10 their needs, and that the installation is safe, and
11 of good quality.
12 To help ensure the dealer has the
13 appropriate knowledge and training to accomplish
14 these installations, the ADA relies on the
15 industries quality assurance program. All ADA
16 dealers are required to be ADA accredited -- excuse
17 me, QAP accredited. This allows us the confidence
18 that veterans are getting the highest quality of
19 care that I think we all agree they deserve.
20 Matt and I are here today because we
21 don't want to -- we want to see standards enacted
22 that are meaningful. We do not want to see the

1 process of creating standards eroded to where they
2 provide limited or no value to our veterans as well
3 as the driving public.
4 We also want to help ensure that no
5 Adaptive equipment products are excluded. Our
6 goal is that no veteran or any person sharing our
7 nation's roads is exposed to dangers because a
8 product the VA purchased required minimal or no
9 safety standards pertaining to its installation.
10 It's also our goal to make sure veterans
11 receive proper training on the equipment that's
12 issued to them.
13 Please allow me to walk you through two
14 real-life scenarios of what could be considered
15 simple installations. These are the type of
16 installations that we urge are not excluded.
17 Example Number 1, a deal installs an
18 exterior-mounted scooter lift on a vehicle that had
19 previously had a trailer hitch installed. On the
20 surface, not very complex or difficult, however,
21 the lift installation requires a certain amount of
22 weight capacity and power to operate.

1 Would the installer know to check the
2 weight capacity of an existing hitch or just assume
3 it is suitable? And how would he or she run the
4 wiring? It may be argued that running a power wire
5 to a battery is a simple task. Perhaps, but not
6 always.
7 For instance, in a simple situation, if
8 the wire goes to a battery pack, in the trunk of
9 the car, how is it routed and how is it protected
10 from the constant motion of the trunk lid?
11 If the wire runs through or under the
12 vehicle to the OEM, original equipment
13 manufacturer's battery, within the engine
14 compartment, how is that wire routed? What
15 creates heat under a vehicle, could it melt the wire
16 casing, and what moves under a vehicle that could
17 abrade the wire, causing a short?
18 Wires have been damaged and a fire can
19 be caused in a vehicle that's transporting a
20 veteran with very limited mobility.
21 In addition to the most obvious
22 questions, what path can the wire take that will

1 not create electrical interference for an OEM
2 component and how does that question become more
3 complex with the rapid advancement of automotive
4 technology?
5 These questions and others will need to
6 be answered via a high-quality routine training for
7 installers. A seemingly simple installation can
8 become very dangerous when handled by the
9 untrained.
10 Increasing complexity and the
11 advancement of automotive technology will make
12 quality training and ongoing training mandatory.
13 The simple hitch-mounted lift can cause
14 other serious safety implications if someone who's
15 not properly trained is performing the
16 installation. With securing anything to the hitch
17 of a motor vehicle, there's several important
18 dynamics that come into play; towing capacity,
19 hitch capacity, axle weight, and tongue weight.
20 Let me further define those terms.
21 Towing capacity is the total weight of what you are
22 pulling and is rarely, if ever, an issue with our

1 industry's products. This maximum capacity is
2 established by the OEM, original equipment
3 manufacturer, such as Ford, Chevrolet, or
4 Chrysler.
5 Hitch capacity is the maximum weight
6 the trailer hitch is capable of holding and is
7 established by the hitch manufacturer. Hitch
8 capacity has nothing to do with the weight that any
9 particular motor vehicle can accommodate.
10 Axle weight is the weight borne by each
11 axle of the motor vehicle. The maximum capacity
12 is established by the OEM, original equipment
13 manufacturer, and is engineered to provide maximum
14 vehicle control and stability.
15 And lastly tongue weight. Tongue
16 weight is the downward force exerted on the vehicle
17 at the point of the hitch/lift connection.
18 Excessive tongue weights can impact the safety
19 performance of a motor vehicle. Vehicle
20 manufacturers perform rigorous testing to
21 establish specifications for any weight-related
22 issues that could affect the drivability of their

1 products.

2 When someone who's not properly trained

3 installs a hitch and a lift on the back of a vehicle

4 that exceeds the OEM manufacturer specifications

5 for that vehicle, the safety of the occupants and

6 the driving public can be placed at risk.

7 As the combined weight of the hitch and

8 lift, as well as the wheelchair and scooter push

9 down on the back of the vehicle, additional weight

10 is placed on the rear axle and may be lessened on

11 the front axle. This, in turn, can impact the

12 traction available at the front wheels.

13 As such, altering the axle weight

14 beyond certain limits can significantly reduce the

15 breaking and steering capacity of the vehicle,

16 making for an unsafe situation.

17 This risk can be assessed and

18 eliminated by using tools such as four-wheel scales

19 or a tongue-weight scale, allowing the installer

20 to weigh the vehicle and fully assess and

21 understand the altered axle weight, or, at minimum,

22 determine the tongue weight, making sure it's

1 within certain tolerances and confirming a safe
2 installation.
3 Skipping a critical step like this puts
4 our veterans and the driving public at risk.
5 Requiring the use of a full array of common industry
6 trade tools helps keep our veterans and the driving
7 public safe.
8 How dangerous is a simple installation
9 when something's gone wrong? Aside from the
10 weight and electrical issues I discussed
11 previously, there are known instances of scooters
12 and wheelchairs that were not properly secured to
13 the lift platform and have fallen onto a public
14 thoroughfare while the vehicle is underway.
15 A large wheelchair rolling down the
16 highway can be catastrophic to an approaching
17 motorist.
18 A well-trained installer who properly
19 educates the veteran on the use of the lift and the
20 securement of the mobility device can greatly
21 reduce or even eliminate this risk. As has been
22 mentioned previously, there are a multitude of

1 combinations of various things that impact the use
2 of an outside lift.
3 Please note that this multitude and
4 broad range of devices that secure a scooter or
5 wheelchair to a platform can have great impact.
6 Knowing how each performs with any given mobility
7 device and training the veteran and/or the
8 caregiver, is a critical part of the entire lift
9 provision experience.
10 Example 2, another example of a simple
11 installation would include wheelchair and occupant
12 restraints installed in a van, typically for a
13 wheelchair user. Drill a few holes, tighten a few
14 bolts, and you're done, until there's an accident.
15 At 30 miles per hour, an accident can
16 generate 20 Gs of force, that's 20 times the weight
17 of gravity as we experience it standing here today,
18 and as an example, a 200-pound person seated in a
19 250-pound wheelchair, can generate 9000 pounds of
20 force.
21 Standard bolts versus graded bolts
22 would likely sheer. Bolts without proper backing

1 plates or large washers behind the secure points
2 could pull through the vehicle chassis sheet metal.
3 This is one more example of things the veteran
4 cannot see.
5 He or she can only trust that the
6 installation is safe. And in actuality, the
7 veteran is relying on the installer for his or her
8 physical well-being. The exclusion of any product
9 from safety standards or standards that are so
10 watered down as to be ineffective, would be a
11 serious disservice to our veterans as well as the
12 driving public.
13 So how does the VA establish standards
14 without, one, going through a lengthy and
15 technically specific standards development
16 process, and two, creating standards that are
17 ineffective and do not provide the safety our
18 veterans, their caregivers, and the driving public
19 deserves?
20 The ADA recommends, as one model, using
21 what's already been established, proven, and
22 adopted by many states, the Quality Assurance

1 Program of the National Mobility Equipment Dealers
2 Association, or NMEDA.
3 NMEDA is a non-profit organization,
4 their Quality Assurance Program, QAP, has been in
5 existence and repeatedly refined for over 20 years,
6 and is underpinned by the NMEDA guidelines. The
7 guidelines are an industry-produced set of
8 procedures written and regularly updated by
9 industry professionals.
10 The guidelines cover the full range of
11 vehicular mobility equipment and form a base of
12 knowledge that assures a positive outcome. We all
13 know that business dislikes regulation, but in the
14 case -- pardon me.
15 But when an industry comes together and
16 regulates itself, as is the case with the NMEDA QAP,
17 there's something valuable therein. These
18 guidelines work for the veterans, they work for the
19 dealers, they work for the industry, and they also
20 act to protect the driving public.
21 The QAP program's not unduly burdensome
22 on any dealer committed to quality installations.

1 There are different levels of accreditation, with
2 one inclusive of less complex bolt-on
3 installations, such as lifts, as well as those
4 addressing more complex modifications.
5 This allows the most effective
6 standards to be applied to installers based on the
7 products they install without undue burden,
8 maximizing the installer base for both the VA and
9 for the veterans.
10 And as a point of record, you can be a
11 QAP dealer without being a NMEDA member, and thus,
12 have those qualifications from the QAP program.
13 We urge you to take a close look at the
14 QAP program and the NMEDA guidelines, and use
15 what's already been created by experts in the
16 industry as a model for those minimum standards.
17 We also ask that you listen to those in the industry
18 that choose to do things the best and safest way
19 possible and keep the safety of our veterans at the
20 forefront as the rulemaking process continues.
21 The veteran, their caregiver, and the
22 driving public are all reliant on the quality of

1 the installation for their safety and the
2 convenience of a product that works. They deserve
3 safety no matter what product is installed.
4 As a dealer network dedicated to
5 quality, we at the ADA respectfully ask that you
6 implement standards across all product lines that
7 are meaningful to the veteran as well as the driving
8 public. Thank you for the opportunity to present
9 our views.
10 MS. NECHANICKY: Thank you very much.
11 At this time, I'd like to ask Speakers 6 through
12 10 to come up to the front. We'll take just a
13 minute to make that change. Speaker Number 6, you
14 can approach the podium. Thank you.
15 Also, while we're getting settled, we
16 do need to give you a reminder that if you have a
17 badge, you have the sticky badge or a regular badge,
18 you do need to keep it on at all times, when you
19 go out to either the restrooms or to get -- over
20 to the canteen.
21 There is coffee on the other side, so
22 just make sure you keep your badge on. It is

1 important for us. Okay. I think we're ready.
2 Thank you. Speaker Number 6, you may proceed.
3 MR. LIPPS: Hi. Thank you very much
4 for the opportunity to be here. I want to go off
5 script right away. I thought it'd take me a little
6 longer, but I appreciate what you're doing. I
7 recently had to serve on a hearing panel for eight
8 hours, and after the first hour or so, it's very
9 difficult to stay focused, so thank you, and I
10 appreciate exactly how hard what you're doing is.
11 The speaker that draws Number 51's
12 information is just as important as the speaker
13 that draws Number 3, or in my case, Number 6, which,
14 now you need to pay attention.
15 So I appreciate your interest in
16 exploring how the VMSA impacts veterans on Main
17 Street and small businesses that serve veterans on
18 Main Street. I'm Scott Lipps. My family and I own
19 Home Care Mobility, a small DME that specializes
20 in access and mobility products in Franklin, Ohio.
21 Home Care Mobility works with an FSS and
22 GSA and serves the Dayton, Cincinnati, Columbus,

1 and Cleveland, Ohio VAs. We've also been in
2 meetings with the Fort Wayne and Indianapolis VAs
3 to initiate services in their areas.
4 Additionally, my father, Kenny Lipps,
5 a Korean War-era veteran, U.S. Army, and I own
6 Serving Veterans Mobility. This company
7 specializes in simple, non-complex vehicle lifts,
8 vertical lifts, stair lifts, and ramps.
9 Serving Veterans Mobility operates
10 with an FSS and has been going through the
11 application process for approximately six months
12 for our CVE -- our Certified Veteran-owned
13 Enterprise.
14 For the past six years, we've been
15 blessed to install approximately 1,000 lifts for
16 U.S. veterans. All 1,000 successful
17 installations have been done at the veteran's home
18 or location of choice. We have never performed an
19 install at our facility, and we have never used a
20 four-wheel scale.
21 We serve the veteran, and the veteran
22 does not serve us. An interesting bit of

1 information about our organization is we also own
2 a company called Sleep Tight Mattress Factory and
3 Showroom. Our employees all try to maneuver
4 themselves around the work for Home Care Mobility,
5 because at the completion of each job, we present
6 the veteran with an American flag for their
7 service.
8 Our employees do not see or hear a lot
9 of emotion for sewing a mattress correctly, but
10 presenting that flag gives them the opportunity to
11 see a lot of misty eyes and a lot of family members
12 catch their breath.
13 Finally, more than having the
14 opportunity to be on the frontline serving
15 veterans, I feel uniquely qualified to provide
16 input into this process. I'm a two-term former
17 mayor of Franklin, Ohio, and I currently serve as
18 state representative for Ohio's 62nd District.
19 As a 17-year public servant, I've
20 worked to serve the entire community, not special
21 interest groups, not those with the loudest voice,
22 not those with the most money, and not those that

1 try to work the system for their own benefit instead
2 of the overall interest for all.
3 Having watched this process play out
4 over the past few years, it's my opinion the VA is
5 at a unique crossroads. From my perspective, I see
6 on one hand, a large trade organization controlled
7 by two or three large van companies, looking out
8 for their members, and displaying a transparent
9 profit-drive motive.
10 On the other hand, I see thousands of
11 small business owners, just like us, often fabric
12 of the community leaders, that hire locally, live
13 locally, work locally, reinvest their products
14 locally, and donate locally, that are servicing
15 thousands of veterans every day without issues,
16 problems, or complaints.
17 So who should we support? The VA has
18 always supported local services and clearly had a
19 mandate to guarantee open and easy access to
20 service for all veterans. It is without question
21 that NMEDA controls or dominates the market for
22 vehicle modifications today, including van

1 conversions, driving controls, transfer seats, and
2 other auto modifications.
3 They do not control the market for
4 vehicle lifts. In fact, they have a minority share
5 of the vehicle lift market in general, and the VA
6 market in particular.
7 From a small business owner's
8 standpoint, and from a state representative
9 viewpoint, it appears to be a market grab for NMEDA
10 to take control over another market segment,
11 eliminate competition, and dramatically reduce
12 access to service for the VA and veterans.
13 I do not mean to offend you with such
14 a strong statement, but let's be clear, is this
15 really about safety? Our company's, Home Care
16 Mobility and Serving Veterans Mobility, has
17 successfully installed 1,000 lifts without even
18 being in the news for a product failure, without
19 complaints of shoddy workmanship, failure to do the
20 wiring correctly, or fail to provide on-time
21 service and adhere to manufacturer warranty
22 guidelines.

1 As you develop your handbook and
2 regulations, please avoid over-complicating a
3 well-designed process that has successfully served
4 tens of thousands of veterans.
5 Forcing thousands of small businesses
6 to inappropriate follow profit-driven motives of
7 one organization's program will limit access to
8 service for veterans, will increase cost to the VA,
9 will eliminate thousands of small businesses
10 across the nation dedicated to and experienced in
11 serving veterans.
12 It will not improve safety, but it will
13 drive up the profits of a few select companies that
14 figured out a way to play the VA and the system
15 politically.
16 When you think about the process of
17 certifying a product, who knows better than the
18 manufacturer? We represent today, eight
19 manufacturers. They research, design, test, and
20 they build their products. They issue a warranty,
21 a guarantee, and training on their products.
22 How could a third-party organization,

1 with no research, no designing, maybe even no
2 testing, on hundreds of products do a better job
3 certifying that product than the manufacturers?
4 The experts themselves.
5 Again, I feel compelled to ask, is this
6 about safety or is this about profit? I read the
7 VMSA legislation and understand the VA may approve
8 an option for third-party certification
9 organizations.
10 What does this add to the current
11 structure? We have installed 1000 lifts safely.
12 Every installer is certified. If it's a two-man
13 install, both installers are certified in our
14 organization.
15 We're certified, we're trained, we wear
16 labeled, clearly-marked uniforms. We display
17 identification badges with pictures, we drive
18 clearly-marked vehicles, all for the safety and
19 peace of mind of the veteran and their family.
20 What does a third-party certifier add
21 to that process? Maybe what is added is cost or
22 barriers to market entry, or limited access to

1 service, a sort of mini-monopoly, if you will, a
2 layer of time, costs, and burdensome rules and
3 regulations.
4 And for the record, should a
5 third-party certifying organization be required,
6 NMEDA should most definitely be that certifying
7 organization. It would be like the fox guarding
8 the hen house. It'd be like taking your Chevy to
9 a Ford dealer for warranty work. It is not common
10 sense and it does nothing positive for our
11 industry.
12 The VA must seriously consider
13 financial conflict of interest controls for any
14 third-party certifying associations or
15 organizations that serve in a certifying role.
16 Today, when specifying a lift, we use
17 manufacturers' compatibility calculators. We're
18 often told by our manufacturing partner which lift
19 is appropriate for that specific veteran's
20 install. The manufacturer needs to control this
21 process. It's a simple and effective method that
22 doesn't need rules to over-complicate it. It

1 simply works.
2 It has been replicated tens of
3 thousands of times. If the mousetrap works, why
4 do we need a new mousetrap? Unless someone has
5 found a possible path to increase their
6 marketshare, their profits, and build a monopoly.
7 NMEDA requires payment of membership
8 due fees and recognizes QAP standards of only the
9 manufacturers in their network. We choose not to
10 belong to NMEDA. We choose to put veterans first,
11 not profits. We serve our veterans, we should not
12 have to pay to serve our veterans and conduct
13 business with the VA.
14 So in conclusion, thank you for the
15 opportunity to be here today. I really appreciate
16 that you're taking this afternoon and listening to
17 third parties and the IPs. We enjoy serving
18 veterans through our service businesses. The VA
19 should not over-complicate the certification
20 process by creating detailed standards for each
21 product.
22 If you require a third-party

1 certification, please provide a choice of using
2 manufacturer certification or an independent
3 third-party certifier.
4 Standards such as QAP should be forced
5 on thousands of dealers across the country that
6 already perform admirably. Thousands of small
7 business service companies with a long track record
8 of successfully serving veterans should not be
9 forced out of business.
10 If it smells like money and not safety,
11 maybe you need to reread it. Thank you for
12 allowing us to serve veterans over the past six
13 years and thank you for the opportunity to be here
14 today.
15 MS. NECHANICKY: Thank you. Speaker
16 Number 7, please approach the podium.
17 MR. GEORGE: Hi. My name is John
18 George and I would like to thank the panel for
19 allowing me this opportunity. It's kind of
20 surreal being a welder by trade from a small town
21 in Southern California to take part in this
22 process. It's very different.

1 I own a small business that was created
2 specifically to do home installations at veterans'
3 homes on auto lifts for scooters and wheelchairs.
4 I was working as a manager of a shop that provided
5 the services at a physical location, about five
6 miles from the VA, and we had a couple requests from
7 the VA that people that literally couldn't make it
8 out of the home and get to the facility, was there
9 any way we could go out and do it.
10 And we weren't equipped, the business
11 wasn't equipped, for it, and the owner wasn't
12 interested in doing it because it just -- he just
13 wasn't interested.
14 So over the next few months, it spawned
15 an idea and I spoke with some of the manufacturers
16 that provided the equipment to us that we installed
17 for the veterans because we were just performing
18 the labor, and I took the idea, and I stepped out,
19 and I started John George Welding as an opportunity
20 to equip -- I equipped a commercial truck with,
21 basically, the same equipment that we had in the
22 shop that I work in, and went out, and started

1 taking the equipment that was supplied by the
2 vendor that was selling it to the VA, and I would
3 take it out and perform all the labor and
4 installation services at their house.
5 Over the years, it kind of snowballed.
6 I became a dealer for a couple different pieces of
7 equipment, and in some cases, sold it to the VA as
8 well as installed it, and it just kind of spawned
9 from there.
10 It didn't take, really, that long to
11 realize what -- the veteran's faces. It's things
12 that we take for granted, it's just unbelievable.
13 A lot of them, it's just simply the sheer distance.
14 I work for the West Los Angeles VA and
15 the Sepulveda VA, and they serve, obviously, the
16 metropolitan areas in which they are, but they have
17 satellite clinics in Santa Barbara, Santa Maria,
18 and Bakersfield, which, the range of Santa Maria
19 Clinic from LA is about 200 miles.
20 And by the time you get most of the way,
21 then you run into the traffic, so it can literally
22 take three to four hours to get there. And if

1 you've ever driven from Los Angeles to San
2 Francisco, there's a lot of gap in there. And
3 everybody who lives in those gaps has got
4 tremendous traveling distances.
5 Some guys are on oxygen, they'd have to
6 take a trunk full of bottles to be able to make a
7 trip like that; sometimes stay overnight. We've
8 partnered with the VA. Currently, we go two days
9 a month to the Bakersfield clinic, and we setup at
10 the clinic, and perform the services that were
11 scheduled.
12 So the guys that, they come locally, to
13 the local VA, and then outlying areas, we always
14 go out.
15 My concern is to preserve that service.
16 I mean, these guys are -- you know, I've developed
17 relationships with these guys. I've done well
18 over 4000 lifts. I've been doing it -- I started
19 in 2003 and I've done, for almost 2000 vets, I've
20 done 4000 lifts, so multiple cars for some of the
21 same guys.
22 These guys have, you know, quite a few

1 of them have become family. I've been invited to
2 the family picnics, and I see them on a regular
3 basis. I do service and repairs. I just don't --
4 I can't -- in California, we're so regulated.
5 We're operating on the payment schedule of a
6 national contract and operating in California.
7 It's a little bit tighter. It's more
8 expensive to operate in the first place. My fear
9 is that anything, regardless of whether it's
10 adopting NMEDA or it's a third party, I don't know
11 how a third party can set themselves up and
12 accomplish everything that they need to accomplish
13 for free.
14 Obviously, they're going to have to
15 pass it along. Then if I have to pay, then I have
16 to try to pass it along. I go to the manufacturer's
17 certifications and I have to be renewed every three
18 years. The manufacturer doesn't charge me.
19 They're protecting themselves from me and they're
20 helping me.
21 So I think it's clearly my hope to see
22 that that's the way it continues to be. We have

1 a network of guys that we help each other in
2 California, like, if somebody's schedule or
3 somebody's out of town, I'll get a call from one
4 of the other VAs, hey, John's out of town, can you
5 come down and do it? And we work with each other.
6 And what we all have in common is, we
7 are all owner-operators. When I say John George
8 Welding has done 4000 lifts in almost 15 years, John
9 George did them all. I tightened every nut, I
10 tightened every bolt, I ran every wire, and so my
11 business model isn't certifying me as the boss, and
12 then having somebody that, once the shop that's
13 certified, then somebody else is actually doing the
14 work.
15 I recently was at the VA and one of the
16 guys heard me talking about the NMEDA, and he said,
17 oh, hey, what does that mean? He said, I got this
18 bill, and he showed me a bill from another mobility
19 supplier, and they had done a lift, and they charged
20 $85 for NMEDA certification.
21 So that was the dealer's way of passing
22 along that fee. So the VA paid for it. The

1 business can't absorb that, and I'm not eligible
2 to be a NMEDA dealer, just because of the way I
3 operate and I don't have a physical facility.
4 The whole thing about a four-corner
5 scale, my hobby is, we build off-road race cars to
6 race in the desert, and when you build a race car,
7 you put the chassis on scales as you assemble the
8 car, and you're trying to keep it balanced.
9 Well, in this particular case, the
10 whole concept of an outside lift, the four-corner
11 scales is of no value once you've decided you're
12 putting that lift on that car because there's
13 nothing you can do to affect where the weight is
14 going to wind up.
15 So that is only critical at the approval
16 process. So the approval process is the burden of
17 the manufacturer's working in conjunction with the
18 ratings of the vehicle manufacturer to determine
19 if that lift is acceptable for that vehicle or not.
20 For me to carry four-corner scales in
21 a truck, it's possible, it's expensive, it's more
22 steps, but to put that car on the scales doesn't

1 do any good. The lift still goes where it goes and
2 the scooter rides on the back. So having that
3 effect on site is really of no value.
4 I'm just concerned that whatever
5 process you guys choose, it's an unbelievable
6 burden that you guys are faced with to determine
7 what the standards are and who's competent to
8 certify and how that looks.
9 I just urge you to just preserve what
10 we do because we're out there working with the guys,
11 we're at the house, you know, we're training the
12 veteran, in a lot of cases, the veteran is not
13 actually the one driving the car, it's either the
14 son or daughter, or the wife, so we get everybody
15 involved.
16 The whole family comes out to checkout
17 his scooter and, you know, watches us train whoever
18 the driver is, and for a lot of these guys, it's
19 a big deal and they've waited a long time. And it's
20 very important and I take it very seriously, and
21 I hope to do it and serve these guys as long as I'm
22 physically capable.

1 So I just want to thank you for your
2 service to the VA and to the veterans as well.
3 Thank you very much.
4 MS. NECHANICKY: Thank you. Speaker
5 Number 8. Let us get the timer set. Okay.
6 MR. GATES: Well, thank you for letting
7 me be here. My name is Bill Gates. Probably when
8 you saw it on the thing -- not the one you're
9 thinking of. I get it all over. I've had to show
10 my I.D. before.
11 You'll find out real quick I'm not a
12 public speaker. I'm going to have to bounce around
13 and I will try not to, and if I sound nervous, it's
14 not for speaking here, it's for the seriousness of
15 why we're here.
16 You're going to hear the horror
17 stories, you're going to hear how simple it is, I'm
18 just an installer. I don't manufacturer. I deal
19 with the manufacturers. We've been trained by the
20 manufacturers, Harmar, in this case, is the main
21 one.
22 I firmly believe in the fact, you know,

1 we've heard it before, follow the money, but in a
2 little different way. Who better can train us than
3 the manufacturer, because who better has the most
4 at stake if something happens?
5 If that lift falls off, yes, they're
6 going to come to me and my company for installing
7 it, which is myself and my two sons. I'm an Air
8 Force veteran. I was in the Air Force for eight
9 years. We hear about all the training.
10 I have a bit of a problem with that. I
11 think everybody should be trained and I think the
12 idea of safety for our veterans can never be taken
13 lightly and we should always be improving on it,
14 but I don't care if you're, and I don't want to pick
15 on any one occupation, but whether a doctor,
16 whether a lawyer, whether a contractor, which, I
17 am a licensed contractor as well for other things
18 I do for the VA, but it still comes down to the
19 integrity of the individual doing the work.
20 You can have all the training, all the
21 certificates, I can have a whole sleeve full of
22 certifications, I do this and I do that, and it

1 means zero.
2 I was fortunate enough to retire from
3 a vending company at a fairly early age, I taught
4 customer service, and we carried that on. I was
5 actually asked to do work for the VA in Battle
6 Creek. Since then, I do work for the Battle Creek
7 VA, Ann Arbor, Detroit, Saginaw, and now, Mount
8 Pleasant up in the Upper Peninsula.
9 And the joke is, in Michigan, maybe
10 other where, you know, if you're in VA, you can kind
11 of show them, I'm from here. Well, the point from
12 the bottom of Michigan to the bridge isn't any
13 further than the point from the east side to the
14 west side up in the Upper Peninsula.
15 And we started working with the Mount
16 Pleasant VA, or Iron Mountain VA, up in the Upper
17 Peninsula. We've only been there about two and a
18 half years now. I've already had two veterans that
19 say that VA's offered me a chair, one is a chair
20 and one is a scooter, for the past two and a half
21 years, and I've refused it because I cannot drive
22 seven hours to Madison, Wisconsin to have my lift

1 installed. I can't do it.

2 By the time I load up and -- I heard one

3 time, I load up the oxygen, find a place to stay,

4 wait there, drive back, I said, that's just not

5 worth it. So basically, they're homebound. They

6 can't go anywhere.

7 There are other places in this country,

8 like California, just as far, I know there's other

9 places in the northern Midwest, that, were running

10 into the same thing.

11 I don't have a problem with being

12 certified. I think we need to learn just as much

13 as we possibly can, but when we hear about lifts

14 being installed that the wiring can burn up. Sure

15 it could. It absolutely could. Again, it comes

16 back to the integrity of the installer. Has he

17 been taught and does he follow what he's been

18 taught?

19 If installed properly, there's a

20 circuit breaker up front. That should eliminate

21 99 percent of that. I've done approximately 600

22 lifts in the nine years that I've worked for the

1 VA, we've never had an electrical issue, we've
2 never had one fall off.
3 We've had three that we've refused to
4 put on because the vehicle was not solid enough to
5 handle it. I mean, in Michigan, they rust and it
6 worked out great. The VA was able to get them a
7 different vehicle. Within the next year, we had
8 put a lift on for them.
9 I don't want to beat-up all the stuff
10 you've been told. You know, and again, you're
11 going to hear the horror stories. I think for
12 those of us that are out in the field and working
13 with the veterans who are able to give them service,
14 that if we force them to come to our shops, which,
15 I do have a small shop, I do not use it, they can't
16 do it.
17 I mean, they're in a power wheelchair
18 or they're in a scooter for a reason. And it's not,
19 I think -- you know, we're here to serve the veteran
20 and not the other way around, to make it easier for
21 us or to make it more profitable for us.
22 I'm very concerned when a company or

1 non-profit, however you want to call them, want to
2 come in and, yes, we will certify you at a cost.
3 Really? I'm already certified with the
4 manufacturer. I don't think it gets much better
5 than that. I've been a mechanic over the years.
6 I mean, I understand it.
7 Now, can just anybody pick up a handful
8 of tools and go out and install a lift? Absolutely
9 not. But I think with companies, and again, I have
10 to use Harmar because I deal with them quite a bit,
11 I mean, as tight as they are, I mean, when we look
12 at a vehicle, depending on what make vehicle it is,
13 and again, they talk about a four-corner scales,
14 quite honestly, for what we do, it means absolutely
15 nothing.
16 I mean, it sounds great. Oh, the
17 frontend's going to lift off and they can't steer,
18 I'm just going to say, bologna. It doesn't happen.
19 No different than if you put three heavy people in
20 the backseat. Oh, my goodness, you can't do that,
21 because they'd never drive down the road, or if you
22 put a heavy person on the right side, it's going

1 to pull to the right. No, it's the same thing.
2 If that vehicle manufacturer says their
3 vehicle will handle 400 pounds. When we figure the
4 lift -- first, we have to figure the type of chair
5 they have, okay, then we have to figure, what
6 seating is on that chair, because not all chairs
7 are created equal, we get, say, it's a Pride, for
8 example, we get ahold of Pride with the serial
9 number, exactly what does this chair weigh?
10 Because this chair may have different seating than
11 another chair, just like if it weighs 80 pounds
12 less.
13 Okay. If that combination is so much
14 as 1 pound over, 1 pound, and we've had it happen,
15 you don't get a lift from Harmar. It's not going
16 on that vehicle. Now, will we try to do some other
17 things? Can we go to a different style lift? Can
18 we possibly use a lift without a swing away, which
19 would take another 50, 60 pounds off that car if
20 that's agreeable to the veteran, you know, do they
21 want the lift, do they want access to their trunk
22 when it's on? There are different things that can

1 be done.

2 But to have a third-party organization
3 come in and say, but we can train you better, I don't
4 know how much better you can get trained. To me
5 it's like that little thing when you start -- you
6 tell a secret to somebody and it goes to the next
7 person, it goes to the next person, it gets watered
8 down. No, we're getting it, not the old cliche,
9 but we're getting it straight from the horse's
10 mouth.

11 We're getting it from the people that,
12 hey, if there's a lawsuit, we got skin in the game.
13 We have the most to lose.

14 My biggest concern, one of my biggest
15 concerns, is, again, we have to have safety, we have
16 to improve, there's always room for improvement,
17 is that the pendulum will swing, as it sometimes
18 does, often does, too far the other way.

19 I think it needs to stop somewhere in
20 the middle to where, okay, we got to look at some
21 common sense here and say, you know, when it comes
22 to the complex, you know, where you're splitting

1 a car right down the middle or you're taking out
2 a whole section, absolutely, I mean, you can't just
3 have anybody doing it in their garage because they
4 got a welder and a few cable ties, and they can make
5 it work.
6 But when we're putting a lift on the
7 back of a car, that we've heard it referred to like
8 putting a bike rack on, and it's really not much
9 more, it's just a bike rack that folds up and flops
10 down, when it comes to hooking the electrical, you
11 know, it made it sound like those of us that do it,
12 we don't have a clue where the car flexes or we don't
13 have a clue where the heat comes from, yes, we do.
14 We do.
15 I've done 600 of them, a little over,
16 and we haven't had one problem yet. Have we had
17 lift -- or power chairs fall off lifts?
18 Absolutely. But not because they weren't trained.
19 It's because they either got a
20 different caregiver or there have been a couple
21 instances, they've hit the garage sale, found
22 another chair, because sometimes both husband and

1 wife, somebody else needs a chair, they put a chair
2 or a scooter on that lift that it wasn't designed
3 for, wasn't setup for, and it wasn't on there
4 properly, and it has fallen off.
5 And is it a danger to cars on the road?
6 Absolutely. The hundreds of thousands of lifts
7 that are out on the road today, you know, I mean,
8 we see it on T.V. all the time, if you've taken this
9 drug, we can sue this drug company, if you got hit
10 by a motorcycle, we can do them. If you got hit
11 by a truck.
12 I have not seen one on there, if your
13 lift fell off the back of your car, we can get you
14 compensation for it. It's just not that prevalent
15 because the majority of the people out there
16 installing have the pride and the common sense to
17 do it right.
18 Are there a few bad apples? Of course.
19 There's always going to be. But I think with the
20 VA doing what they're doing, what the manufacturers
21 doing what they're doing, with those of us that take
22 pride in our business and work with the veterans,

1 for instance, I was fortunate enough, I could
2 retire early.
3 I didn't like it, I was asked to work
4 for the VA. I started out with the Battle Creek
5 VA, I don't know if all the VAs do it, we received,
6 like, a distinguished service award from the Battle
7 Creek VA, just because of, and again, I don't know
8 if all the VAs do it, they do follow-up calls on
9 a certain percentage of the calls we go on, because
10 we also repair scooters and do grab bars, and they
11 said we get no negatives. None.
12 I mean, everybody should get some, they
13 said, you guys get none. Then we were asked to work
14 with Ann Arbor. Ann Arbor, it went to Detroit,
15 Detroit on up to Iron Mountain. They said, we
16 can't get people that'll drive 150 miles to service
17 our stuff. We live in the southwest corner of
18 Michigan, so to the bridge for us, it's about three
19 and a half hours, and we do the UP.
20 We go up there once a week, or at least
21 once every ten days, to take care of our veterans
22 because they can't get anybody else to do it. We

1 do the lifts with them. And again, they can't
2 travel.
3 My hopes for the VA is that they will
4 understand that the veteran has to come first and
5 yes, we do need regulations, we need the safety,
6 but again, I don't want to see that pendulum swing
7 too far the other way. Again, I'd like to thank
8 you guys for the service of being here, but also,
9 what you guys don't understand, and I've also
10 explained it to the people at the hospitals we work
11 with, I would love to have you go with me for one
12 day, because you guys get beat-up, the VA, in
13 general, gets beat-up so bad by the media, and it
14 makes me so angry, because, for lack of a better
15 term, almost all the veterans I deal with, you guys
16 walk on water.
17 You really do. They appreciate what
18 you do. Of course, the media can find the
19 negatives, just like today, you're going to hear
20 the negatives, they appreciate -- I can't even get
21 into it. Again, being a veteran, hey, I just don't
22 think it comes any better than that. As you say,

1 you found out, I'm not a public speaker, but that's
2 my feelings on it.
3 I hope when you take this under
4 consideration you say, hey, we need some safety
5 standards, but let's not take it too far to where
6 it really hurts the veteran. Thank you.
7 MS. NECHANICKY: Thank you. Speaker
8 Number 9. If you can hold until we get the timer
9 set.
10 MR. JOHNSON: Sure.
11 MS. NECHANICKY: Thanks. Okay.
12 Thank you.
13 MR. JOHNSON: Thank you. Hello. My
14 name is Seth Johnson. I'm Senior Vice President
15 of Government Affairs for Pride Mobility Products,
16 Corporation. Pride is a world leader in the
17 design, development, and manufacture of
18 consumer-inspired mobility products, standard
19 power wheelchairs, complex rehab, power
20 wheelchairs for highly individualized and
21 customized to address the unique needs of the
22 individual.

1 We also manufacture travel mobility
2 products, scooters, lift chairs, and the reason why
3 I'm here today, to talk about wheelchair lift and
4 ramps that we also manufacture.
5 We're headquartered in Exeter,
6 Pennsylvania and we're dedicated to providing
7 expertly designed, engineered, and tested, both
8 internally and independently, products that
9 incorporate technologically innovative features,
10 enabling consumers, including many veterans, to
11 achieve the highest quality of life.
12 Appreciate the opportunity to provide
13 the Department of Veterans Affairs with input as
14 it develops policy regarding the quality and safety
15 standards for providers of modifications services
16 under the Automotive Adaptive Equipment Program to
17 implement the Veterans Mobility Safety Act of 2016.
18 Our comments will focus on four key
19 areas, the need to differentiate between simple and
20 complex vehicle modifications, the need to provide
21 a framework for quality and safety standards
22 appropriate for simple modifications, and ensure

1 quality installation, safety, convenience, and
2 cost effectiveness for the veteran, the need to
3 allow certification of knowledge and skills of AAE
4 providers by the manufacturer for the installation
5 and service of products offered to the veteran, and
6 lastly, the need to preserve the ability for
7 in-home or a veteran preference installation of
8 non-complex automotive adaptive equipment.
9 Pride Mobility is uniquely qualified as
10 a manufacturer, both of internal and external
11 wheelchair scooter lifts to help guide the
12 Department of Veterans Affairs in the development
13 of an appropriate framework to ensure the safety
14 and well-being of veterans, their families, and the
15 general public.
16 We'd welcome the opportunity to do an
17 in-service for any of you here today, or your staffs
18 at the department, on both the equipment, the
19 installation, and also, provide an overview of our
20 provider vehicle lift certification program.
21 First point, differentiation in levels
22 of modification complexity. And I'm going to

1 summarize my remarks. We're a part of the RFI and
2 did provide specific recommendations with regard
3 to the definition of both complex and simple.
4 To us, this is one of the most important
5 aspects of the VA's effort to formulate an
6 appropriate approach to implementing the VMSA. In
7 recognition that all vehicle modifications are not
8 identical in terms of difficulty of an installation
9 and also, the risk to the end user.
10 As a manufacturer of lifts for
11 unoccupied motorized wheelchairs and scooters, we
12 note that these products are significantly
13 different than complex modifications, as they do
14 not directly affect the safe operation of the
15 vehicle, do not alter the structural integrity of
16 the vehicle, and therefore, should not be
17 considered complex modifications.
18 Moving on to standards for quality and
19 safety, currently, automotive and AAE
20 manufacturer's standards fall under multiple
21 government and industry standards, including those
22 developed by NHTSA, who's here today, Society for

1 Automotive Engineers, or SAE, no one set of
2 existing standards, as I'm sure you know from the
3 research that you've done in preparation for today
4 and since the bill was passed, covers all the
5 different types of AAE that we're talking about
6 here today.
7 While we are members of NMEDA, we do not
8 support the QAP program being adopted in its
9 entirety to help meet the requirements under the
10 law. In order to assist the department in
11 developing appropriate standards for simple
12 modifications, we believe the following would
13 ensure quality installations, modifications, the
14 safety of our veteran customers and cost
15 effectiveness.
16 Manufacturer standards.
17 Manufacturers should ensure that all installers
18 have personal certificates of completion based on
19 individual product training and education for the
20 manufacturer products that they are installing.
21 Manufacturers should maintain those
22 records of the installers that are certified on

1 their products for a period of five years or as long
2 as the installer is active in installing that
3 manufacturer's products.
4 Each manufacturer should be required to
5 provide certificates or badges recognizing the
6 individual as a certified installer of their
7 products. Manufacturer should have a documented
8 quality system with work instructions, appropriate
9 product documentation, and manufacturing
10 standards.
11 And each manufacturer should have a
12 system for the installer to evaluate product
13 compatibility for a specific vehicle mobility
14 device combination.
15 Installer standards, each installer
16 should select the appropriate product for the
17 vehicle based on manufacturer guidelines. The
18 equipment should be installed to the
19 manufacturer's standards and specifications.
20 Each installer should be certified by the
21 manufacturer and each installation should be
22 overseen by a certified installer.

1 The installer should only install the
2 equipment if the working condition and location are
3 acceptable for the safe operation and performance
4 of the installation, per the manufacturer's
5 certification program.
6 And then as far as the veteran or the
7 customer, they should be trained on the appropriate
8 operation, the safe operation, of the equipment,
9 be provided with easy-to-follow operating and
10 maintenance instructions for the equipment,
11 provided with product warranty information and
12 registration of the product, and provided with the
13 installer and manufacturer's contact information
14 in the event they need to reach out to them with
15 a question.
16 And then, the customer, or the veteran,
17 would sign an approval document indicating that the
18 product was installed and completed. The
19 installer would then retain that record of the
20 customer approval and provide to the manufacturer
21 and/or the VA as deemed appropriate. The
22 installer would be required to retain the

1 information for five years.
2 Moving on to manufacturer
3 certification. It's appropriate that the VA
4 develop standards in accordance with Section
5 3(b)(4) of the VMSA that provides for certification
6 of AAE providers by manufacturers of products
7 offered to the veteran.
8 AAE manufacturers have the most
9 detailed knowledge of their products, and thus, the
10 best qualified to certify the affiliated dealers
11 and installers on those products.
12 We recommend the Department implement
13 the manufacturer certification provision as
14 follows, all installers should have personal
15 certificates of completion from the manufacturer
16 for the product they're installing, manufacturer
17 should maintain installation records for a minimum
18 of five years, or as along as the installer is
19 active as an installer for the manufacturer.
20 Each manufacturer would provide
21 certificates or badges recognizing the individual
22 as a certified installer. Speak briefly about

1 Pride Mobility's certification program. We do
2 have Pride Vehicle Lift Certificate Program that
3 provides the learner, or in this case, the
4 individual that wants to be the installer of any
5 of our vehicle lifts with the education tools to
6 recognize the Pride vehicle lift models currently
7 available and identify the individual features and
8 benefits to better assist in helping the end user
9 identify the best product for their vehicle.
10 The three learning objectives of our
11 program include, the learner is able to identify
12 the individual features and benefits available
13 with the Pride vehicle lift models currently
14 available on the market, the learner, or in this
15 case, the individual must be the installer, would
16 also be able to identify the installation
17 troubleshooting tips for our vehicle lifts through
18 available training.
19 The learner would then, or the
20 installer, have to demonstrate applicable
21 knowledge in order to receive their certificate by
22 physically completing successful installation of

1 Pride vehicle lift models included in the program.
2 Our program is two phases. The first
3 phase is an overview and instructional video that's
4 provided via online portal. There's a successful
5 quiz score at the end of that process. It's
6 required in order to pass Phase 1 of the training.
7 Phase 2 is the actual onsite, hands-on training and
8 installation.
9 This is in person with an instructor
10 that requires successful installation in order to
11 pass. There's also a test at the end of that in
12 order to complete Phase 2.
13 Our vehicle lift certification program
14 is available, once you receive the certificate, for
15 a two-year period from the date of completion of
16 Phase 2, a certificate holder is required to
17 complete a refresher vehicle lift course within 30
18 days from their certificate expiration date in
19 order to continue to purchase our products for
20 installation on any vehicles, both to veterans and
21 also those outside of the VA system.
22 Lastly, I wanted to echo what others

1 have mentioned here earlier today, preservation of
2 home installations and deliveries. It's very
3 important that any necessary regulatory framework
4 for AAE installations and modifications preserve
5 the current ability of veterans to receive such
6 services and deliveries of vehicles at their home
7 or other designated location of convenience to the
8 veteran.
9 Our products are provided to thousands
10 of veterans annually in their home or place of
11 preference. Adding a lift to their vehicle
12 permits them to transport a power wheelchair or
13 scooter, providing them mobility that allows them
14 to go to work or allow them to carry on a normal
15 life.
16 In conclusion, I just want to thank you
17 for the opportunity today to share our insight and
18 views on the establishment of quality and safety
19 standards for providers of modification services
20 under the AAE program.
21 We'd be happy to meet and discuss our
22 comments in more detail, as well as provide a tour

1 of our corporate facility, an opportunity to see,
2 firsthand, our Pride vehicle lift certification
3 program. Thank you.
4 MS. NECHANICKY: Thank you. Speaker
5 Number 10. If you could just hold until we get the
6 timer set. Okay. Thank you.
7 MR. HARRIS: Good morning. My name is
8 Mike Harris. I'm the President of Rollx Vans.
9 Rollx Vans has been modifying vehicles for over 40
10 years, and I've personally been with the company
11 for 26 years.
12 During the past 40 years we've had the
13 privilege to work with thousands of veterans. We
14 structurally modify minivans and full-size vans.
15 Our conversions are tested to meet applicable FMVSS
16 standards.
17 We also install other equipment, such
18 as hand controls, power tie-downs, transfer seats,
19 and lifts built by other manufacturers. We have
20 a different business model than most of the other
21 vendors in our industry.
22 We manufacture and sell wheelchair

1 accessible vans direct to the consumer throughout
2 the United States. We compete with both the
3 manufacturers and brick-and-mortar dealers. This
4 competition is good for the consumers we all serve.
5 A great example of this would be the
6 at-home delivery and service model Rollx Vans
7 pioneered over 20 years ago. This service is
8 provided by our own factory-trained technicians to
9 go to the customer's house for both the delivery
10 and after sales servicing of their vehicle.
11 We provide this service to rural and
12 highly rural areas, as well as urban locations.
13 We've found new hand control drivers are much more
14 comfortable driving for the first time, and at
15 their convenience, in their own area versus driving
16 two to three hours home from a brick-and-mortar
17 location.
18 Driver educators often meet our
19 technicians at the customer's home and are there
20 for final fitting and test drive. Our at-home
21 service and delivery model has been overwhelmingly
22 endorsed by our customers and actually adopted by

1 a number of our competitors.
2 Our experience working with the VA has
3 been positive. One of the VA's strengths is that
4 it has maintained veteran choice and open vendor
5 competition as core pillars of the VA's system.
6 This has worked well to provide veterans the
7 choices they have earned and allowed businesses to
8 compete to provide better products and services.
9 Maintaining veteran choice and open
10 vendor competition is critical to anything that is
11 developed. We believe there's an opportunity to
12 help increase competition and veteran choice. It
13 would be to establish a federal I.D. for all
14 approved vendors.
15 Each approved modifier should have a
16 federal I.D. number which is nationally recognize
17 by all VAs around the country. This is similar to
18 the VA's FSS system in place today.
19 This will simplify the approval and
20 inspection process for field VA personnel. It
21 would also eliminate confusion about eligible
22 purchasing and help ensure veteran choice across

1 the country.
2 We understand the VMSA tasks the VA with
3 developing a process for selecting a third-party
4 certifier. A little background on Rollx Vans'
5 certification and memberships. Rollx Vans is ISO
6 9001:2008 certified. We are registered with
7 NHTSA. We have an A-plus rating with the Better
8 Business Bureau. We hold contracts with the GSA
9 and FSS. We are also an NTEA member with an MVP
10 certification.
11 While we are proud of our
12 certifications and memberships, we believe
13 manufacturer's certification should be the only
14 requirement for modifiers. For the past 26 years,
15 I've personally seen this work well for our company
16 and all the other manufacturers we represent.
17 In today's highly-publicized and
18 litigious society, selfishly, no manufacturer or
19 installer wants to expose an end user to any undue
20 risk. The downside for a company is just far too
21 great.
22 If the VA chooses a third-party

1 certifying entity, it should be, one, independent,
2 two, inclusive of all business models, and three,
3 completely free from any conflicts of interest.
4 Any third-party standard also needs to be
5 independently created and independently
6 administered.
7 An internationally recognized example
8 of this is ISO. Our experience as a member of NMEDA
9 does not meet the independent and inclusive
10 standards for a third-party certifier, nor does
11 NMEDA meet the conflict of interest clause, as
12 specified by the Veterans Mobility Safety Act.
13 Rollx Vans was a NMEDA dealer member for
14 23 years. During our 23-year tenure, NMEDA never
15 fields one customer complaint about our company nor
16 did they receive one quality or safety complaint
17 about Rollx Vans. We also had a perfect QAP audit
18 record with NMEDA.
19 Yet, in 2013, after a 23-year spotless
20 history with NMEDA, the NMEDA board terminated
21 Rollx Vans as a member. The NMEDA board is made
22 up of brick-and-mortar dealers and we compete with

1 them all over the country.
2 Rollx Vans was removed from NMEDA by a
3 vote of the NMEDA board based on a complaint from
4 a board member for selling in that board member's
5 area.
6 Six weeks prior to terminating us, the
7 CEO of NMEDA, Dave Hubbard, personally approached
8 me during the National VA Wheelchair Games, and
9 said, Mike, in my five years with NMEDA, I've only
10 heard great things about your company. Keep up the
11 great work.
12 If an organization were truly about
13 safety and looking out for the end user, why would
14 they terminate a company they never had one
15 customer or safety complaint about in 23 years? A
16 company that also had a perfect QAP audit record.
17 Two other manufacturer competitors
18 were also removed from NMEDA along with Rollx Vans.
19 I don't know if NMEDA fielded any complaints from
20 them, however, I can tell both of those are very
21 formidable competitors and force us to continually
22 improve, as we do them.

1 Based on our experience with NMEDA, we
2 have serious concerns about the conflicts of
3 interest for NMEDA or any trade association who
4 represents business interests in our industry.
5 Another concern we had which would
6 limit veteran choice and open vendor competition
7 is state licensing. The Federal Trade Commission
8 recently weighed-in on this issue with a statement,
9 direct-to-consumer auto sales, it's not just about
10 Tesla, the FTC states, "A fundamental principle of
11 competition is that consumers, not regulation,
12 should determine what and how they buy."
13 Limiting veteran choices by geography
14 would run counter to this FTC statement. The
15 success of the direct-to-consumer model is seen
16 throughout our country today in companies like
17 Tesla and Amazon. Where the FTC states that
18 competition, not regulation, should determine what
19 and how consumers buy, state licensing will ensure
20 that regulation determines what and how they
21 purchase.
22 Whatever changes VA incorporates, we

1 hope it continues to support veteran choice and
2 open market competition, as this will continue to
3 benefit our veterans. Thank you for your time.
4 MS. NECHANICKY: Thank you. Thank
5 you, speakers. We'll have Speakers 11 through 15
6 come on up. And at this time, I'm going to ask the
7 panel if you'd like to stand up and stretch, maybe,
8 for a minute while we make this switch.
9 (Whereupon, the above-entitled matter went off the record at 11:03 a.m.
10 and resumed at 11:08 a.m.)
11 MS. NECHANICKY: Okay. We're ready to
12 get started. Speaker Number 11 is at the podium.
13 With this group of speakers, we will be breaking
14 for lunch at 12:00 noon, so there may be a break
15 with this group of speakers for the lunchtime, but
16 we'll see how far we get. So are you ready, Speaker
17 11?
18 MR. BELSON: I am.
19 MS. NECHANICKY: Okay. Thank you.
20 MR. BELSON: My full name is William W.
21 Belson, but most people call me Bill. For the last
22 28 years I've had the honor of being the Director

1 of Engineering at Bruno Independent Living Aids.
2 I do ask your forgiveness up-front because if my
3 presentation isn't very polished, as an engineer,
4 I'm much more comfortable solving problems or
5 dealing with technical issues than standing in
6 front of a group and making comments.
7 Bruno is a U.S.-based manufacturer of
8 equipment to assist those with physical
9 challenges. Bruno employs approximately 400,
10 many of whom are veterans, in three plants located
11 outside of Milwaukee and Oconomowoc, Wisconsin, to
12 design, manufacture, assemble, and test products
13 we product there.
14 We also have an extensive training
15 facility where we train new and re-certify existing
16 installers. As a family-owned business, founded
17 by a veteran, Michael Bruno, Sr., we've taken great
18 pride in supplying innovative, high-quality
19 equipment to assist veterans with their automotive
20 challenges for over 33 years.
21 We appreciate the opportunity to give
22 our input to this very important step to the VA.

1 I want to take a few minutes and cover some
2 important features from our February response and
3 add support on important points that were not
4 covered in detail in that response.
5 I plan in submitting these comments in
6 writing later this week. As a manufacturer, it is
7 our great interest to make sure that the veteran's
8 vehicle needs are assessed correctly, the
9 appropriate equipment chosen, that equipment is
10 successfully installed no matter where the
11 location, and the veteran or caregiver correctly
12 trained in the use of the equipment, and that it
13 is serviced effectively afterwards.
14 Bruno strongly supports industry
15 advancement as part of our corporate continuous
16 improvement culture. This takes many forms inside
17 Bruno, including participating in industry
18 standards. For example, I am currently the
19 chairperson in the Society of Automotive
20 Engineers, SAE, Adaptive Devices Committee, as
21 well as I also sit on the Crash Test Simulation
22 Committee for SAE.

1 SAE is a forum for voluntary industry
2 standards and technical documents, which, in the
3 case of the Adaptive Devices Committee, deal with
4 issues specific to modifications of
5 privately-licensed vehicles for those with
6 disabilities.
7 I do also participate on several
8 industry coalition guideline committees, such as
9 NMEDA's Manufacturer's Quality Assurance Program,
10 as well as their guidelines committee.
11 Bruno feels the VA should look at the
12 complexity of the equipment being installed and
13 define their standard and quality requirements for
14 both safety and quality in risk step increments.
15 As the installation and operation
16 increase in complexity, or potential severity of
17 the failure occurrence as a result of incorrect
18 installation, the requirements and validation
19 should increase proportionally.
20 The equipment needed to allow a veteran
21 to transport themselves or their mobility
22 equipment ranges from very straightforward bolt-on

1 accessories, which tend to be called low-tech, to
2 extremely complex structural vehicle alterations
3 and sophisticated driving control replacements,
4 hi-tech.
5 The industry currently seems to define
6 levels of modification into both structural and
7 non-structural as well as low-tech and hi-tech.
8 Structural changes are adaptations that
9 permanently convert a vehicle, such as lowering the
10 floor or raising the roof.
11 Non-structural are adaptations that
12 are bolt-in, allowing the vehicle to be reverted
13 back to the vehicle's original condition after
14 removal of the AAE.
15 Low-tech is a category that does not
16 require active modifying the vehicle control
17 systems, where hi-tech does require equipment
18 interface that actively modifies the vehicle
19 control systems and has a higher level of
20 complexity.
21 One thing I want to make sure the VA is
22 aware of is that trends in new vehicle development

1 over the last ten years are forcing more AAE
2 equipment into this high-tech category.
3 Most products that Bruno manufactures
4 are considered low-tech, though, this does not mean
5 that they can be installed by personnel who have
6 not had significant product training and
7 understanding of critical evaluation requirements
8 that installers need to adhere to to create a safe
9 and successful installation.
10 As a manufacturer, Bruno provides
11 training and evaluates the attendee's performance
12 before issuing certificates. Bruno also has a
13 re-certification requirement for dealers to keep
14 them current on our products.
15 Exterior lifts are a good example of
16 this, on the surface, they look simple and
17 straightforward, but in reality, they are often
18 confusing and require some post-installation
19 review to ensure that the vehicle's operating
20 characteristics have not been compromised.
21 The exterior lift installation is not
22 a structural one, it's not a structural

1 modification at all, it's more of a dynamic
2 modification to the vehicle. If the lift and
3 mobility device weight on the rear of the vehicle
4 exceeds the OEM's, the vehicle manufacturer's
5 recommendations, of either tongue weight or axle
6 loading, the vehicle's handling characteristics,
7 including steering, braking, and control are
8 negatively affected.
9 This will put the vet, their
10 passengers, and others traveling on the road in
11 close proximity in danger.
12 Unlike a bicycle carrier carrying a
13 25-pound bicycle, most mobility equipment is many
14 times heavier. Actually, in my experience, an
15 awful lot of more than 15 times heavier than the
16 average bicycle on the back of a vehicle.
17 This weight creates a vastly different
18 dynamic scenario for vehicle performance.
19 Interestingly, many OEMs are now, in the last two
20 years, eliminating even bicycle carriers to be used
21 on their vehicles without voiding the vehicle
22 warranty. Most of those are hybrid vehicles that

1 are coming out, but they've eliminated all exterior
2 lifts on their vehicles.
3 Installation situations can be further
4 complicated due to several factors, including the
5 vehicle condition, especially if its structural
6 integrity and suspension state as well as
7 incomplete or inaccurate automotive component
8 ratings, such as hitch manufacturers rating the
9 hitch for a different load amount than the vehicle
10 OEM does for the same application.
11 This causes quite a bit of confusion on
12 the industry for those that aren't trained in the
13 installation or following manufacturer's
14 guidelines.
15 To safely resolve these issues, the
16 installer needs to be able to inspect and verify
17 the condition of the vehicle. I personally am
18 aware of many situations on older vehicles where
19 the underside of the vehicle was compromised by
20 corrosion to the point where the vehicle could not
21 structurally support the addition of the hitch
22 installation when the vehicle, outwardly, looked

1 in good shape.
2 The installer must also understand
3 vehicle construction to safely install the lift
4 following the manufacturer's installation
5 instructions. I have partaken in several field
6 investigations where a lift installed by a
7 non-trained installer had wiring routed attached
8 to both exhaust or through operating moving
9 components, which caused the wiring to have a
10 problem.
11 After installation, an installer needs
12 to validate, in a measured way, that the vehicle
13 lift mobility combinations have not compromised
14 the vehicle handling and performance
15 characteristics. And finally, document and train
16 the veteran or caregiver on safe handling.
17 Measurements with a scale system are
18 easily within the ability of a trained installer,
19 no matter the location where the installation takes
20 place. There are many scale operations, not just
21 four-wheel scales, such as a single location tongue
22 weight scale.

1 Additionally, based on our experience,
2 there are frequently an incompatibility between
3 the size and/or weight of the mobility equipment
4 issued to the vet, and the vet's automotive vehicle
5 capability to transport this issued mobility
6 equipment.
7 This is most often where the vehicle
8 characteristics, such as door height or interior
9 cargo space will allow an interior lift option, and
10 the exterior options are not available because of
11 the OEM rating tongue weight capacity.
12 This forces the vet to look at acquiring
13 either a different vehicle or attempting ways to
14 carry the mobility device in an unsafe manner. If
15 there continues to be this disconnect between large
16 mobility devices issued and the vet's vehicle
17 ability to carry them, the VA should consider
18 looking at alternative methods that don't affect
19 the vehicles handling characteristics.
20 I do strongly believe that the VA needs
21 to require all modifiers installing AAE devices to
22 comply with motor vehicle safety standards. Since

1 FMVSS standards are federal law, they should be,
2 at the minimum, the compliance required.
3 NHTSA issues federal motor vehicle
4 safety standards, interpretations, and exemptions
5 that they have crafted for vehicle modifications
6 to people with disabilities that are specified
7 under 49 CFR Part 595.7. This should be a minimum
8 requirement as well.
9 There are several states that have
10 standards and requirements related to the
11 performance and safety when they fund devices.
12 I'm most familiar with the ones from the state of
13 Texas, with Texas Workforce Commission, which used
14 to, until last year, be called DARS, as well as
15 Massachusetts and California.
16 They, along with SAE and the Rehab
17 Engineering & Assistive Technology Society of
18 North America, RESNA, have developed voluntary
19 standards addressing safety for vehicles, along
20 with wheelchair tie-downs and occupant restraint
21 systems.
22 There are several organizations and

1 entities that have created systems, including
2 checklists, which help ensure the quality and
3 safety of an installation. Some of the most common
4 ones I'm familiar with, as I mentioned, are SAE
5 standards, the State of Texas Workforce Commission
6 and it's subcontractor, Texas A&M Transportation
7 Institute, which handles the ones for the State of
8 Texas, the State of Massachusetts Rehabilitation
9 and Technology Department, and the State of
10 California Department of Rehabilitation.
11 NMEDA as well, through their dealer
12 Quality Assurance Program, and compliance review
13 programs. For other items I wanted to make a point
14 of, I feel that proof of insurance is a logical
15 safeguard, not only for the veteran's personal
16 property, as well as a good starting point that the
17 installer is a legitimate business and should also
18 be a requirement.
19 A manufacturer offering a warranty is
20 a sign of confidence in the performance of the
21 equipment and would be prudent on the VA's part to
22 protect not only the VA's investment in AAE

1 equipment, but also to provide peace of mind for
2 the veteran receiving the equipment.
3 The warranty should provide a minimum
4 uniform coverage for all lifts within that type of
5 structure. I thank you for the opportunity and the
6 time that you've given us to make these comments.
7 I'm more than happy to answer further questions and
8 do plan on submitting this information in writing
9 in the time period. Thank you very much.
10 MS. NECHANICKY: Thank you. Speaker
11 Number 12. If you can just hold until we get the
12 timer set. Okay.
13 MR. NELSON: My name is Rick Nelson.
14 I'm the Director of Customer Care and After Sales
15 for BraunAbility. And I just lost my name tag.
16 It's been falling off all day.
17 I've worked in the mobility industry
18 for 25 years. BraunAbility manufacturers
19 wheelchair-accessible vehicles and both
20 commercial and retail wheelchair lifts. My
21 department at BraunAbility is responsible for
22 supporting our products, dealers, customers, after

1 the sale of the product.
2 We do this in several different ways,
3 such as a dedicated technical service call center,
4 dedicated call center for our customers, called
5 Customer Experience Group, a service parts
6 warehouse with 95 percent same-day shipping, a
7 dedicated service, training, and field service
8 department, a service facility in Mesa, Arizona to
9 support our Western customers and dealers, 24/7
10 emergency service for technical assistance for our
11 dealers.
12 My department has 25 team members to
13 support our customers and answer over 250,000
14 calls, chats, and other contacts annually, with
15 roughly 30 percent of those being veterans. It is
16 our passion and mission to ensure the user of our
17 products have a worry-free experience.
18 The after-sales mission statement is,
19 keep in life and move in experience. What this
20 means to my department is, if a product breaks down,
21 we must restore the customer's mobility freedom as
22 quickly as possible so they can enjoy their life

1 without worry and additional anxiety that we
2 already know they have too much of.
3 This customer focus is the reason we
4 established the support structure. Without a
5 strong, well-trained, and experienced dealer
6 network, we lose the key to our success and could
7 not effectively support and protect our veteran
8 customers without our dealers.
9 Our dealers are our eyes and ears in the
10 field, they have an intimate relationship with our
11 customer and know the family dynamics, needs, and
12 sometimes help the customer from themselves. This
13 is something BraunAbility cannot do over the phone
14 from hundreds of miles away. We need boots on the
15 ground, trained dealers with the experience of
16 knowing what's safe and what's not safe to ensure
17 the customer is supported and protected.
18 This is why BraunAbility fully supports
19 the development of VA regulations and to ensure the
20 veterans are supported and protected throughout
21 their AAE program experience.
22 Regardless of a manufacturer or type of

1 automobile adaptive equipment, the veteran
2 deserves the very best, and we in the mobility
3 industry need to ensure they are safe, kept safe,
4 and by all means possible, ensure they keep their
5 mobility.
6 Our request is simple, that the VA
7 establish meaningful, enforceable standards for
8 AAE equipment and installation so that a veteran
9 is provided safe, appropriate outcomes. To that
10 end, I'd like to share with you ways that
11 BraunAbility ensures safe and appropriate
12 outcomes.
13 Our first line of defense to protect our
14 veteran customers is to ensure that they have
15 product, the product does not leave our
16 manufacturing facility in substandard conditions.
17 We need enforced manufacturing of production
18 quality standards.
19 I assume most of the mobility
20 manufacturers adopt the ISO 9001 quality standard.
21 While this is a good start, it is not nearly enough.
22 It's not specific enough for our industry. Our

1 products are used by customers who require a higher
2 standard, not the basic.
3 From BraunAbility's perspective, the
4 NMEDA quality standards are industry focused and
5 provide quality standards for all mobility
6 products. BraunAbility is an active participant
7 in NMEDA's manufacturing quality program because
8 we believe the mobility customers need assurance
9 from a well-established mobility industry
10 regulation body, that the products they purchase
11 are safe, reliable, and supported throughout their
12 life.
13 We are open to any other industry
14 quality standard and/or regulation that advances
15 product safety and reliability. However, we are
16 not in favor of self-regulation or
17 self-certification, for obvious reasons.
18 The VA needs assistance of an impartial
19 third body to ensure these standards are met and
20 corporate responsibility and accountability are
21 achieved.
22 Our second line of defense to protect

1 our customers is to ensure the product is installed
2 correctly to keep the customer safe and the product
3 remains reliable throughout the product life.
4 One way BraunAbility achieves this is
5 through our training program. Lost your name tag
6 too. In order to be a BraunAbility dealer, you
7 must have a certified technician. That technician
8 must go through roughly 15 hours of online content
9 and once they certify on that online content, they
10 quality for a three-day hands-on class; live class.
11 Once certified, that technician must
12 re-certify every two years to keep their
13 certification. Our technician training program
14 follows the NMEDA QAP guidelines since most of our
15 dealers are members of NMEDA.
16 It does not matter the complexity of the
17 mobility product. There is no replacement for a
18 trained, experienced installer. In fact,
19 BraunAbility will not sell our products, no matter
20 how simple they may seem, to an end user or
21 unauthorized dealer.
22 If we find that a dealer is selling our

1 product directly to end users or uncertified
2 agencies, that dealer is in jeopardy of losing
3 their dealership status and is required, at their
4 own expense, to find that product, inspect the
5 installation, reinstall it if necessary, and
6 report back to BraunAbility once done.
7 We take this very seriously because we
8 have, unfortunately, experienced the consequences
9 of untrained installations. As you can imagine,
10 from the millions of calls my department's handled
11 over the years, we've had our share of horror
12 stories.
13 For instance, we make a product called
14 Chair Topper. This is an enclosed manual
15 wheelchair storage product which looks much like
16 a luggage carrier on the top of the vehicle. This
17 is an extremely installation -- this is, seemingly,
18 a simple installation and some would say it could
19 be done by a good shade-tree mechanic.
20 From our experience, any time you're
21 required to run power to a batter, you need to know
22 what you're doing. Even a typical car dealer

1 technician would not have the experience for this
2 type of installation, for an experienced installer
3 will know where the pinch points are, know not to
4 run power wire at the very bottom of the vehicle,
5 keep it away from hot areas, such as exhaust, know
6 how the engine will torque while putting it in drive
7 and reverse.
8 These are just a few areas that you need
9 to take into account when modifying a vehicle.
10 These are precautions that a trained technician
11 will know and they'll know how to safely install
12 the product, and they have the experience with that
13 product.
14 And this is something a run-of-the-mill
15 call car dealership technician would not have
16 experience with.
17 We have had end user customers attempt
18 to move their mobility product from one vehicle to
19 the other, either themselves or with a friend or
20 family member. Our experience with installing --
21 because of their experience with installing
22 mobility equipment has created fires, personal

1 injury, property damage to other vehicles, and in
2 many cases, with the Chair Topper, fallen off the
3 top of the vehicle at highway speed.
4 These are the experiences that I
5 remember and these are the experiences that keep
6 my focus on protecting the customer and endorsing
7 meaningful regulations, common sense guidelines
8 for equipment and installations.
9 The good news is, BraunAbility has an
10 experienced dealer member that can step in,
11 evaluate these situations, and do what's necessary
12 to restore our customer's mobility freedom.
13 In addition to these safety issues, a
14 trained dealer will be able to evaluate the
15 customer product and will have the knowledge of
16 multiple products that could best suit the veteran
17 and their family.
18 In the case with lift installations, I
19 know many dealers have not been able to install
20 lifts in customer vehicles because of what the
21 customer stated and what was actual reality. For
22 instance, certain wheelchair lifts are not

1 recommended for 1/2-ton vehicles.
2 Or the customer may have additional
3 equipment installed that, if they install the
4 wheelchair lift, would overload the vehicle and
5 exceed GVWR, which is gross vehicle weight rating,
6 creating unsafe driving conditions.
7 I know nowadays, vehicle manufacturers
8 are doing what they can to increase fuel mileage.
9 One significant way that they're achieving this is
10 by reducing chassis weight and designing
11 suspension systems to closely achieve GVWR, and
12 they are not over-engineering these suspension
13 components.
14 For our mobility industry, we need to
15 ensure the products we install remain under GVWR,
16 installers must understand the vehicle, weight of
17 the vehicle, the equipment, wheelchair weight, and
18 the family using the vehicle.
19 The only way to ensure our veterans are
20 protected is to weigh the vehicle with the
21 equipment installed before they take delivery.
22 This is one of NMEDA's QAP requirements and this

1 should absolutely be a requirement included in VA's
2 AAE program standards.
3 I have experience with overloaded
4 vehicles and the consequences. BraunAbility
5 manufactures commercial lowered-floor vehicle
6 accessible vehicles. There have been many times
7 when commercial operators using our products will
8 overload those vehicles with extra passengers or
9 luggage.
10 The results have been broken axles,
11 suspension components, poor braking, and even
12 accidents. At a minimum, very poor alignment and
13 worn-out tires; premature worn-out tires.
14 Again, we need to protect our veterans
15 before they get behind the wheel. Until the VA
16 establishes a requirement for trained, experience
17 mobility technicians who can inspect and evaluate
18 with the veteran, vehicle application, equipment
19 installation, the veteran's safety will be in
20 jeopardy.
21 Our third line of defense to protect the
22 veteran is to ensure they're supported with their

1 mobility products throughout the life of the
2 product.
3 Every mechanical device requires
4 maintenance and eventual repair. Again, to ensure
5 customer satisfaction, safety, and reliability, a
6 trained eye is required to evaluate mobility
7 products, and that comes from a trained mobility
8 technician.
9 Mobility technicians receive product
10 service bulletins from manufacturers, have stock
11 parts on hand, and most of all, they know the
12 product and have a trained eye to catch anything
13 out of the ordinary.
14 The mobility products in our industry
15 builds and supports require an extra level of
16 scrutiny. After all, we're not building
17 appliances, we're manufacturing products that
18 enrich the lives of the most deserving customer,
19 our wounded veterans.
20 Our products are supporting
21 wheelchairs, wheelchair occupants, allowing the
22 veterans to operate their vehicles with driving

1 aids. These are moving vehicles. It requires our
2 utmost effort to make sure our veterans are
3 protected throughout their mobility experience.
4 It is BraunAbility's official position
5 that no mobility product should be installed or
6 serviced by someone without mobility experience.
7 The risks are absolutely too high.
8 To me, there's no more deserving person
9 that our disabled veterans. And again, I applaud
10 you for the efforts to create regulations that will
11 ensure appropriate outcomes for veterans pursuing
12 their mobility freedom.
13 Thank you for standing guard and
14 protecting the safety of our veterans, and
15 BraunAbility stands with you. We very much
16 appreciate it. Thank you for allowing me this
17 time.
18 MS. NECHANICKY: Thank you. Speaker
19 Number 13, you can take the podium, please. Just
20 hold until we get the timer set. Okay.
21 MS. GREEN: Good morning. I'm
22 thankful for this opportunity to participate in

1 this panel today. The work before us is important,
2 as it involves the safety and independence of our
3 veterans, but I also see that it offers an
4 opportunity to look at the full scope of services
5 available to our veterans under driver rehab.
6 My name's Elizabeth Green and I'm here
7 representing the Association for Driver
8 Rehabilitation Specialists, or ADED, A-D-E-D.
9 Those savvy panel members will notice that our
10 acronym doesn't match our name. ADED was our
11 original name, the Association for Driver
12 Educators for the Disabled.
13 Before being hired as ADED's Executive
14 Director, I was an occupation therapist and a
15 certified driver rehab specialists for a small
16 hospital in Hickory, North Carolina, where I
17 currently reside, and where ADED calls home.
18 My career got started, however, in
19 occupational therapy at the Ioannis A. Lougaris VA
20 Medical Center in Reno, Nevada. I was the only TO
21 in the nursing home care unit at that time. And
22 in the early 1990s, I had the pleasure of working

1 with veterans that had served in World War I, second
2 World War, Korea, Vietnam, and other calls of duty.
3 It was those founding years as an
4 occupational therapist that I gained great respect
5 for the sacrifices that our veterans make and for
6 the institution the Veterans Health Administration
7 that has a duty to care for them.
8 In my office in Hickory hangs three
9 photographs, two of those photographs were taken
10 by one of our outpatient therapists during an
11 occupational therapy session, who was an amateur
12 photographer and trying his skills out during that
13 session.
14 The third photograph is actually a
15 signed publicity photo of a character actor named
16 Black Bart. Now, Black Bart was a resident at the
17 nursing home care unit. Remember, this is Reno,
18 close to Virginia City, of Bonanza fame, if you
19 remember that.
20 Black Bart would visit every day. He
21 helped construct the wheelchair accessible planter
22 boxes that we made for our therapeutic garden,

1 which, I just Google mapped it the other day, and
2 I think that space is still in use today, which is
3 quite an accomplishment.
4 I keep those photographs in my office
5 as a reminder, not only of the service the our
6 veterans have given and how much they've given up
7 for our country, but also for my roots in
8 occupational therapy and the service that we all
9 provide.
10 It's an honor for me to work with
11 veterans at that time and it's an honor for me to
12 be able to speak for them today. ADED was
13 established in 1977 as a non-for-profit
14 professional network promoting excellence in the
15 field of driver rehabilitation.
16 We advocate for and facilitate safe,
17 independent community mobility. ADED has
18 established best practice guidelines for the
19 delivery of driver rehabilitation services and a
20 robust code of ethics for practitioners.
21 Our diverse membership represents a
22 variety of professional backgrounds, including

1 driver educators, kinesiotherapists, mobility
2 equipment dealers, occupational and physical
3 therapists, among others.
4 Our professional members, driver
5 rehabilitation specialists, serve consumers of all
6 ages and all abilities in achieving their goal of
7 independence with personal transportation.
8 We have 960 members within the U.S.,
9 Canada, and abroad. A certified driver
10 rehabilitation specialists credential, the CDRS,
11 can only be obtained through ADED. To earn this
12 prestigious CDRS credential, a candidate must meet
13 baseline professional and educational background,
14 for example, four-year Allied Healthcare degree,
15 and minimum experience working in the field, over
16 1000 hours of direct hand-on experience.
17 The CDRS is considered the gold
18 standard in medically-based driver evaluations and
19 is highly regarded as a professional credential
20 within the field of driver rehab.
21 Due to the complexity and the variety
22 of the automotive adaptive equipment available,

1 and the complexity of operating a motor vehicle
2 with a disability, a comprehensive driver
3 evaluation and equipment prescription should be
4 required to ensure that only the most
5 medically-appropriate equipment is installed in or
6 on the veteran's vehicle.
7 This comprehensive evaluation
8 conducted by a driver rehab specialist is a complex
9 analysis of the veteran's medical background,
10 their personal needs, functional status, and
11 impairments that determine fitness to drive and
12 eligibility to operate a vehicle that has been
13 modified or adapted.
14 Prescriptions generated based on this
15 driver evaluation reduces costs and avoids
16 valuable time lost in correcting errors caused by
17 the installation of equipment not properly suited
18 to that veteran's needs or not properly installed.
19 It is ADED's position that the DRS
20 should be responsible for ensuring that all
21 Automotive Adaptive Equipment recommendations
22 follow existing standards and guidelines, and that

1 they educate their clients about the National
2 Mobility Equipment Dealer's Quality Assurance
3 Program.
4 ADED recognizes the QAP is setting the
5 standard for safety and vehicle modifications and
6 adaptive equipment installation. QAP-accredited
7 dealers are held to the highest standards and the
8 current NMEDA guidelines strongly recommend that
9 DRS providers are the dealer's first choice for
10 prescriptions prior to the installation of any
11 equipment.
12 When considering implementation of the
13 section regarding equipment installations, we
14 recommend relying on the QAP and the NMEDA
15 guidelines as your roadmap. There are currently
16 49 driver rehab programs in the VA, I don't need
17 to tell you that, but I was pleased to hear that,
18 employing a total of about 115 driver rehab
19 specialists.
20 All eligible therapists in that program
21 must go through a two-week training course which
22 incorporates ADED's best practice guidelines in

1 their training curriculum. These are
2 highly-skilled professionals who play a critical
3 role in the process of assisting veterans and
4 returning to driving.
5 These DRS's within the VA are also
6 instrumental in ensuring that only the most
7 medically-appropriate equipment is installed in or
8 on the veteran's vehicle.
9 Quite frankly, we do question whether
10 115 providers is sufficient to meet demand,
11 considering the number of veterans being served.
12 We encourage this panel to consider conducting a
13 needs assessment to ensure that our veterans have
14 reasonable access to DRS services where they live.
15 I realize the scope of today's hearing
16 is specifically focused on Section 3 of the Act.
17 I do encourage the VA to expand their thinking
18 beyond equipment installations and take this
19 opportunity to consider the full spectrum of
20 services with respect to driving and those related
21 AAE programs available to veterans.
22 I would like to draw your attention to

1 Section 2 of the Act, which allows the veteran to
2 be given the opportunity to make personal
3 selections in relation to the automobile or other
4 conveyance.
5 The DRS plays a critical role in
6 assisting the veteran in making the optimum
7 selection for both the vehicle and automotive
8 adaptive equipment. By first consulting with the
9 DRS, the veteran will enhance their awareness of
10 their functional abilities, gain a greater
11 understanding of the special adaptations
12 available, and learn about the best options suited
13 to fit their unique needs and situations.
14 It is ADED's position that involving
15 the DRS in the veteran's equipment selection
16 process, as noted in Section 2, will lead to the
17 most appropriate solutions.
18 The role of the DRS is currently unclear
19 in two key VA handbooks. Automotive Adaptive
20 Equipment Program and Driver Rehabilitation for
21 Veterans with Disabilities Program.
22 ADED recommends updates to both of

1 these handbooks to more clearly define and outline
2 the role of the DRS and the appropriate sequence
3 of events for veterans referred to the VA driver
4 rehab programs.
5 It is our position that the DRS should
6 be involved whenever a veteran pursues
7 modifications or adaptations to operate a motor
8 vehicle. To assist this panel with implementation
9 of Section 3 of the Act, ADED has detailed
10 recommendations in our written statement for VHA
11 Handbook 1173.4.
12 I'd like to briefly highlight three of
13 the recommendations that we have included in our
14 written statement. Number one, the requirements
15 for prescriptions, as stated in the handbook, are
16 vague and open to interpretation. This can lead
17 to inconsistencies among centers, which can lead
18 to improper equipment being authorized or
19 installed for the veteran.
20 Our recommendation is that for all
21 veterans requiring an automotive adaptive
22 equipment, that the driver rehabilitation

1 specialist produce a report based on a
2 comprehensive driver evaluation, including an
3 analysis of the veteran's needs and a description
4 of the recommended solutions.
5 Number two, it is unclear if the
6 handbook allows equipment to be installed without
7 a prescription, who is authorized to write that
8 prescription, and who authorizes any changes to the
9 prescription.
10 ADED recommends ensuring that
11 prescriptions are generated by a DRS based on a
12 comprehensive driver evaluation and that the DRS
13 approve any changes.
14 And finally, there's no requirement for
15 a final fitting. This important step ensures that
16 the installed equipment is in accordance with the
17 prescription and that the veteran can access their
18 personal modified vehicle and safely use the
19 prescribed equipment as intended.
20 ADED recommends requiring that prior to
21 the veteran taking possession of their modified
22 vehicle, a final fitting should be scheduled with

1 the client, the DRS, and the mobility equipment
2 dealer or the installer.
3 Enactment of the Veterans Mobility
4 Safety Act of 2016 provides opportunities to ensure
5 that installations are performed by qualified
6 professionals and to advance the quality of the
7 spectrum of services available to our veterans.
8 There is a process in place for driver
9 rehab services and we applaud that. However, in
10 practice among various centers, is inconsistent
11 due to vague handbook guidelines. We hope you take
12 this opportunity to not only address the
13 qualifications of the equipment installer, but
14 also to look at the entire process, to improve
15 access to services, veteran safety, and ensuring
16 that only the most medically-appropriate equipment
17 is improved.
18 ADED fully supports our driver rehab
19 specialists in the VA system and is willing to
20 engage as an education partner, guide in best
21 practice, and a resource for professional
22 development. Thank you for your time and your

1 attention today.
2 I appreciate your care for our veterans
3 and I look forward to seeing you take this
4 opportunity to increase the quality, and safety,
5 and efficiency of Automotive Adaptive Equipment
6 Program services. Our veterans are counting on
7 your guidance and your leadership. Thank you.
8 MS. NECHANICKY: Thank you. Speaker
9 Number 14. Okay.
10 MR. WESTON: Thank you for the
11 opportunity to share VMI's perspective as a
12 wheelchair-accessible vehicle manufacturer at
13 this hearing. My name is Jeff Weston and I'm VMI's
14 Executive Vice President for Business Development
15 and Sales, and my passion runs deep for veterans.
16 I was a graduate of the United States
17 Military Academy, spent five years in the Army as
18 a helicopter and airplane pilot, and although I
19 left 25 years ago from the service, I have a number
20 of classmates that are still serving in active duty
21 and many of them are still in government as well.
22 I'm very proud to call myself a veteran

1 and I'm passionate about making sure that our
2 veterans know that, should they be injured while
3 serving, that we have their backs when they come
4 home.
5 VMI's been in business for about 25
6 years and we're looked at from the original
7 equipment manufacturers, the OEMs, as a
8 second-tier manufacturer, where we modify or
9 convert, you'll hear that term as well, convert
10 vehicles to allow wheelchair accessibility.
11 We are one of only two manufactures in
12 the industry to be approved by the three largest
13 OEMs manufacturing of minivans in the world; Honda,
14 Toyota, and FCA, Dodge-Chrysler.
15 We're currently the only
16 gold-qualified supplier for Toyota. That's their
17 highest rating for quality. Minivans are the most
18 common vehicle modified for wheelchair access
19 today, and that's primarily because they have the
20 most interior space, maneuverability, and the
21 front-wheel driving system.
22 Other vehicle types such as SUVs,

1 trucks, and others, have limited volume in the
2 industry at this point in time. VMI has two
3 concerns when we develop a wheelchair-accessible
4 vehicle. The first one is safety and the second
5 one is making sure that that vehicle meets the
6 consumer's needs.
7 We believe that safety is paramount and
8 it's our first priority during the design and
9 development process. We focus on building
10 high-quality products that consumers, veterans in
11 this case, want and need so that we take the
12 following characteristics into consideration as we
13 do that development process.
14 First of all, we believe that it's
15 important that throughout manufacturers,
16 wheelchair-accessible vehicle manufacturers, that
17 are provided to veterans, the
18 wheelchair-accessible vehicles that are provided
19 to veterans, are manufactured by companies that
20 have formal approval by the OEM to modify their
21 vehicle.
22 Modified vehicles should perform as

1 close to the OEM as possible, meeting all the safety
2 standards. Wheelchair-accessible vehicle
3 manufacturers should publicly show that each of
4 their vehicles modified meets NHTSA and FMVSS'
5 crash safety standards after the vehicle
6 modification.
7 Wheelchair tie-downs and passenger
8 restraint systems should meet FMVSS and RESNA
9 requirements. Veterans should also have written
10 documentation about patient assessment to ensure
11 that the vehicle fits their needs.
12 This will, in turn, ensure that items
13 such as proper line of sight and maneuverability
14 inside the vehicle are achieved. Veterans should
15 be provided a demonstration of the proper operation
16 and functionality of the vehicle modification or
17 conversion, and the OEM vehicle functions prior to
18 delivery.
19 This demonstration should be
20 documented when conducted and it should also be
21 noted that the veteran understood that
22 demonstration.

1 When additional equipment is needed,
2 such as hand controls or electromechanical
3 wheelchair locking devices, only dealers that are
4 approved by the manufacturer of the added equipment
5 should be utilized for this installation for
6 veterans.
7 These dealers should have proper
8 calibrated equipment, they should be properly
9 trained, and these dealers should have proper
10 procedures from the manufacturer for that
11 installation of equipment.
12 Technicians performing the
13 installation or adding of additional equipment, or
14 repairing the vehicle, should also be certified by
15 the manufacturer of the equipment or the
16 modifications being performed, and that should be
17 done by the manufacturer.
18 Technicians performed installations or
19 repairs that are adding equipment should also be
20 ensured to do that. Dealers should maintain
21 records that document the installation of all the
22 added equipment and repairs for that vehicle for

1 five years.
2 VMI modifies the latest OEM vehicles,
3 many of which come with numerous computer and
4 safety systems built into the vehicle. We believe
5 that it's also very important that the sales staff
6 that supports the veteran in their acquisition
7 process be properly trained or certified by the
8 manufacturer so that they can properly demonstrate
9 the functionality of the modification of the OEM
10 vehicle before we get too far down the line.
11 VMI is also involved in the
12 distribution of occupied vehicle lifts. Occupied
13 vehicle lifts are products that lift the wheelchair
14 with the occupant from the ground to the floor and
15 the entry and exit of the vehicle. Generally,
16 these lifts are added to larger full-size vans or
17 similar vehicles.
18 Again, VMI's chief concern is that the
19 lifts that we distribute are installed properly so
20 that veterans are provided high-quality, safe
21 products for access to their vehicle.
22 VMI recommends this following criteria

1 to be used by the VA. All occupied lifts should
2 be installed with interlocking system to prevent
3 vehicle movement while the lift is in operation.
4 Occupied lifts provided to veterans should meet all
5 FMVSS standards, occupied lifts provided to
6 veterans should be designed, tested, and certified
7 to the rated capacity of the vehicle application
8 by the manufacturer.
9 All occupied lift installations should
10 incorporate certified vehicle specific lift kits
11 provided by the manufacturer. Any technician
12 installing an occupied lift to a vehicle should be
13 approved by the manufacturer to perform that
14 installation.
15 Technicians should utilize proper
16 installation process, NADA-developed standards
17 for occupied vehicle lifts should require
18 technician utilization of appropriate equipment,
19 tools, to complete the installation so that the
20 lift performs safely, reliably, and as designed.
21 All work should be documented and on
22 file for audit. Any technician installing an

1 occupied lift on a vehicle should be properly
2 insured as well.
3 It's important, as I've stated above,
4 that not only are these standards adopted by you,
5 but that you monitor the compliance. We had a
6 saying when I was back in the Army that you inspect
7 what you expect.
8 So as the VA establishes requirements
9 and standards to ensure safety and quality for all
10 of our veterans, qualified third parties should be
11 trusted to ensure vendor compliance with VA
12 standards.
13 It's VMI's recommendation that the VA
14 rely on the National Mobility Equipment Dealers
15 Association for guidance and partnership in this
16 important standard development endeavor.
17 VMI's been a NMEDA member for many years
18 and we intend to continue our membership in the
19 nation's leading association for mobility
20 manufacturers and professionals. NMEDA has spent
21 decades developing best practices and guidelines
22 for safe quality products and installations.

1 NMEDA's QAP supports better outcomes by
2 establishing and monitoring standards for
3 installation. Servicing and support for products
4 in the field as well.
5 The VA, and more specifically, the
6 veteran, deserves the best, or at least the closest
7 approximation thereof, and right now, the NMEDA QAP
8 supports that outcome.
9 Thank you for your time listening to the
10 input and thank you for your efforts in supporting
11 our veterans.
12 MS. NECHANICKY: Thank you. At this
13 time, I think we will break for lunch, if that's
14 okay, and we'll have Speaker Number 15 will take
15 the podium when we get back and have Speakers 16
16 through 20 to sit up front.
17 Please, if you leave the building, know
18 that you -- for lunch, know that you will have to
19 come back through security. There is a canteen
20 right down the hall here, and a coffee shop, if
21 you'd like to just get something right here.
22 We're going to put the timer on one hour

1 and we will start again promptly when that time has
2 expired. So thank you very much. Folks on the
3 phone, we'll be back in one hour and we will mute
4 you until we come back online. Thank you very
5 much.
6 (Whereupon, the above-entitled matter went off the record at 11:55 a.m.
7 and resumed at 12:58 p.m.)
8 MS. NECHANICKY: Okay. If we can have
9 Speakers 16 through 20 come up front. That'd be
10 great. And we'll start off with Speaker Number 15.
11 I think we're ready to get going. Okay. I think
12 we're ready to get started. Thank you, everyone,
13 for being here. Speakers, if you can give your
14 cards to Patricia, she'll be timekeeping for us
15 this afternoon. Ready? Are you ready? Okay.
16 Go ahead. Thank you.
17 MR. LANGFIELD: Thank you. Good
18 afternoon, everyone. My name is Danny Langfield.
19 I am the Chief Executive Officer for the National
20 Mobility Equipment Dealers Association and I am
21 speaking today on behalf of NMEDA. It is also my
22 job to make sure no one falls into a post-lunch nap,

1 so I'm going to keep it snappy and bright.
2 I want to start by thanking the agency
3 for the opportunity to meet here today. As I've
4 been looking around the room, I'm gratified to see
5 the presence of so many stakeholders for whom these
6 issues are so significant. A lot of busy people
7 came a long way to be a part of this meeting today.
8 I think your presence underscores the
9 importance of the matter before us and I want to
10 thank all of you, regardless of your positions on
11 this matter, for participating in the process.
12 Now I'd like to join the distinguished
13 representative from Ohio in going off script for
14 just a moment and addressing other previous
15 comments. Apparently, there is this notion that
16 NMEDA is somehow looking to prevent driveway
17 installs of lifts. This is simply wrong.
18 Our guidelines specifically provide a
19 policy for driveway installs, do not require
20 four-corner scales, and were developed by the
21 actual lift manufacturers, including Harmar. The
22 individual who served on that committee from Harmar

1 voted in favor of this policy, and that's a matter
2 of record.
3 The other notion appears to be that we
4 think everyone should be required to be QAP.
5 That's simply not the case. The VMSA provides for
6 manufacturer certification, clearly, and we have
7 no quarrel with that, if it's responsibly
8 administered.
9 What we are asking for is meaningful
10 standards, no matter who is doing the certifying.
11 I think we need to ask ourselves, if these folks
12 are doing such an outstanding job of installs, why
13 are they so afraid of meaningful standards?
14 All right. Back to my regularly
15 scheduled comments. For those of you who may not
16 be entirely familiar with our Association, I will
17 provide a little background. NMEDA was
18 established in 1989 as a not-for-profit trade
19 association dedicated to expanding opportunities
20 for people with disabilities to safely drive or be
21 transported in vehicles modified with mobility
22 equipment to fit their specific needs.

1 As a 501(c)(6), professional trade
2 association, NMEDA's membership consists of
3 mobility and equipment dealers, manufacturers,
4 driver rehabilitation specialists, healthcare
5 practitioners, rehabilitation experts, engineers,
6 and other mobility equipment industry
7 professionals.
8 Contrary to previous testimony, we are
9 not run by two or three large operators. We
10 actually have dozens of single-point members,
11 including the sitting board members. Our
12 association offers an accreditation, known as the
13 Quality Assurance Program.
14 At this point in the day, I bet that is
15 not a surprise announcement to the panel. While
16 this accreditation is required of NMEDA members,
17 it is open to all businesses. In other words, you
18 do not need to be a NMEDA member to be QAP
19 accredited. And let me belabor the point, you
20 don't need to be a NMEDA member to be QAP
21 accredited.
22 QAP is the only nationally recognized

1 accreditation program for the adaptive mobility
2 equipment industry. It's based on the principle
3 that, in order to satisfy customers consistently,
4 companies must have a systematic and documented
5 approach to quality.
6 The program was developed to elevate
7 the level of dealer performance to reliably meet
8 consumers' transportation needs on the safest
9 manner possible. I'd like to highlight a few
10 requirements of the program now.
11 Dealers must, among other things,
12 maintain certain insurance, including product,
13 completed operations, and garage keepers insurance
14 for liability purposes, and to protect the consumer
15 and the dealer.
16 They must have technicians who are
17 certified for the equipment they sell and seldom
18 service. They must maintain detailed records of
19 all adaptive work for at least seven years that are
20 specific to a customer and vehicle for traceability
21 and future reference.
22 And they must undergo an audit process,

1 at least annually, by a separate entity to ensure
2 to compliance with the QAP rules, NMEDA guidelines,
3 certain aspects of the Americans with Disabilities
4 Act, the NHTSA Federal Motor Vehicle Safety
5 Standards, and make inoperative mandates as
6 required.
7 The integrity of the Quality Assurance
8 Program is of paramount importance to our
9 association. Failure to comply with the program's
10 tenets results in suspension. If corrective
11 action is not taken and independently verified, the
12 QAP designation is revoked. We take it seriously.
13 We are very proud of the fact that
14 multiple agencies and organizations directly
15 endorse or recommend QAP dealers, including state
16 voc rehab agencies in the following states,
17 Alabama, Arizona, California, Colorado,
18 Connecticut, Florida, Georgia, Indiana, Kentucky,
19 Louisiana, Maryland, Missouri, New Hampshire, New
20 Jersey, New Mexico, New York, North Carolina, Ohio,
21 South Carolina, Tennessee, and Vermont.
22 Groups that directly endorse QAP

1 include the United Spinal Association, Vets First,
2 the American Stroke Association, National Multiple
3 Sclerosis Society, the Christopher and Dana Reed
4 Foundation, Spina Bifida Association, United
5 Cerebral Palsy, Cure SMA, spinal muscular atrophy,
6 the Association for Driver Rehab Specialists, the
7 Assistive Technology Industry Association, the
8 National Organization for Vehicle Accessibility,
9 and the Seniors Resource Guide.
10 We are also proud partners of Paralyzed
11 Veterans of America, the Rehab Engineering Society
12 of North America, the Case Managers Society of
13 America, the National Coalition for Assistive
14 Rehab Technology, the Amputee Association, ALS
15 Association, the American occupational Therapy
16 Association, and the International Seating
17 Symposium.
18 I hope you will forgive the list of bona
19 fides, but as the old expression goes, we'd be glad
20 to be judged by the company we keep. Turning now
21 to the matter before us today. Previous remarks
22 by other organizations have indicated that

1 establishing standards for all types of AAE would
2 be a significant, perhaps even overwhelming task
3 for the VA.
4 These comments insinuate, if not
5 outright state, that such an undertaking is more
6 trouble that it is worth. What an unfortunate
7 position to take. I am unaware of a priority
8 higher than establishing meaningful safety
9 standards for those veterans who appeal to the VA
10 for assistance with their mobility needs.
11 Is establishing such standards an easy
12 task? No, it is not. I feel like NMEDA is
13 uniquely positioned to address the magnitude of
14 such an undertaking, as we have spent the last 28
15 years establishing just such standards.
16 To our association, there is no more
17 important mission than establishing quality
18 mobility standards for folks with disabilities,
19 veteran and civilian alike. In fact, it's the
20 reason we exist.
21 Look, there's no reason to put too fine
22 a point on this, there are dealers, manufacturers,

1 and installers out there who will cut corners in
2 the interest of making an extra buck. I don't
3 think anyone in this room is very excited about that
4 reality, but nonetheless, it is the reality.
5 So the question is, how does the VA
6 avoid lining the pockets of these bad operators at
7 the expense of the safety and well-being of our
8 country's veterans? It's simple. The answer if
9 found in the legislation that has brought us all
10 together in this room today, by establishing and
11 enforcing meaningful standards for the
12 manufacturing, installation, and service of AAE.
13 Now, that answer may be simple, that
14 doesn't make it easy, right? But you know what?
15 It's okay. Most of country's important
16 achievements of their government or private sector
17 accomplishments come at the expense of a lot of
18 blood, sweat, and tears, time and treasure.
19 So if anyone in this room thinks the
20 effort isn't worth it when the end result is a
21 better, safer outcome for our veterans, that person
22 ought to take a hard look in the mirror, because

1 quite frankly, those aren't priorities to be proud
2 of.
3 Some have suggested that NMEDA has a
4 financial conflict of interest here, as of the
5 28-year history of working to improve the industry
6 was somehow all about the money. Smarter people
7 than me can and will easily refute this argument,
8 but I wanted to take a moment to address this
9 underlying failure to understand how associations
10 work.
11 Frankly, I was a little embarrassed for
12 the representative that he didn't understand this
13 just a little bit better. Trade associations
14 exist to achieve collectively that which cannot be
15 achieved individually. NMEDA is a corporation
16 that does not have a will or purpose of its own.
17 The will and purpose of this
18 association is exclusively the will and purpose of
19 its collective members, governed by its
20 duly-elected board of directors and managed by its
21 staff, to advance the interest of an industry.
22 The notion that there is some

1 malevolent murky force in the background cackling
2 evilly and plotting the domination of an industry
3 is absurd. Our board is made up of a dedicated
4 industry veterans and leaders from all over the
5 United States and Canada, and our board includes
6 not just wheelchair van dealers, but also
7 manufacturers and certified driver rehabilitation
8 specialists.
9 One of these manufacturers is the chair
10 of our finance committee. The other chair is our
11 manufacturers Quality Assurance Program
12 committee. These are not symbolic roles or
13 figureheads. These folks are actively involved in
14 the business of our association.
15 We are highly inclusive, sometimes
16 almost to a fault. I'm proud of the fact that some
17 of our members who bitterly oppose the Veterans
18 Mobility Safety Act had representation on our
19 association's committees. As a matter of fact,
20 they still serve on those committees today. But
21 that's how associations are supposed to work. You
22 may not always get your way, but regardless of your

1 views, you will be invited to participate in the
2 process and to have your voice heard.
3 Now, when it comes to exterior hitch
4 lifts, topic du jour, there has been a concentrated
5 effort of both the legislature and now before the
6 VA, to exempt or significantly reduce regulation.
7 I don't think any reasonable person can
8 refuse to acknowledge that there is a problem with
9 lifts being installed inappropriately. Not even
10 the manufacturers make that argument, although,
11 the severity of the problem may be debated by
12 reasonable people, and I do have a good working
13 relationship with the Harmar CEO, much to the
14 chagrin of folks on both sides of that deal, I
15 think.
16 Nonetheless, the fundamental element
17 in the room is this, what constitutes an
18 appropriate application for the installation of an
19 exterior-mounted hitch lift? There are two sides
20 here, and I think they're very clearly
21 differentiated.
22 On one side, we have certain hitch lift

1 manufacturers, and their allies, who take the
2 position that only they know the secret formula for
3 appropriate installations. When asked for that
4 formula, they tell us, essentially, don't worry
5 your pretty little heads about it. An application
6 is appropriate if we say it is.
7 A cynical observer may be forgiven for
8 wondering if those manufacturers might be taking
9 that position in order to protect their own
10 financial interests. On the other side, we have
11 a non-profit trade association with a 28-year track
12 record of working with the industry to establish
13 continuously improving safety standards, of
14 course, not just for hitch lifts, but for all AAE.
15 We believe that a weight-based standard
16 must be developed and enforced to ensure
17 appropriate applications. The associations
18 position is echoed by any number of industry
19 stakeholders, many represented here today, who
20 conspicuously do not have a financial interest in
21 the outcome.
22 So I'll leave you to the agency to

1 determine which side is more aligned with our
2 veteran's needs. I'll close by asking for just two
3 concrete outcomes from this process as the VA
4 undertakes to implement the Veterans Mobility
5 Safety Act.
6 Number one, create meaningful
7 standards for all AAE. Don't shrink from the
8 moment because the task may seem daunting. You
9 have a room full of stakeholders here who stand
10 ready to assist in any way we can.
11 Number two, enforce those standards
12 with meaningful consequences for those who would
13 cut corners at the expense of our veterans safety.
14 At the end of the day, rules without enforcement
15 are just empty words on the page. Thank you very
16 much for your time and attention today.
17 MS. NECHANICKY: Thank you. Speaker
18 Number 16. Let's hold for the timer. Okay.
19 MR. COOK: Good afternoon. My name is
20 Sam Cook. I'm President of Superior Van & Mobility
21 and a proud supporter of the Veterans Mobility
22 Safety Act and its intended goals of making

1 installation safer for veterans.
2 Superior Van & Mobility is an industry
3 leader, providing state-of-the-art mobility
4 solutions for consumer and commercial
5 transportation. We are a proud member of NMEDA and
6 a willing participant in NMEDA's Quality Assurance
7 Program. Superior currently has operations -- ten
8 locations, operating in Indiana, Kentucky,
9 Tennessee, and Louisiana.
10 As a second-generation mobility
11 dealer, I am proud of my role in the community and
12 the products that we serve. Throughout my decades
13 of mobility dealing as a professional, I have seen
14 the difference in what quality installations can
15 do to brighten the outlook of the disabled member
16 of the community.
17 Consequently, I've also seen what poor
18 installation, not only looks like firsthand, but
19 what it does to the people that we are trying to
20 serve, potentially life-threatening impact that it
21 can have on the person relying on that
22 installation.

1 I have also shared my expertise and
2 knowledge with the House of Representatives
3 Veterans Affairs Committee, which, I testified
4 before Congress and contributed multiple written
5 submissions before the House and Senate Veterans
6 Affairs Committee.
7 As a past NMEDA President, I take my
8 role in preserving the safety and security of not
9 only the disabled community, but of the driving
10 community very seriously. I've been a long-time
11 advocate of the VA handbook update and the
12 development of meaningful standards for equipment
13 and installations.
14 As such, I fully endorse the policy
15 changes that the VMSA is trying to make and pleased
16 with the VA to come up with comprehensive quality
17 standards for the provider for installer mobility
18 equipment.
19 I want to talk a little bit about the
20 simple installations. The simple installation,
21 you know, that's an easy term, say, well, it's
22 simple. It shouldn't have anything. Well, some

1 of the simplest things that the VA pays for are some
2 of the least expensive things that the VA pays for,
3 an outside lift, a spinner knob, a set of pedal
4 extensions.
5 These things are very, very -- and if
6 they're not, they might sound simple because
7 they're not, you know, $50,000, but what they do
8 and what they can do to affect not only the veteran
9 but the driving public, is very important.
10 You know, when you look and you compare
11 an outside lift to a bicycle rack, which was
12 installed earlier, I mean, they both do have a hitch
13 and they both slide in, but that's where it stops.
14 I never seen a bicycle weigh 300 or 400
15 pounds. I've never seen a bike rack require power.
16 And, you know, those things are -- you know, we have
17 to be very careful. You know, it's just easy to
18 say, you know, we're all here to protect the
19 veteran, but we have to think, well, how
20 self-serving are we going to be?
21 So I just think we need to be careful
22 when we're talking simple and not simple, because

1 what we do every day affects the lives of people
2 and I don't think there's anything that we do that
3 I would call simple.
4 There's a reason why the car dealers
5 don't do what we do, there's a reason why car
6 dealers don't install lifts, there's a reason why
7 car dealers don't install hand controls, because
8 these things are, you need to be trained
9 professionally. And you say -- you know, I'm very
10 much a supporter of manufacturer's training.
11 All of our employees go through
12 manufacturer training, but how do we know -- how
13 does the manufacturer know that the guy that I have
14 installing that lift has been through training?
15 There is no check, there is no anything. They
16 usually send me the lift and say, put it on, Sam.
17 Well, I could have Tom do it, I could
18 have Bob do it, well, being a member of QAP, RADCO,
19 an outside third-party inspection firm, comes in
20 twice a year to our facilities and looks at the
21 records and says, they've pulled randomly, and they
22 say, this lift was installed on January 15th, and

1 Tom did it, we need to see his certificate, and it
2 was also inspected by Bob, let's see his
3 certificate.
4 And these are things that the VA, you
5 all don't have time to go out and check these
6 things, you don't have a lot of time to see, do they
7 have insurance? Does the facility meet ADA
8 guidelines? Are the welders certified? And
9 these are the things that, you know, again, you all
10 have enough to do.
11 It's been stated many times, you know,
12 the reputation that the VA just has a bunch of
13 people with their feet propped up, you know, I know
14 that's not the case because I've seen -- I've been
15 here in Washington, and when we see every day in
16 the field what VA employees do, so they don't need
17 to be inspectors or don't need to be this.
18 This program is already in place. You
19 know, it was also mentioned earlier that, you know,
20 we need a grace period, time to ramp up, well, to
21 me, if you're doing this job right now, and sure,
22 the guys that testified earlier, you could tell,

1 passionate, and great guys, and I don't know any
2 of them that spoke, but you could tell they knew
3 what they were doing, and did that, but so many of
4 the times, these installations are not done by
5 folks that are qualified because we have no way of
6 knowing, nobody has any way of knowing.
7 It's just, the manufacturer says this,
8 watch something online, you don't have to go
9 anywhere, don't have to do anything, watch a video,
10 and now you're certified. So those are the things
11 that the QAP program ensures that this is done.
12 And again, it's not just my word, it's,
13 somebody has to come in and audit that. You know,
14 when I started coming to Washington several years
15 ago, you know, this whole -- our whole first task
16 was updating the VA handbook, because as we all
17 know, the VA handbook mostly deals with full-size
18 vans and adaptations that were done many years ago.
19 So we want to be the partner to help you,
20 just like we've said at the beginning on our first
21 meeting. It's very important for us. We reached
22 out to NHTSA several years ago and we're a partner

1 with them, and things that go from our make and
2 operative forms, that we work hand-in-hand with
3 them.
4 And NMEDA wants to be that voice with
5 the VA to partner and to help serve the veterans
6 in the future. Kind of went off script there.
7 Again, the QAP program is something that is ready
8 to go right now. We don't have to wait, we don't
9 have to do anything, it's something -- it's tried
10 and true, and proven, and we have the ability right
11 now to weed out the bad apples.
12 Just because you pay us, just because
13 you send a check into NMEDA, doesn't mean you're
14 a NMEDA member. You have to pass that and we have
15 suspensions every month, there are people who get
16 suspended from the program for not doing it
17 correctly. Again, thank you for your time and
18 appreciate your effort.
19 MS. NECHANICKY: Thank you. Speaker
20 Number 17. Ready? Go ahead.
21 MR. BLAKE: Thank you so much.
22 MS. NECHANICKY: Thank you.

1 MR. BLAKE: Thank you. My name's Chad
2 Blake. I'm the Chief Operating Officer of the
3 Ability Center, based on San Diego, California.
4 I'm also the current President the National
5 Mobility Equipment Dealers Association.
6 A little bit about the work that Ability
7 Center does as an automotive mobility dealer.
8 Specific to the VA, we have 13 locations, we work
9 in 4 states, we deal with approximately 15
10 different Veterans Administration hospitals,
11 things like that.
12 Just a quick couple of comments before
13 I get to my written portion, that we talked about
14 earlier, the first is this idea of control. I'm
15 here today and I believe in the Veterans Mobility
16 Safety Act because I believe it gives the VA the
17 control, okay?
18 It is my hope that the VA will set
19 meaningful standards for all of us that are in that
20 space and as Ability Center is a NMEDA members and
21 president, we are more than open to doing whatever
22 we have to do to meet those standards.

1 The second piece that I would say, is
2 this concept about financial gain and financial
3 conflict of interest. I'll be honest with you,
4 Ability Centers are consumer auto mobility dealer.
5 Less than 30 percent of our total annual revenue
6 is tied to all third-party payers.
7 That's the VA being the top third-party
8 payer, to vocational rehab, so this conversation
9 that we're having today needs to pivot to, really,
10 what the intent of the law was. It's not about the
11 money. It's always been about ensuring positive
12 outcomes for our veterans.
13 It goes without saying that automotive
14 adaptive equipment is a benefit that every
15 qualified veteran deserves. These veterans and
16 their sacrifice can never be fully recognized and
17 these AAE benefits that are available because our
18 veterans need them.
19 They need them to get to work, they need
20 them to get to medical appointments, and they need
21 them to live an independent and active life.
22 In order to achieve these outcomes, the

1 individual equipment products and the final
2 complete vehicle need to function correctly,
3 safely, and effectively. We've talked about
4 different ways that this law could be implemented,
5 and I'll just echo what Mike Savicki said
6 initially, which is, whatever we do here today,
7 let's make sure that the veteran is put first in
8 all of the discussion. They're the customer.
9 I also understand that the VA is the
10 customer as well. As a mobility equipment
11 provider, I understand that the best outcomes are
12 always achieved when all parties, the veteran, the
13 VA, the dealer or installer, the manufacturer, the
14 driver rehab specialist, we all come together and
15 have an equal invested interest in creating a
16 positive, safe, and quality outcome for the
17 veteran.
18 We're all in this together so let's use
19 this opportunity to decree AAE program standards
20 that will provide outstanding service to our
21 veterans. For a VA provider to provide consistent
22 and repeatable quality standards, certain elements

1 must be in place.

2 The first and most important is a clear

3 and understandable directive from the VA. That's

4 why the update of the VHA handbook 1173.4, as

5 required by this law, is so important. The

6 handbook has not been updated in over ten years and

7 as the auto mobility industry has evolved quite a

8 bit during this time period, it's important that

9 consistent results require clear expectations.

10 And the VA's AAE vendor requirements

11 need to be clearly defined. Another element that

12 must be put in place by for the VA is to produce

13 consistent results for veterans is the creation,

14 implementation, and enforcement of specific

15 meaningful standards for providers regarding the

16 prescription, selection, application,

17 installation, and veteran training of all auto

18 adaptive equipment products across the entire

19 spectrum of complexity.

20 There shouldn't be one product left out

21 of this element. Obviously, different products

22 are going to require different criteria, I think

1 everybody understands that, but exempting any
2 category or item from adherence to a standard will
3 create a gap in the veteran's experience.
4 This opens the door for the poor,
5 inappropriate, and unsafe outcomes, and will do
6 nothing to prevent duplicative spending. A final
7 element that I'll mention is accountability
8 measures connected to veteran's outcomes.
9 At the point of initial acquisition of
10 the products, all providers and manufacturers
11 should be required to perform and document a
12 standardized needs analysis for veterans. A needs
13 analysis is a key to matching the correct product
14 with the veteran's mobility needs, while also
15 considering the product's intended use.
16 A range of factors that should be
17 considered when looking in this process include the
18 size of the VA-provided power mobility device, the
19 veteran's vehicle, the condition of the vehicle,
20 any additional equipment on the vehicle, and the
21 ability of the veteran to safely operate the
22 adaptive equipment product, as well as

1 environmental factors, such as frequency of use,
2 the vet's driveway, garage, et cetera.
3 Most issues that arise with improper
4 outcomes and unhappy customers in the auto mobility
5 industry, start with an incomplete needs analysis
6 at the very beginning of the process, so that's
7 regardless of third-party payer or retail.
8 You don't do a good needs analysis,
9 you're not going to get a good outcome.
10 Accountability measures should also be considered
11 as the VA develops standards for the installation
12 of these products, specifically, every VA provider
13 should be required to install equipment to all
14 manufacturer standards, and this installation must
15 be documented.
16 Obviously, each provider should be
17 certified by the product manufacturer and each
18 installation must be completed and overseen by a
19 certified installer.
20 An installer should take appropriate
21 and reasonable action to ensure that the
22 installation area is safe and protected,

1 regardless of where that takes place.
2 It could be at a facility, it could be
3 at the VA, it could be at a veteran's home. It just
4 needs to be safe. Regardless, manufacturers --
5 regarding manufacturers, excuse me, each
6 manufacturer should be required to ensure that
7 their designated installers have been trained and
8 certified, and manufacturers should have a
9 documented quality system with work instructions
10 and installation standards for each product that
11 it manufactures and sells to the VA.
12 Finally, VA standards should require
13 training and demonstration of the product to the
14 veteran and the veteran's family or caregiver that
15 will use it. All veterans that receive AAE
16 benefits should be provided with instructions on
17 how to operate the equipment, should understand the
18 product's maintenance requirements, they should
19 also be provided the product warranty, and should
20 be provided information regarding who to contact
21 if there's performance or safety issues.
22 By implementing such accountability

1 measures at initial intake, at installation, and
2 at and after delivery, the VA can better ensure the
3 veterans receive appropriate, safe, quality, and
4 effective automotive adaptive equipment outcomes.
5 It's also important to mention the
6 financial impact of poor outcomes for the VA,
7 specifically, situations where the VA pays for the
8 auto mobility products that never get installed.
9 In one 12-month period, our company, Ability
10 Center, had nine lifts delivered to one location
11 that the local VA purchased on contracts, where the
12 application was incorrect and the installation
13 could not be completed.
14 Those lifts sat there, on average, for
15 over 90 days. Some of the brand-new lifts were
16 taken by the VA to be warehoused. The rest were
17 taken back by the manufacturer. In every case, the
18 veteran didn't get an outcome for, on average, an
19 additional 30 days, and some didn't end up getting
20 lifts at all.
21 There has to be a better operational
22 approach to handling this. The VA should stop

1 paying for veteran's outcomes twice. The VA must
2 have some level of recourse to allow them to recoup
3 monies from providers, installers, or
4 manufacturers when these situations arise.
5 This should also be true for all
6 manufacturers and providers, regardless if it's
7 contract or if it's a purchase on free market. It
8 doesn't matter the methodology of the business, it
9 just matters that we need to be fiscally
10 responsible.
11 Every stakeholder must be committed to
12 working with the VA to ensure that this type of
13 financial waste is mitigated, and ideally,
14 eliminated. By doing this, we will also improve
15 the level of service for our veterans.
16 Safety, quality, accountability, and
17 financial responsibility are a way of life for
18 Ability Center and for other members of NMEDA's
19 Quality Assurance Program.
20 Ability Center participates by choice
21 in the QAP program for two reasons. One reason is
22 to provide the highest quality products in the

1 safest installation manner possible. The second
2 reason is to have a systematic approach with
3 established standards that allows our dealership
4 to appropriately mitigate risk.
5 Our customers are in difficult
6 situations because of their disabilities, and our
7 goal is always to improve the customer's quality
8 of life. A program like NMEDA QAP provides a clear
9 path to achieving our goal of being the best
10 mobility dealership that we can be.
11 It is my sincere hope that when the VA
12 implements and enforces the VMSA standards for
13 manufacturers and providers that work in the
14 mobility space, the veteran experience will become
15 safer and of higher quality.
16 And most importantly, more practical
17 for the veteran and his or her family. Personal
18 independence and personal mobility affirms the
19 supreme value and dignity of the individual.
20 In conclusion, I respectfully ask for
21 three things as the VA implements the Veterans
22 Mobility Safety Act of 2016. One, update the VA

1 handbook, two, include meaningful enforceable
2 criteria and standards for all products,
3 providers, and manufacturers across the board,
4 three, implement accountability measures that are
5 consistent at initial product acquisition, at
6 product installation, and at and after product
7 delivery.
8 I thank you so much for your time and
9 the opportunity to share my thoughts.
10 MS. NECHANICKY: Thank you. Speaker
11 Number 18. Okay. Speaker Number 19.
12 MS. SCHOPPMAN: Good afternoon. My
13 name is Amy Schoppman and I am the Director of
14 Government Relations for the National Mobility
15 Equipment Dealers Association. Before holding my
16 current position, I spent six years working with
17 NMEDA as one of the organization's representatives
18 here in Washington.
19 As some of you on the VA panel may
20 already be aware, I have been involved in the effort
21 to update VHA handbook 1173.4 since that effort
22 began in 2010 and I'm privileged to be here today

1 as we all collectively bring that effort to its
2 conclusion.
3 I'd like to begin with a brief history
4 of the Veterans Mobility Safety Act, or the VMSA,
5 as I'll refer to the law throughout. The VMSA was
6 introduced in the House of Representatives in
7 September of 2015 and the decision to introduce
8 legislation was not one that NMEDA approached
9 casually.
10 For approximately five years, from 2010
11 to 2015, NMEDA tried to avoid the pursuit of a
12 legislative solution by meeting at least annually
13 with VA to discuss the matter of a handbook update.
14 Our motivations for the handbook update
15 were twofold. One, VHA handbook 1173.4 had not
16 been updated since the 2000. After ten years, and
17 now, after nearly 17 years, much has changed in the
18 automotive mobility industry.
19 Vehicles were becoming more
20 technologically sophisticated and more powerful.
21 New automotive mobility equipment had been
22 developed and introduced to the market and no

1 longer were consumers limited to the choice of a
2 lowered floor, raised roof full-size van or nothing
3 at all.
4 So there was certainly an interest in
5 updating the handbook to bring it into concert with
6 the technical and consumer reality of the modern
7 day, and two, over the years, instances of
8 inappropriate or unsafe vehicle modifications have
9 been brought to NMEDA's attention.
10 Many of our dealer members reported in
11 engaging in what I'll refer to as repeat
12 installations. Meaning, a veteran had approached
13 a NMEDA dealer, or in some cases was referred by
14 VA to a NMEDA dealer, to correct a faulty, unsafe,
15 or medically or otherwise inappropriate
16 installation.
17 These reports reached a crescendo
18 around 2010, which is when the handbook update
19 effort began in earnest. NMEDA sincerely believed
20 that VA clarification of policy, including the
21 establishment of clear, meaningful, enforceable
22 standards for auto adaptive equipment and

1 installations would help reduce wasteful spending
2 on these repeat installations and would help to
3 improve the veteran's overall AAE program
4 experience.
5 During that period, from 2010 to 2015,
6 NMEDA received assurances from VA that the handbook
7 update proposal was reasonable, appropriate, and
8 would eventually be pursued. Concerned about the
9 possibility of a serious injury or loss of life due
10 to an inappropriate auto adaptive equipment
11 installation before VA completed a handbook
12 update, NMEDA worked with a bipartisan group of
13 members serving on the House Veterans Affairs
14 committee to introduce the VMSA and ultimately
15 accelerate the handbook update process.
16 In 2015, I spent quite a bite of time
17 on Capitol Hill, educating congressional offices
18 on automotive mobility solutions and explaining
19 NMEDA's effort to improve VA's AAE program.
20 The number one question I received by
21 far was, doesn't VA already have standards for this
22 program? And I would explain, not really. The

1 primary guidance document is outdated, it is
2 interpreted in different ways at different
3 facilities, and from a practical standpoint, no,
4 there are no standards for this program.
5 And out of all 535 congressional
6 offices that were visited, not one of them objected
7 to the VMSA. In fact, the VMSA was passed by
8 unanimous consent in both the House and Senate
9 before being signed into law by then President
10 Obama last December.
11 The overwhelming bipartisan
12 congressional support during a Congress which saw
13 the passage of relatively few acts signed into
14 public law is party why NMEDA found it so surprising
15 that auto adaptive equipment industry
16 stakeholders, some of them current members of
17 NMEDA, were leading the opposition to VA
18 establishment of meaningful standards for the AAE
19 program.
20 Now, using one stakeholder's proposed
21 standards for so-called simple modifications as an
22 example, I'd like to illustrate some important

1 differences in the ways VA can approach the
2 concepts of safety and quality.
3 As outlined in their February 17, 2017
4 response to VA's initial VMSA request for
5 information, these stakeholders proposed
6 manufacturer and installation standards for
7 so-called simple modifications.
8 These proposed standards make no
9 reference to liability insurance requirements to
10 protect the manufacturer, installer, or veteran
11 consumer, make no reference to the use of
12 automotive-grade wiring if necessary, make no
13 reference to minimum product warranty
14 requirements, make no reference to required tools
15 or tool calibration, make no reference to the
16 performance of a weight analysis, specifically
17 urge VA "not to adopt any standard or regulation
18 that requires the use of four-corner scales or
19 other equipment that would be infeasible for use"
20 -- or excuse me, "that would be infeasible to use
21 for installation of equipment at a customer's
22 home."

1 And I would note that other equipment
2 is a euphemism for equipment capable of performing
3 a weight analysis.
4 And finally, these standards rely
5 heavily, almost exclusively, on manufacturers to
6 determine which product is most appropriate for the
7 veteran and the veteran's vehicle. I suspect a
8 driver rehab specialist in the room may object to
9 this approach.
10 All of the above elements would be
11 present, and in fact, are present in NMEDA's
12 proposed standards, specifically, guidelines
13 policy 40A, also known as the offsite installation
14 and servicing policy for exterior hitch-mounted
15 lifts.
16 This policy requires insurance, tool
17 calibration, weight analysis, and all the rest.
18 And it needs to be pointed out that a stakeholder
19 in this very room voluntarily adheres to, and in
20 fact, was quite involved in developing and
21 approving NMEDA guidelines policy 40A.
22 Yet, they have proposed a different

1 lesser standard for VA adoption. Why should
2 veterans be subjected to a lesser standard of
3 quality and safety than the general public? Why
4 would a stakeholder repeatedly insist on
5 preserving a veteran's ability to receive an
6 at-home installation only to propose a standard for
7 at-home installation that is so technically
8 incomplete and so watered down as to be
9 meaningless?
10 Why would a stakeholder omit from their
11 proposed VA standard, key safety elements that this
12 stakeholder otherwise agrees to enforce in their
13 capacity as a NMEDA member?
14 VA should follow-up with this
15 stakeholder and ask those questions. In the
16 meantime, I will reiterate what many others have
17 emphasized throughout the day, that in the
18 automotive mobility industry, weight is a very
19 important component of the work that is performed.
20 OEMs are being challenged to provide
21 higher fuel efficiency, and one of the ways they
22 are meeting that goal is by reducing the weight of

1 the vehicle. That means the available load
2 carrying capacity is most likely less and with less
3 available load carrying capacity, there is less
4 room to work with, weight-wise, when vehicles are
5 modified.
6 Put into the mix the weight added to the
7 tongue from a hitch-mounted lift, not to mention
8 the personal mobility device being carried by that
9 lift, and it's easy to see that mobility dealers
10 and installers need to have a thorough
11 understanding of how weight dynamics interact to
12 be able to perform a proper weight analysis that
13 will allow a modifier to deliver a safe vehicle to
14 the veteran and user.
15 Moving on to the issue of so-called
16 simple modifications, much has been said today
17 regarding this matter, I won't spend time
18 reiterating those arguments, instead, I will share
19 with you the results of the failure mode and effects
20 analysis conducted by NMEDA's Director of Quality
21 Assurance.
22 The entire analysis will be attached to

1 NMEDA's written submission, but the results may be
2 summarized as follows. The "simple modification
3 product categories proposed in the February 17
4 written submission", and to reiterate, those
5 simple categories include wheelchair securement
6 systems, ramps, car toppers, manual,
7 non-integrated gas controls, manual,
8 non-integrated brake controls, left foot
9 accelerator pedals, and unoccupied scooter or
10 wheelchair lifts.
11 These categories are subject to several
12 potential failure modes, including loose hardware,
13 improper torque, improper grade hardware, improper
14 length hardware, and improper equipment mounting.
15 The potential effects of such failure
16 include vehicle instability, loss of control,
17 collision, accident, and death. We can argue all
18 day about the simplicity of certain types of
19 equipment, in fact, I think we may have already done
20 so, but simple or not, all equipment categories can
21 be dangerous if the equipment fails due to
22 manufacturer or installer error.

1 Does the law instruct VA to promulgate
2 standards for safety and quality of AAE and
3 installation of AAE, including defining
4 differentiations in levels of modification
5 complexity? Yes, it does.
6 Does the law direct VA to absolve entire
7 equipment categories from compliance with
8 standards for safety and quality by virtue of their
9 so-called simplicity? No, it does not.
10 And the VMSA's congressional sponsors,
11 in a letter that will also be attached to NMEDA's
12 written submission, agree with NMEDA's position
13 that it was never the intention of the VMSA for any
14 equipment category or equipment installer to be
15 relieved of adherence to safety and quality
16 standards due to the equipment or installation's
17 perceived non-complexity. Please take this into
18 consideration.
19 The rulemaking is too important to the
20 safety of veterans the driving public for VA to
21 produce rules that do not apply to entire equipment
22 or modification categories.

1 Finally, I just want to say that I know
2 you're probably sick of hearing from NMEDA at this
3 point, and Shayla, I'm looking at you, we have a
4 passion for advocacy when it comes to accessible
5 transportation and automotive mobility solutions,
6 and VA has been on the receiving end of that passion
7 for nearly seven years at this point.
8 But if you would like to hear about the
9 value of NMEDA and QAP standards from an entity
10 other than NMEDA and other than the stakeholders
11 in this room, I suggest reaching out to
12 California's Department of Rehabilitation
13 Services, which requires all contract vehicle
14 manufacturers and modifiers to hold QAP status.
15 In their own words, "The QAP status
16 provides the Department of Rehabilitation with an
17 assurance that the vendor follows the NMEDA
18 guidelines and the manufacturer's instructions
19 when providing their service."
20 North Carolina's Vocational
21 Rehabilitation Services note that a, "highly
22 significant component when ensuring the quality,

1 safety, and reliability of vehicle modifications
2 is through reliance on NMEDA's Quality Assurance
3 Program and its commitment to benefitting the lives
4 and outcomes of individuals with disabilities."
5 Or the Georgia Vocational
6 Rehabilitation Agency, which, again, in their own
7 words, "Made the decision that to best serve our
8 clients, we should require minimum safety and
9 quality standards when selecting a dealer to
10 perform AAE work."
11 "We searched for safety" -- excuse me,
12 "we searched for existing industry standards and
13 found that NMEDA has an excellent Quality Assurance
14 Program. Helping those we serve should be at the
15 foundation of all decisions we make and supporting
16 common sense safety and quality standards
17 exemplifies that commitment."
18 "For those reasons, the Georgia
19 Vocational Rehabilitation Agency strongly
20 supports NMEDA QAP and suggests that all state VR
21 systems consider referring, recommending, or
22 requiring QAP standards for AAE dealers and

1 installers."

2 VA may also wish to consult with PSA
3 Insurance, the leading independent insurance
4 brokerage and risk management firm for mobility
5 dealers, which states, "that adherence to formal
6 guidelines and installation standards for all
7 categories of mobility equipment leads to a
8 favorable loss/claim history, meaning fewer
9 third-party bodily injury and property damage
10 claims, than providers with no such guidelines and
11 standards in place."

12 Looks like I'm just about out of time.
13 I was hoping to address some of the remarks made
14 in the morning session that I don't think were
15 factually accurate, but we will address those in
16 our written submission.

17 I want to remind everyone that NMEDA is
18 a non-profit association dedicated entirely to
19 improving the quality and safety of automotive
20 mobility solutions. We will always be prepared to
21 assist VA with any endeavor relating to the AAE
22 program and I thank you for your time.

1 MS. NECHANICKY: Thank you. Speaker
2 Number 20.
3 MR. DOWNS: Good afternoon. I'm Fred
4 Downs. PVA Prosthetic consultant. Been using
5 adaptive equipment for 49 years, so it's an issue
6 that's very important to us in the PVA. When the
7 PVA first involved itself in the passage of the
8 Veterans Mobility Safety Act, our biggest concern
9 was ensuring that a safety standards for installing
10 automobile adaptive equipment were implemented,
11 the end user would not be negatively impacted.
12 The risks, as we saw them, were that
13 either by design or by poor implementation of this
14 law, veterans might begin to lose access to vendors
15 who have long provided disabled veterans with safe
16 products.
17 VA must rely to the greatest extent
18 possible on Sections 3(c)(1) and (2). VA is
19 charged with developing safety standards, but
20 these standards were not intended to govern the
21 entire industry. They are only supposed to serve
22 as a benchmark by which others are judged.

1 VA standards should only be directly
2 employed when provider fails to present
3 certification from the product manufacturer or a
4 trade association that incorporates adherence to
5 stringent safety standards as part of its
6 membership.
7 This law should not be viewed as an
8 opportunity for VA to expand regulations on the
9 industry. The goal is to identify providers who
10 are offering substandard installations and
11 unwilling to adhere to basic industry safety
12 standards, that when these providers are
13 identified, they should face a choice, become
14 certified in the VA standards or stop doing
15 business with VA.
16 In practical terms, this is what the law
17 envisions. VA first develops a baseline set of
18 safety standards for automobile adaptive
19 equipment, manufacturers and trade associations
20 should then be given the opportunity to present the
21 standards they currently employ and have VA make
22 a determination that the entity meets or exceeds

1 the VA-developed standards.
2 Three, upon a favorable determination,
3 these entities should carry a designation allowing
4 for their certification to be a substitute for VA
5 standards. Four, any vendor who is certified
6 under one of these designated manufacturers or
7 trade associations, so long as they're operating
8 under the scope of that certification, would be
9 eligible to serve veterans.
10 Five, the only administrative burden
11 that vendors should expect to incur is showing
12 proof of their certification upon reimbursement
13 from VA for services provided.
14 The remaining issue is how VA should go
15 about directly certifying vendors who do not wish
16 to interact with manufacturers or trade
17 associations. Our suggestion is that VA utilize
18 the same technique that various states use to
19 enforce safety inspections on privately-owned
20 vehicles.
21 There already an existing apparatus of
22 qualified entities to evaluate vehicles, service

1 stations, auto body shops, et cetera. The states
2 did not need to create their own infrastructures
3 for inspections.
4 Similarly, there is a pre-existing
5 infrastructure here represented in this room.
6 They are here in the room and on the phone. VA
7 should partner with the industry and setup a
8 similar structure. We believe VA has the ability
9 to stay completely out of the ground-level task of
10 certifying individuals. That is the direction we
11 hope VA will pursue. That concludes our
12 statement.
13 MS. NECHANICKY: Thank you. At this
14 time, I'd like to invite up to the reserve seating,
15 Numbers 21 through 24. Okay. Number 21.
16 MR. BLUMKIN: Good afternoon. My name
17 is Eugene Blumkin. I represent the State of
18 Massachusetts, Massachusetts Rehabilitation
19 Commission. Mass Rehab Commission is a state
20 vocational rehabilitation agency operating under
21 Rehabilitation Act of 1972.
22 I think I am the only vocational rehab

1 representative sitting in this room, beyond the
2 state vocational rehab agencies. I've been
3 working on vehicle rehabilitations for very long
4 time.
5 In Mass, we have commission, we have a
6 vehicle modification program that was established
7 back in, probably, around 1973, and we provide
8 vehicle modifications to clients of vocational
9 rehabilitation, who are people with disabilities,
10 who are looking for competitive employment.
11 Recently, we added another part of the
12 program, we provide vehicle modifications to
13 clients of Money Follows the Person. That's the
14 program funded by Medicaid and provides
15 modifications to vehicles of people who are being
16 moved out of long-term rehab facilities or nursing
17 homes to live in their own houses.
18 The program is funded by the same
19 dollars as Veterans Administration. 80 percent of
20 funds are federal funds, roughly 20 percent are
21 state funds, so we pretty much doing the same type
22 of work as you are doing and we believe that the

1 type of a program that you are running should be
2 very similar to ours.
3 Actually, our program should be very
4 similar to yours because your program started even
5 before ours. When I started the job back in 1991,
6 I started looking for standards or some kind of
7 implementation, what I could use to base our
8 program on, and one of the main documents that I
9 found was the list of approved equipment from VA.
10 It was approximately a three-page list
11 of equipment. Equipment was listed based on
12 manufacturer of the equipment. And when I started
13 asking how that equipment was approved and what are
14 the standards, I couldn't find an answer.
15 And actually, I didn't look for an
16 answer because we didn't have any means to test any
17 equipment, we didn't have our own standards, so we
18 were relying on that list for about five or six
19 years, and then NMEDA came along with the QAP
20 program, and that's something we've been utilizing
21 since, along with our own performance criteria and
22 technical specifications that we developed about

1 the same time.
2 So our program consists of three parts,
3 first part is driver evaluation. We use -- for all
4 parts of the program, we use contracted parties,
5 contracted vendors, so we have driving schools who
6 employ driver rehab specialists, most of them were
7 employed certified driver rehab specialists, even
8 though we do not have a requirement of that
9 certification.
10 They voluntarily decided to obtain it.
11 We require driver evaluation for all and each
12 vehicle modification. Originally, we would
13 permit simple -- we shouldn't call them simple
14 anymore, hand controls, to install based on a
15 doctor's prescription, but we later realized that
16 doctors really don't know anything about hand
17 controls.
18 So now, for all modifications,
19 including some very, very small one and inexpensive
20 ones, like steering knob, for instance, we require
21 full-blown driver evaluation, and that evaluation
22 usually valid for one year, unless it's a

1 progressive disability where condition changes
2 even faster.
3 The second part is the actual vehicle
4 modification. We do it competitively. For each
5 job, we issue bid, or quote request. The way we
6 broke down the program into two parts is we have
7 structural and non-structural vehicle
8 modifications, and that was one of the questions
9 that was asked -- we were asked to comment on.
10 Structural modifications are
11 modifications that alter the structure of the
12 vehicle, not only physical structure, but also
13 operational structure. For instance, simple
14 sedan, if it just has hand controls to be installed,
15 we consider it to be non-structural vehicle
16 modification.
17 If the same sedan requires low-effort
18 steering, or zero-effort steering installed, we
19 would consider it to be a structural modification.
20 And our procurement system is a little bit
21 different, it's more involved for structural
22 modifications. It requires a full-blown bid as

1 opposed to for non-structural, it requires a quote;
2 submission to quotes.
3 So again, we procure it competitively.
4 We have consumer choice program. If the consumer
5 decides to go with the company that is not the
6 lowest bidder, we permit consumer to do that, as
7 long as consumer pays the difference.
8 We service -- we modify roughly 50 cars
9 --- 50 vehicles a year and I calculated that over
10 the years, I inspected probably around thousands
11 of vehicles. We inspect every and each
12 structurally modified vehicles --- vehicle. Some
13 states, notably, State of New Hampshire, they made
14 a decision to inspect every vehicle, regardless of
15 how small the modification is.
16 In our practice, sometimes, actually,
17 very often, more severe problems arise with the
18 small modifications. Good example would be
19 left-foot gas pedal, which is a very inexpensive
20 modification compared to some high-tech
21 modifications, it's about $350, and
22 liability-wise, it turns out being probably the

1 most expensive type of modifications our vendors
2 do.
3 Who are the vendors who we work with?
4 We have eight vendors in the Commonwealth and they
5 all have a five-year, extendable for another five
6 years, contract that we award based on the RFR that
7 we issue every ten years.
8 And our Request for Response, RFR,
9 describes not only the way they have to work with
10 us, but also, the type of feedback we're going to
11 solicit from them and what type of consumer
12 satisfaction surveys we're going to do, and also,
13 it obviously describes procurement system.
14 Out of those eight vendors, we have one
15 company that has five locations. So obviously,
16 competition is important. The problem that we
17 have to deal currently because the industry is
18 consolidating, and consolidating very rapidly.
19 And that's something our procurement system has to
20 deal with because sometimes we get just one bid for
21 the job.
22 Again, inspections are done in all

1 structural cases. And after the vehicle is
2 modified, we send the client, if it's a new client,
3 never drove before, we send him or her to contractor
4 who provides driver training, necessary driver
5 training.
6 There are several important issues that
7 we were asked to comment on originally and I just
8 want to concentrate on some of them. One of the
9 questions was, how we see the program that VA
10 supposed to establish.
11 We would like to see the program that
12 covers the whole country and we would like to see
13 VA conducting its business in adaptive equipment
14 the same way regardless of where that particular
15 VA location is, because we've seen, and I've heard
16 from my vendors, that different regions deal with
17 adaptive modifications differently, not only in
18 terms of procurement, but also, how long it takes
19 to deliver modifications and what happens after the
20 modifications are delivered.
21 So that's very important. We would
22 like to see that program to be manager with high

1 level of technical supervision. We believe that
2 VA has the means, well, certainly compared to us
3 has the means, and has the responsibility to
4 provide the high-level technical supervision,
5 including developing as we say technical
6 standards, and providing inspection, possibly, of
7 all vehicle modifications.
8 And inspections should be provided by
9 either people working for VA or by people
10 contracted by VA; independent contractors
11 contracted by VA.
12 We would like to see good follow-up, we
13 would like to see consumers, veterans, having some
14 effect on the process, so there should be very good
15 communication line between VA and veterans so they
16 can report any problems, and the problem could be
17 improved as a result.
18 In terms of using the current
19 standards, I think VA should build upon whatever
20 is available right now, and that includes,
21 obviously, a Society of Automotive Engineers
22 Adaptive Device Standards Committee Recommended

1 Practices and Standards, as well as FMVSS standards
2 that obviously, kind of, must inhere, as well as
3 NMEDA and QAP guidelines, and whatever standards
4 they issue.
5 NMEDA has a relatively new program that
6 is called Compliance Review Program that we've been
7 very successfully using for our purposes as a path
8 to compliance when new equipment becomes
9 available, for instance, Chrysler Pacifica
10 conversions just came on the market, both from VMI
11 and Braun, and using the NMEDA Compliance Review
12 Program, they were able to approve them for our
13 consumers very quickly.
14 In the old days, it would take us
15 reviewing all the crash test results and it would
16 take a long time to accomplish. We would like and
17 we would really like to see differentiation in
18 terms of the difficulty of the equipment and
19 installations, and not in terms of the cost,
20 regardless of how you call it, structural,
21 non-structural, but it should be different
22 procedure for those because they require different

1 level of technical supervision and focus.
2 We also submitted some comments
3 regarding the education and certifications that we
4 would like to see from people running that program
5 and we believe that technical background is the
6 must there as well.
7 Couple of comments in addition to the
8 main comments. Prescriptions, we firmly believe
9 that qualified prescription needs to be obtained
10 in each and every case. I think that's kind of
11 self-explanatory because vendors would not touch
12 the vehicle nowadays if they don't have a
13 prescription. Most vendors, at least in our
14 state, but that's something that should be part of
15 the program.
16 As far as the driveway installation, I
17 think we would leave it to manufacturers and VA,
18 whatever they decide to do. I think a lot of it
19 will be dependent on the insurance regulations, and
20 if the insurance company would prohibit the vendor
21 from installing something on somebody's driveway,
22 that would be the end of it, because otherwise, they

1 wouldn't be able to operate.
2 Well, and finally, I'd like to note that
3 whatever opinions expressed here, they may not
4 necessarily be the opinions of the Commonwealth of
5 Massachusetts, and I want to thank you for inviting
6 me here. Thank you.
7 MS. NECHANICKY: Thank you. Speaker
8 Number 22.
9 MR. LORE: Thank you for allowing me to
10 speak. I'm the child of a battle-wounded Korean
11 War veteran and that was the partial motivation to
12 get into the mobility business. I've probably
13 been in the mobility business longer than anyone
14 in this room, except Mr. Downs.
15 I started in '86 and grew a company in
16 New England called Ride Away and, you know, that's
17 been the motivation for, really, my life. And I
18 was in the business before there were any standards
19 and I saw all the stuff that went on, and the bad
20 installations, and people being hurt
21 significantly, and I've been in the business after
22 there were standards.

1 And I can tell you that the change in
2 what the consumer gets for a product today is night
3 and day over what they got back in the day. And
4 I've heard the arguments on both sides and I think
5 that the manufacturers who don't go through
6 brick-and-mortar dealers, they brought in some
7 great people; their best installers.
8 But I could tell you, being in the
9 business as long as I was, a lot of the repairs we
10 did from bad installations weren't from the great
11 installers. In fact, I think it would be almost
12 a shame if you decided to allow the manufacturers
13 to make the rules for what the installers should
14 do, because oftentimes, the manufacturers want to
15 sell product.
16 And they're going to take, in a given
17 area, the person that is willing to do the
18 installation. And I think that when you really
19 look at what is the best outcome for the veteran
20 and what is the best way to go about proper product
21 delivery, it requires knowledge, and a good working
22 knowledge, sometimes an extensive knowledge, on

1 four fronts, the adaptive equipment you're
2 installing, the personal mobility device, so the
3 wheelchair, scooter, whatever, you have to
4 understand that, you have to understand vehicles,
5 which, by the way, they change and get updated every
6 September, so that's a moving target, and then
7 finally, and most important, and people haven't
8 really talked about this, is the ability of your
9 client.
10 Because so often, I've seen
11 installations occur where the client will look up
12 and say, that's great, but I can't use it. And
13 sometimes in these situations the client has a
14 progressive illness, and that has to be taken into
15 account too.
16 So manufacturers may understand
17 adaptive equipment and they may understand
18 vehicles, but they're really not going to be the
19 ones on the front line working with the clients and
20 their abilities, and the personal mobility
21 devices.
22 Someone today said, well, once you

1 install the lift, there's no sense weighing it
2 because the horse is out of the barn and it's too
3 late. No, it's not. I can't tell you how many
4 times I stopped the vehicle from being delivered
5 because it created a condition that was unsafe.
6 That's what you need to expect from the
7 people you're paying, just like you need to expect
8 from the people you're paying, if there's a piece
9 of equipment that isn't appropriate, that doesn't
10 go into storage, you shouldn't pay for it.
11 I think that whenever I get involved
12 with these installations, I think about, if I had
13 a loved one who needed adaptive equipment and
14 knowing what I know being in the business 30-some
15 years, what would I expect for them?
16 I would expect an installer who is
17 competent and trains its people to the highest
18 standards. I prefer dealers who carry multiple
19 product lines. One of the problems when you carry
20 one product line, it's a tough business, it's a
21 moving target, the consumer's going to get that
22 product line, which may or may not be the best for

1 them.

2 I would also expect, and Liz from ADED
3 said this, and Eugene seconded it, a proper
4 prescription, not only for drivers, but too often
5 I see improperly prescribed, and I know there's
6 millions of dollars in waste of equipment that
7 can't be used, we should begin to prescribe
8 equipment for most passenger setups that have any
9 kind of complexity.

10 I don't know how you legislate this, but
11 you want an attitude of safety before sales. You
12 want to expect 24-hour service. The veterans
13 should be able to pick up the phone, on the weekend,
14 and get assistance. That's absolutely minimum.

15 You want depth of service so that when
16 you're dealing with a company that has one tech,
17 and I get that, I mean, sometimes that what you
18 have, that's not the company I would choose for my
19 loved ones, because if that person wanted to take
20 a vacation, or got sick, I would want somebody who
21 might be able to help them.

22 And even though I've been in the

1 business 30 years, I'm not a mechanic, so I don't
2 know how to fix this stuff. You want proper
3 insurance so when and if there's a catastrophic
4 situation, there's not also catastrophic financial
5 loss to your loved one.
6 You want consumer choice. I mean,
7 look, the average cost of today's vehicle, at a new
8 vehicle place, $33,000. I believe that it's the
9 person who owns that asset that should be deciding
10 who's going to drill into it or who's going to wire
11 it.
12 And finally, you know, the most
13 powerful and technologically advanced equipment in
14 everybody's house today is their vehicle. And
15 since the vehicles advance every year, our industry
16 can only stay up with those changes by having a
17 partnership of all related stakeholders, including
18 equipment manufacturers, auto manufacturers,
19 Society of Automotive Engineers, Federal Motor
20 Vehicle Safety Standards of experts, and more.
21 I mean, that's what NMEDA and the QAP
22 does. It keeps everybody abreast of what's going

1 on. And a manufacturer is not -- it's just,
2 there's too much. It's not possible for a small
3 manufacturer to stay up on that in this niche
4 business.
5 I would, just in closing, say, let's not
6 go backwards and choose no quality standards for
7 our veterans. I worked in the business when there
8 weren't any and a lot of people were hurt physically
9 and financially.
10 And when making decisions about this
11 auto adaptive program, simple do it as if you're
12 making a decision for one of your loved ones,
13 because you are, ultimately. Thank you.
14 COURT REPORTER: Can I have your name
15 please?
16 MR. LORE: Mark Lore.
17 MS. NECHANICKY: Thank you. Do we
18 have a Speaker Number 23? Okay. Speaker Number
19 24. Oh, hold on until we get the timer going. You
20 can go to the podium. We cut a few seconds off your
21 time. We didn't want to do that. Okay. Thank
22 you.

1 MR. GOCH: (Foreign language spoken.)
2 David Goch. Oh, you don't speak Thai. I'm an Air
3 Force brat. My dad was a Korean War veteran and
4 a Vietnam veteran. In 1969 and 1970, I lived in
5 Thailand. My mom, my brother, and I lived in a
6 corrugated shack with two Thai women out in Somboon
7 while my dad flew missions.
8 And when my dad came back stateside,
9 ultimately retiring from the military, he had a
10 partial service-connected disability, which
11 ultimately led to the end of his life. My dad
12 currently is interned at Arlington.
13 In addition, I'm also partner at
14 Webster Chamberlain & Bean. It's a law firm here
15 in D.C. Now, we're in an anomaly when it comes to
16 D.C. firms. We're not the white-shoe firm
17 representing big business, Wall Street, corporate
18 America, and a private investment in equity.
19 My firm only represents non-profit
20 organizations, many of whom relieve the burdens of
21 government, which entitle them to their tax-exempt
22 status, thus, while I'm merely an agent of

1 industry, NMEDA is my client.
2 Hopefully I have presented my bona
3 fides as a lawyer as well as my passion for this
4 issue. Section 3(f) of the VMSA addresses
5 conflicts of interest, specifically, "The
6 Secretary shall minimize the possibility of
7 conflicts of interest to the extent practicable",
8 and then addresses procedures against the use of
9 certifying organizations that have a financial
10 conflict of interest.
11 The intention here is to avoid decision
12 making ability of a certifying body being
13 compromised by a conflict. While the intentions
14 are laudable, the VA should not interpret this
15 language narrowly or in such a way to exclude the
16 only organization, NMEDA, a non-profit
17 organization, that has experience in setting up a
18 national certification and accreditation system
19 for the mobility industry from participating.
20 In the United States Supreme Court
21 case, Chung Fook v. White (1924), going back, the
22 court found that justices normally impose a

1 absurdity rule which states the statute cannot be
2 interpreted literally if it would lead to an absurd
3 result.
4 Leaping forward seven decades, even the
5 most vocal supporters of textualism have
6 recognized this soft plain meaning rule, and that's
7 the United States v. X-Citement Video in one
8 Justice Scalia's descent, somehow limiting or
9 excluding NMEDA from this process would be absurd.
10 The general definition of a conflict of
11 interest is a situation in which a person or
12 organization is involved in multiple interests,
13 financial or otherwise, one of which could corrupt
14 the motivation of decision making of that
15 individual or organization.
16 Simply put, NMEDA doesn't fit into this
17 definition. NMEDA does not have multiple
18 interests. NMEDA has one interest: it was
19 established to better the lives of the disabled
20 community through the use of mobility equipment.
21 NMEDA is not driven by a financial goal.
22 We don't have the goal of selling one more unit or

1 filling warehouses with products that may or may
2 not be used. NMEDA does have a board of directors,
3 12 individuals who are in this industry. They are
4 competitors. That's important. They compete
5 against each other, but the board sets the
6 strategic vision, it does not have operational
7 capabilities. It's not involved in day-to-day.
8 Interestingly, earlier, two speakers
9 suggested some notion that NMEDA's involvement
10 would be monopolistic, that was one term, and the
11 other one said a monopoly would result. This is
12 a torch in interpretation of the law. It's akin
13 to creating monsters under the bed.
14 As an aside, two years ago, as a result
15 of a company losing its QAP certification, they
16 submitted a complaint to the FTC, an anti-trust
17 complaint, suggesting QAP resulted in an
18 anti-trust monopoly being a type of anti-trust.
19 Now, a lot of people today obviously
20 argue about the success or effectiveness of the
21 government, but the government is good at one
22 thing, and that's prosecuting anti-trust. The

1 government has over a 90 percent success rate,
2 historically, in prosecuting anti-trust.
3 Well, as a result of that
4 investigation, which I was involved in, there was
5 no outcome. No changes. No consent order. No
6 remedial action.
7 Because of NMEDA's status under the
8 Internal Revenue Code as a 501(c)(6) organization,
9 NMEDA is not organized for profit and no part of
10 its net earnings benefit any private shareholder
11 or individual, be clear, any benefit that NMEDA or
12 any company related to it derived from being a
13 certifying body under the VMSA, cannot financially
14 benefit member companies, board members, or
15 individuals.
16 To be exempt as a business league under
17 501(c)(6), the activities of the organization must
18 be devoted to improving business conditions of one
19 or more lines of business as distinguished from
20 performing particular services for individual
21 companies.
22 The IRS could revoke NMEDA's tax-exempt

1 status. To be clear, it is a falsehood, a
2 mischaracterization, as someone said earlier, to
3 reference or suggest there's some group of
4 controlling members of NMEDA.
5 NMEDA has a board of directors that is
6 democratically elected by its almost 700 members
7 annually. To put it another way, NMEDA's board
8 changes every year.
9 NMEDA's status as a non-profit exempts
10 it from being conflicted. Unlike a for-profit
11 entity, by its very nature, a for-profit must turn
12 a profit for its shareholders or risk going out of
13 business. To digress, while it's unfortunate, the
14 VMSA did not explicitly cover the issue of a
15 conflict of interest under the manufacturer's
16 certification option.
17 It contains, in my opinion, a greater
18 risk of conflict or impropriety; that truly is the
19 fox guarding the henhouse. To give you an example,
20 if I'm a large manufacturer of a product, it would
21 be easy for me to go to a dealer, or someone new,
22 because we heard from small businesses, installers

1 trying to break into the industry, and declare the
2 need for their loyalty to my product or else you're
3 not going to be certified.
4 The VA should therefore consider more
5 closely which entity is more conflicted, the
6 non-profit, which is singularly motivated by
7 benefitting the community, or the for-profit,
8 which must turn a profit, sell, sell, sell, to be
9 successful and stay in business.
10 NMEDA wouldn't be conflicted under
11 existing law. Earlier it was mentioned the Food
12 Safety Modernization Act. The law provides an
13 accrediting third-party auditor shall not be
14 owned, managed, or controlled by any person.
15 Although VMSA is not that granular,
16 under this scenario, we would not be conflicted.
17 NMEDA is not owned by any entity, unlike a
18 for-profit, they have shareholders. NMEDA is
19 managed by its employees, some of the professionals
20 you heard from today. They are not in the
21 industry.
22 And NMEDA is not controlled by any

1 person, it is governed by the same board of
2 directors that I spoke of, that changes every year.
3 Currently, there are many federal
4 agencies that rely on NGOs, non-profit
5 organizations, including the VA, its successful
6 Service Dog Program, implemented in 2012, the VA
7 promulgated the final rule on VA service dog
8 certification.
9 This rule illustrates what we see as the
10 harmony that can exist between third-party
11 accreditation organizations, which have expertise
12 in an industry, drawing from the broad knowledge
13 of its membership, and a federal agency.
14 In recognizing the unique situation and
15 its own limitations, the VA actually stated, there
16 are no federal standards for service dog training
17 that we can apply, thus, the result is the VA
18 deferring to, I believe it's two, now two
19 associations and their programs for service dogs.
20 To digress again, and discuss my
21 concern about any excess reliance on a manufacturer
22 certification, you know, just to think it through,

1 you think manufacturers grant reciprocity to each
2 other? So in essence, oh, if you're certified
3 there, fine, you're certified for mine? No.
4 They already talked about the
5 proprietary nature of their products. And even if
6 they were, that probably would be unsafe. So then
7 you have a situation and from our unofficial
8 results, there's maybe 100 manufacturers in this
9 space.
10 So if I'm, again, that small business
11 trying to break into that business, how do I pick
12 and choose which I go to? If each one of them have
13 a day, half day, or even multi-day, some do
14 training, and it requires every two or three years
15 re-certification, I have an employee that's out of
16 the office close to 1/3 of the time, just to
17 maintain certification in 100 different
18 manufacturers.
19 This, in itself, is its own barrier to
20 entry, because if I'm breaking into the industry,
21 I'm going to pick the biggest, those that have the
22 largest contracts, and the small manufacturers may

1 not be able to then be successful in their
2 technology, and the advancements thereof,
3 unexperienced.
4 The VA also relies on the National Fire
5 Protection Association safety standards in all VA
6 community residential care facilities. Returning
7 back to the Service Dog Program, the VA stated, "VA
8 reliance on the recognized expertise of a public
9 or private organization is not uncommon, nor is it
10 illegal or questionable, so long as the basis for
11 the reliance is well-reasoned and articulated."
12 Further federal agencies, EPA, CPSC,
13 FHA, OSHA, MSHA, NIOSH, the Coast Guard, they all
14 routinely rely on the use of third-party
15 accreditation. Even one of the most successful
16 ones, USGBC's LEED Program, which is now written
17 into statute in the United States Code 15 USC
18 605(d)(3), specifically calls out LEED.
19 Simply put, NMEDA is not conflicted
20 here, nor should it be excluded from being an
21 accrediting body under the VMSA. Such conclusion
22 would be absurd. NMEDA does not fit in the classic

1 definition of conflict. Indeed, NMEDA is the
2 expert in this industry.
3 In the time I have left, I want to do
4 a speed round and address some of the other
5 comments. Listening to some, there's no problem,
6 nothing to see here. "The mousetrap works." It
7 doesn't.
8 We've brought to you, and you have it
9 in your files, the pictures, the examples, the
10 stories. And to those with the success stories
11 that have spoken, congratulations. A thousand
12 lifts. All successful. That's great. But then
13 we talk about the bad stories. Mike Savicki's
14 story, the gentleman that received second-degree
15 burns from faulty wiring.
16 That's not anomalous. We have
17 delivered, again, to the VA and to the Hill,
18 pictures of an SUV. It was a lift installation and
19 it was poorly wired. Veteran driving along the
20 road, catches on fire, faulty wiring, cab's on
21 fire.
22 We have pictures of the vehicle.

1 Able-bodied people, it would be difficult to pull
2 over and get out of the vehicle in time. This
3 person's in a wheelchair.
4 My rhetorical question is, so you have
5 1000 successful, if I'm the 1001, if that person
6 is okay, or is burned, is that a good ratio? What
7 if it's 1 in 10,001 veterans that is burned because
8 we don't have appropriate standards?
9 And with further automation, my concern
10 is whether or not if you have an electrical problem,
11 does it completely shutdown the car, and now you
12 have a dead car going along at 70 miles an hour.
13 Also anecdotally, when someone said the
14 whole about success story, someone leaned over to
15 me and said, when that car goes out of warranty,
16 we have it in our shop. He literally said, I have
17 four of that manufacturer's product's vehicle in
18 my shop right now.
19 Complex versus simple, in one of the
20 speaker's written testimony they cited ramps,
21 wheelchairs secure systems, manual gas controls,
22 and lifts as being simple. We've already heard

1 about how the wheelchair control system can turn
2 a veteran into a missile, him or herself, if
3 improperly.
4 Ramps. We have pictures of a ramp
5 going up and can't even open the door. The veteran
6 has to go out the passenger side, assuming a
7 passenger is not there. Manual gas control, to
8 some, is pushing down the accelerator with a cane.
9 And lifts, comparing a lift to a bike rack, with
10 all due respect, shows an incredible naivety and
11 misunderstanding of this issue.
12 That's not apples-to-apples, that's
13 not apples-to-oranges. If it goes bad, that's
14 comparing an apple to a ticking time bomb. If a
15 bike falls off the back, it's carbon fiber, it's
16 shattering. Home install, we've talked about
17 that, or it was mentioned, we have ours. It's a
18 good policy.
19 I've seen the Smart cars going down the
20 street doing a wheelie with a lift on the back, and
21 the chair, it should be weighed and balanced. You
22 know, not so subtle gorilla supposedly in the room,

1 800-pound gorilla, is NMEDA, which is funny, when
2 NMEDA is a small association.
3 Our entire budget is a eclipsed,
4 multi-fold, by the lift sales of some of the
5 companies in here that are saying, oh, NMEDA's
6 taking it -- you know what? And it's not about QAP
7 either. If complying with the Americans with
8 Disabilities Act is so difficult, so onerous, that
9 it puts someone out of business with the cost, look
10 at it this way, you're a veteran, you go to a
11 facility that was intended to serve disabled
12 people, but they have less than 25 employees, and
13 you can't use the restroom there.
14 Veterans choice, that's the only thing
15 that's been lauded, we wrote it. We put it in
16 there. And cost, my last point is, it's a red
17 herring. Make no mistake, manufacturers build it
18 into their costs as well.
19 Some will say the veterans come first,
20 there's a difference between saying it and
21 practicing it. Because it may cost them a little
22 bit, all of a sudden the veteran becomes less

1 important. (Foreign language spoken.) That's
2 thank you.
3 MS. NECHANICKY: Thank you. Well,
4 this concludes our public meeting and thank you all
5 for providing your comments to aid us in the
6 development of policy to support the quality
7 standards for the Automobile Adaptive Equipment
8 Program.
9 As mentioned earlier, if you have
10 questions or additional comments, please submit
11 them with your written comments by the instructions
12 from the Federal Registry on June 20, 2017. Have
13 a great day and safe flights back for those of you
14 who have traveled from far. Thank you so much.
15 (Whereupon, the above-entitled matter went off the record at 2:28 p.m.)
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