DR. ROY KEKAHUNA, NATIONAL PRESIDENT, BLINDED VETERANS ASSOCIATION

BLINDED VETERANS ASSOCIATION

TESTIMONY
PRESENTED BY

DR. ROY KEKAHUNA
BVA NATIONAL PRESIDENT

BEFORE A JOINT SESSION OF THE
HOUSE AND SENATE COMMITTEES
ON VETERANS AFFAIRS

MARCH 16, 2011

INTRODUCTION

Madam Chair Murray, Chairman Miller, Ranking Members Senator Burr and Congressman Filner, and other Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA), we appreciate this invitation to present our legislative priorities for 2011. BVA is the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. As more wounded service members return each week from Operation Enduring Freedom (OEF) another new generation of seriously eye injured is being added to the thousands wounded previously from Operation Iraq Freedom (OIF), now known as Operation New Dawn (OND). It is vital that we ensure that these new combat-injured veterans, and those from previous wars, have the full continuum of high-quality vision care and benefits they have earned from the Department Affairs through actions of this Congress.

The establishment of a Vision Center of Excellence (VCE) for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries was authorized by the Fiscal Year (FY) 2008 National Defense Authorization Act (NDAA, Public Law 110-181, Section 1623). The Hearing Center of Excellence (HCE) and Limb Extremity Center of Excellence were established in the FY 2009 NDAA (Public Law 110-417). Congress established these three centers as joint Department of Defense (DOD) and VA programs to improve the care of American military personnel and veterans affected by combat eye, hearing, and limb extremity trauma and to improve clinical coordination between DOD and VA for the treatment of wounded service members suffering from vision and/or hearing loss, or extremity injuries. These centers

are also tasked with developing registries containing up-to-date information on the diagnosis, treatment, and follow-up for the injuries received by our nation's military personnel.

Despite the legislative mandate, and Secretary Gates' inclusion of these three centers as a top priority in the February 2010 Quadrennial Defense Report, bureaucratic problems, governance, and limited budgets have all hindered significant progress toward the establishment of the VCE, HCE, and Limb Extremity Center. While a Director, Deputy Director, and other staff have been appointed to support the VCE, the other two centers lack personnel hampering their missions. Currently, all three defense centers face major challenges in meeting their mandated objectives due to insufficient resources, limited staffing, lack of organizational governance oversight, and inadequate funding.

Since enactment of the 2008 NDAA more than 36 months ago, significant problems in identifying DOD funding, joint staffing issues for 22 months, and slow bureaucratic decisions on the organizational structure has caused unnecessary delays. Evidence for this is that the composition and signing of the DOD/VA three-page Memorandum of Understanding (MOU) took from January 2009 until October of the same year. The DOD letter to the Secretary of the Navy transferring control over the VCE was not signed until November 14, 2010. We found that the Veterans Health Administration (VHA) had reprogrammed FY 2009 $6.9 million in appropriations and spread $1 million over five years.

DOD and VA Information Technology, along with contractor assistance, have developed the Defense Veterans Eye Injury and Vision Registry (DVEIVR) as the very first registry that has the ability to exchange with VA all eye-injury clinical, diagnostic, and surgical records from the battlefield. DVEIVR is to start taking information from the Joint Trauma Tracking Registry (JTTR) this month as pilot test data. Later, extractors will take an estimated 55,000 records involving eye-injured personnel from Military Treatment Facilities and VA Medical Centers and download them into DVEIVR over a time period of several months.

SEAMLESS TRANSITION ISSUES

During the past three years, BVA has worked with Members of these two Committees in an attempt to communicate to the House Armed Services Committee the need to hold DOD accountable for the many organizational problems associated with the Seamless Transition process involving the battle eye-injured and those with visual system dysfunction complications associated with Traumatic Brain Injury (TBI). Currently, severely eye-injured OIF and OEF wounded service members are not centrally tracked, making the implementation of DVEIVR extremely critical. This failure negatively impacts some in their access to the full continuum of VA Eye Care Service, Blind Rehabilitation Service (BRS), and Low-Vision outpatient programs that these committees helped establish. The failure places service members at risk for vision complications from their injuries.

BVA again stresses that, according to DOD data compiled between March 2003 and December 2008, 16 percent of all combat-injured casualties evacuated from Iraq had associated eye injuries. Fortunately, due to advanced forward combat surgery teams and the rapid military evacuation medical system, the lives of 96 percent are being saved, more than ever before in military history. The severely eye injured in these wars have had their vision partially restored because of these improvements but 1,089 are reported by VHA to either have low vision or to

have been blinded, requiring treatment at one of the ten VA Blind Rehabilitation Centers (BRCs) or at low vision clinics. There has been insufficient initial oversight of the VCE by both the Joint Executive Council (JEC) and Health Executive Council (HEC) and failure of both agencies to provide detailed budgets and full staffing. Thanks to the special effort of Senator Murray to ensure in the war supplemental funding of FY 2009 the Capitol Region Construction for renovation of 3,930 square feet of office space at the National Naval Medical Center in Bethesda, it is now expected to be completed in late July 2011. Without this funding, the renovation would not otherwise be occurring today.

BVA requests that Congress appropriate $15 million for FY 2012 and require that VHA report quarterly on its mission plans and the status of DVEIVR. BVA believes that the VCE and its DVEIVR is where improved Seamless Transition of eye care and vision rehabilitation services, as well as veteran and family education, can be developed and refined for the TBI-wounded who have vision system dysfunction or eye trauma. The core mission of the VCE is tracking and ensuring coordination of care, as well as development of evidence-based practices for the care of the eye wounded. Research can be coordinated with the Defense Veterans Brain Injury Centers (DVBIC) and the National Intrepid Center of Excellence (NICOE) for Mental Health and TBI. This research can facilitate data-analyzed documentation of the findings and the publication of clinical plans to improve both acute eye injury care and long-term vision rehabilitation.

Combat blinded veterans often suffer from multiple traumas that include TBI, amputations, neuro-sensory losses, PTSD (found in 44 percent of TBI patients), pain management issues, and depression (affecting 22 percent of those diagnosed with TBI). DVBIC reports that an analysis of the first 433 TBI-wounded found that 19 percent had concomitant amputation of an extremity. Mild TBI was found in 44 percent of these 433 patients and 56 percent were diagnosed with moderate-to-severe TBI. Some 12 percent of those with moderate to severe TBI had penetrating brain trauma. Only VA BRCs can deliver the entire array of medical-surgical and psychiatric specialized care often needed for veterans to fully optimize their rehabilitation outcomes and successfully reintegrate into their families and communities.

TRAUMATIC BRAIN INJURY

According to VA, in FY 2009, 49,207 patients were seen across VA for inpatient and outpatient services related to TBI; 46,990 patients were treated in outpatient clinics, for a total of 83,794 visits. This is a 30 percent increase from FY 2008. In November 2010, VA reported that, altogether, 445,000 OEF/OIF veterans had been screened for possible mild TBI, of whom 83,000 screened positive and consented to additional evaluation. Among that group, 62,000 received completed evaluations. Of those, 34,000 were given a confirmed diagnosis of TBI. In the past year in Afghanistan, Improvised Explosive Device (IED) blasts caused 78 percent of all battle injuries. As of January 30, 2011, a total of 41,983 service members had been wounded or injured in either OIF or OEF conflicts.

Added to the number of penetrating eye injuries are the 63 percent of moderate to severe TBI service members who have suffered visual system dysfunction. The data now comes from various VA research findings based on veterans tested by neuro-ophthalmologists or low-vision optometrists. With increased visual screenings, they are diagnosing higher numbers each month

with vision impairments from blasts.
Although TBIs rarely result in legal blindness, researchers have found rising numbers with TBI functional blindness and the VA Polytrauma Centers in Palo Alto, Richmond, and Tampa have reported that 70 percent of all TBI patients have complained of visual symptoms as a result of their blast exposure. VA research has further revealed that individuals with a diagnosis of TBI visual system dysfunction have at least one, and often three, of the following associated visual disorders: diplopia, convergence disorder, photophobia, ocular-motor dysfunction, color blindness, and an inability to interpret print. One research study that examined 25 TBI veterans found none of the following visual complications diagnosed early in the normal medical evacuation process in the percentages indicated: corneal damage, 20 percent; cataracts, 28 percent; angle recession glaucoma, 32 percent; retinal injury, 22 percent. These complications place veterans at high risk of progressive visual impairments if not diagnosed and treated early .

BVA requests that efforts continue to improve the continuing education and VHA policy on TBI visual screening coordination, and to further provide education on the importance of screening, treatment, and rehabilitation of these visual complications. Service members who have mild, moderate, or severe TBI with visual system impairment, or a penetrating eye injury, must be tracked, especially those of the Army National Guard or Army Reserve, so that their care is ensured and facilitated. The failure to make an early diagnosis of a TBI visual impairment and to appropriately treat it may prevent such veterans from performing basic activities of daily living, resulting in increased unemployment, inability to succeed in future educational programs, greater dependence on government assistance programs, depression, and other psychosocial complications.

As Congress works to finalize the FY2011 appropriations funding, we believe that each of these specialized wounded warrior centers should continue to receive the resources necessary to meet their missions of improving coordination of care between DOD and VA, and of establishing vital war injury registries as mandated in the NDAAs. The following funding levels for the centers of excellence have been identified as needed for Fiscal Year 2011: $5 million for the Limb Extremity Center, $9.5 million for the VCE and $10 million for the HCE. We strongly encourage these Committees to ensure that these three Centers of Excellence have the funding they need to succeed in their missions.

PEER REVIEWED MEDICAL RESEARCH-VISION FUNDING

BVA, along with other Veterans Service Organizations dedicated to serving our Nation's veterans, are joined in supporting the programmatic request of continuing directed funding in FY 2012 for the Peer Reviewed Medical Research-Vision (PRMR-Vision) extramural research line item, funding requested at $10 million. This programmatic line item, which is managed by DOD's Telemedicine and Advanced Technology Research Center (TATRC), was initially created by Congress in FY 2008 appropriations and funded at $4 million. In FY 2010, it was funded at an even lower level of $3.75 million, resulting in lack of funding for several eye trauma research grants. Defense-related vision trauma research warrants a more vigorous investment, especially since Defense Secretary Robert Gates has identified research into Restoration of Sight and Eye Care as one of four top priorities for funding, along with Post Traumatic Stress Disorder (PTSD),

TBI, and Prosthetics. Last February he listed Restoration of Sight and Eye Care second in his Quadrennial Defense Report to Congress.

Today, battlefield conditions have resulted in high percentage of penetrating eye injuries and TBI-related visual system dysfunction among those wounded/evacuated, usually due to IED blast forces. With the U.S expanded presence in Afghanistan, that number is rising even more. Serious combat eye trauma from OIF and OEF was the second most common injury and trails only hearing loss, according to an Office of VA Research and Development article published in October 2008. The November 2008 Medical Surveillance Defense Monthly Report from the Armed Forces Health Center reported that over the past ten years, of the 188,828 ocular injuries reported, there were 4,970 moderate-to-severe penetrating combat eye injuries, 8,441 retinal and choroidal hemorrhage injuries (including retinal detachment), 686 optic nerve injuries, and 4,294 chemical and thermal eye burn injuries.

In addition, each VA Polytrauma Center reports that upwards of 80 percent of all TBI-injured patients complain of visual symptoms associated with their exposure to powerful blasts. VA Polytrauma Centers in Palo Alto, Tampa, and Richmond, along with the Chicago and San Antonio VA Low Vision Clinics, are all reporting similar findings with TBI vision screening. Vision TBI screening programs and accompanying research are vital to ensuring more treatment options for these visual complications. Not unlike the existing specialized research programs on burns, prosthetics, PTSD, and spinal cord injuries, a more vigorously funded PRMR-Vision extramural research program will enable the exploration of new and promising research opportunities that directly meet battlefield needs.

BVA strongly supports the National Alliance for Eye Vision Research's (NAEVR) position that eye and vision research within defense appropriations be increased for the PRMR-Vision program within the DOD's Telemedicine and Advanced Technology Research Center (TATRC). We request, for FY 2012, $10 million as a dedicated line item for PRMR-Vision and point out that eye injury research provides combat surgeons with new treatments that will preserve vision. We also wish to emphasize that the PRMR-Vision line item in defense appropriations is a dedicated funding source for extramural research into immediate battlefield needs. This kind of eye trauma research for wounded warriors is not conducted by the National Eye Institute (NEI) within the National Institutes of Health (NIH). DOD engages representatives of VA and NEI in programmatic review of the vision trauma research grants it receives. Each year dozens of eye trauma research grants cannot be funded because of the limit funded in CDMRP of $4 million, despite the identification by DOD in November of research gaps in both eye trauma and TBI vision programmatic research that must be filled.

DOD-VA HEARING CENTER OF EXCELLENCE

Noise-Induced Hearing Loss and Tinnitus During present-day combat, a single exposure to the impulse noise of an IED can cause immediate tinnitus and hearing damage. An impulse noise is a short burst of acoustic energy, which can be either a single burst or multiple bursts of energy. According to the National Institute for Occupational Safety and Health, prolonged exposure from sounds at 85+ decibel levels (dBA) can be damaging, depending on the length of exposure. For every three-decibel increase, the time an individual needs to be exposed decreases by half, and the chance of noise-induced hearing loss and tinnitus increases exponentially. At 140+ dBA, the

sound pressure level of an
IED, damage occurs instantaneously. Many common military operations and associated noise levels, all exceeding the 140 dBA threshold, occur on the battlefield, making hearing loss and tinnitus the number one injury from the wars. According to the VSO Independent Budget, which quotes an Air Force consultant, more than 130,000 OIF and OEF service members and veterans are service-connected for tinnitus and some 80,000 have various levels of hearing loss.

The National Defense Authorization Act of FY 2009 mandated that DOD establish, in cooperation with VA, a joint DOD-VA Hearing Center of Excellence. Similar to the same problems that have occurred with the VCE, but worse, the HCE has staff of two Air Force officers assigned in San Antonio's Willford Hall, with no full time VA staffing, no programmatic line item funding, and a clear lack of governance from the HEC or JEC. BVA again points out that in the Quadrennial Defense Report of February 2010; Secretary Gates listed "implementation of the Vision, Hearing, and Limb Extremity Centers of Excellence as his second top priority" in the section on health care . GAO 11-114, January 31, 2011 Report found that while hearing loss is a major physical injury from the wars, the progress on starting a registry to track and develop coordinated care between the two systems lags far behind . BVA has become increasingly frustrated that the two major sensory injuries from the wars, vision and hearing, are being mismanaged and lacking oversight by Congressional committees with jurisdiction. The invisible wounds of hearing and visual impairments do not seem to result in budgets for staffing and research that result for other injuries.

Translated into financial terms, the government paid out approximately $1.1 billion in VA disability compensation for tinnitus in 2009. At the current rate of increase, service-connected disability payments to veterans with tinnitus will cost $2.26 billion annually by 2014. While the government will spend increasing amounts to compensate veterans with tinnitus, its investment in hearing trauma defense research pales in comparison (less than 1 percent of current compensation payments combined).

VA RESEARCH

Adequate funding for research is critical for the Rehabilitation Research and Development Service, one of the four components of the Office of Research and Development within VA that directly impacts blinded veterans. This year the VA budget requests cutting research by $71 million. This is an inappropriate reduction. BVA supports the Independent Budget FY 2012 request of $620 million. Disabled service members returning from the war zones need the very finest in research, training, and rehabilitation care. Ensuring adequate funding for such research is crucial. Future research could potentially preserve sight, restore lost functions, and/or prevent further deterioration.

To maintain the current level of VA research activity, inflation in biomedical research and development is assumed at 3.4 percent for FY 2012. The basis for this assumption is the annual change in the Biomedical Research and Development Price Index, which is developed and updated annually by the Bureau of Economic Analysis and the Department of Commerce. It is used by federal research agencies, including the National Institutes of Health, to estimate changes in funding levels necessary to maintain purchasing power. Beyond anticipated inflation, additional VA research funding is needed to (1) address the critical needs of returning Operations

Enduring and Iraqi Freedom (OEF/OIF) veterans and others who were deployed to combat zones in the past; (2) take advantage of opportunities to improve the quality of life for our nation's veterans through "personalized medicine"; and (3) maximize use of VA's expertise in research conducted to evaluate the clinical effectiveness, risks, and benefits of medical treatments.

BVA supports additional funding that is needed to expand research on strategies for overcoming the devastating injuries suffered by veterans of OEF/OIF. Urgent needs are apparent for improvements in prosthetics technologies and rehabilitation methods, as well as more effective treatments for polytrauma, TBI, significant body burns, damage to the eye, and mental health consequences of war, including PTSD, depression, and suicide risk.

HOUSING, EMPLOYMENT, AND LIVING PROGRAMS FOR VETERANS ACT OF 2011 (H.R. 117)

The current Special Adaptive Housing (SAH) requirement has visual acuity standard of 5/200 for eligibility. The 5/200 requirement should be modified for the service-connected blind to 20/200 or less, or to loss of peripheral visual fields to 20 degrees or less. Last June, VBA testified before the VA Subcommittee on Economic Opportunity, expressing support for this change since the 5/200 visual acuity standard is not used to deliver any other Veterans Benefits Administration (VBA). In addition, VHA has a 20/200 visual acuity or less standard for legal blindness. BVA was grateful that H.R. 5290 was passed by the House VA Committee with full bipartisan member support, and approved on the House floor last September. Unfortunately, during the lame duck session, attempts for final passage failed. We thank Congressman Filner for introduction of H.R. 117 in this session and Senator Sanders for his bill that will correct this problem.

If accessible housing grants are not sufficient to allow disabled veterans to live independently at home, the alternative high cost of institutional care in nursing homes will occur. The average private room charge for nursing home care was $212 daily, ($77,380 annually). For a semi-private room it was $191 ($69,715 annually) according to a MetLife 2008 Survey. Even assisted living center charges of $3,031 per month ($36,372 annually) rose another 2 percent in 2008. BVA would point to these more costly alternatives as less desirable than for VA to provide sufficient adaptive housing grants for veterans to remain in their homes and function there independently. BVA requests passage of the "Housing, Employment, and Living Programs for Veterans Act of 2011" (H.R. 117) This legislation includes several of the important provisions that will modify the standards for visual acuity and for eligibility for SAH assistance. Section 14 modifies the amounts of subsistence allowance provided to veterans using Vocational Rehabilitation Services that is vital for disabled veterans returning to college.

REFORMING THE VETERANS' BENEFITS CLAIMS PROCESSING SYSTEM

VBA processed more than a million claims last year, its highest ever total. In addition, the volume of new and reopened claims grew even more. As a result, there were 770,291 claims for disability compensation and pensions pending on January 11, 2011, an increase of 282,790 from one year ago. Overall, 313,007 claims are pending longer than VA's target goal of 125 days, a 69 percent increase in one year. Worse, by VBA's own measurement, the reported accuracy of disability compensation rating decisions was only 83 percent for the 12-month period ending May 31, 2010. VA's Office of the Inspector General found even more errors left unreported.

Over the past two years, VA Secretary Shinseki has focused VBA on "breaking the back of the backlog" of pending claims. However, if VBA is allowed to focus simply on reducing the backlog as its ultimate goal, it will neither sufficiently address the underlying problem nor prevent the backlog from eventually reappearing in an even worse form. To achieve real and lasting success, VBA must focus on reforming itself into a modern, paperless system designed to "decide each claim right the first time." VBA must update its use of outdated information technology soon to remedy this dilemma. VBA is developing an electronic Veterans Benefits Management System (VBMS) the deployment of which would process claims in a paperless environment using a rules-based decision support system.

VBA's numerous pilot programs must ensure that the best claims practices are adopted and integrated to improve quality and accuracy. They must also ensure that the new VBMS is provided sufficient and timely resources to develop into a comprehensive, paperless, and rules-based platform. Further, they must ensure that VBA's employee performance standards and work credit system create adequate incentives for quality and accuracy, not only speed and production. Lastly, the programs must ensure and provide sufficient training and tests to employees, including coaches and managers, regarding the skills, competencies, and knowledge required to do their jobs.

BVA has repeatedly requested in its annual resolutions that VA Information Technology be compliant with Section 508 of the Americans with Disabilities Act. This compliance problem has still not been fixed after many years. Blind VA employees and BVA Field Service Representatives are frequently unable to access the current VA system because of its lack of ADA-compliant features. BVA also recommends that, in order to reduce the claims backlog, a disabled veteran receive a VBA-issued certificate of eligibility for both the adaptive housing and automobile grants at the same time he/she is rated service connected. Why force a VA-rated permanently disabled service-connected veteran to file three more new claims for each of these benefit programs when VBA could certify them and issue eligibility at the time of the initial rating decision for the adaptive housing grant, auto grant, and life insurance programs?

CATASTROPHIC CO-PAYMENTS BILLING

We appreciate Congressional enactment of Public Law 111-163, the "Caregivers and Veterans Omnibus Health Services Act," which became law on May 5, 2010. This legislation prohibits VA from collecting copayments for medical services from catastrophically disabled, nonservice-connected veterans who receive services in both inpatient and outpatient settings. Nevertheless, the mandate has not removed all of the billing problems for these disabled veterans as many continue to be billed for co-payments. Specifically, veterans in Priority Group 4 as well as those in Groups 2 and 3 are receiving bills. The Independent Budget endorsers are pleased that the VA Business office has implemented a plan to ensure that this population of veterans does not continue to be billed for treatment now exempt from charges. Since both BVA and PVA continue to find numerous problems in this regard, VA must remain vigilant and Congress must continue to provide effective oversight to ensure that mistakes are not made that could be financially detrimental to catastrophically disabled veterans. In July 2010, the VA General Counsel released an opinion that addressed questions about the scope of P. L. 111-163. The opinion ruled that the new law prevented VA from collecting funds for any medical services. Because VA has been

slow to install and apply an effective computer patch to the Information Technology billing system, we ask that these Committees ask, in oversight hearings, why the process is so slow and why the timetable for fixing the problem has been extended to July 2011.

VHA ADVANCED FUNDING FOR FY 2012-13

BVA commends the passage of the Veterans Health Care Budget Reform and Transparency Act of 2009, enacted more than a year ago. The legislation must be put to effective use with careful oversight by GAO and congress or the VA health care system will return to insufficient budgets. We must provide VHA with timely, sufficient, and predictable budgets in future years. BVA requests careful oversight of this new process and ask that implementation be transparent, as was intended, for this new health care funding methodology. We are concerned over the rapid expansion of hundreds of administrative personnel, plus the addition of senior management staff, both within VHA and especially at the rapidly expanding VISNs, where hundreds of more new staff now slows down or disrupts the development of local medical center policy by adding layers of bureaucratic reviews and where vital clinical provider positions are left vacant. We suggest an "administrative hiring freeze" of all VHA and VISN networks until each medical center can report to congress that they have filled critical health care staffing positions first.

FUNDING VHA BLIND REHABILITATION SERVICE

Combined with eye injuries among OIF and OEF veterans is an aging veteran population with the growing prevalence of age-related degenerative visual impairments. This group is the challenge of 2011 and far beyond. Currently, 55 outpatient VA programs with 157 new outpatient blind and low-vision VA personnel are now in place. The local programs are improving local services, decreasing waiting times, and providing the approximately 50,574 blinded veterans now enrolled in BRS with care. Studies estimate that there are 156,854 legally blinded veterans and epidemiological projections indicate that there are another 1,160,407 low-vision impaired veterans in the United States. Considering the large number of veterans who may seek these services, ensuring that each VA VISN Director continues to fully fund the Continuum of Care Outpatient Rehabilitation Clinics and BRCs is a high priority for BVA.

BLIND REHABILITATION CENTERS (BRCs)

After more than 60 years of existence and progress, VA BRCs still provide the most ideal environment in which to maximize the rehabilitation of our Nation's blinded veterans. BRCs help blinded veterans acquire the essential adaptive skills to overcome the many social and physical challenges of blindness. Only the inpatient VA BRCs have all of the diverse, specialized nursing staff, orthopedics, neurology, rehabilitative medicine, occupational and physical therapy, pharmacy services, and lab services to treat the complex war wounds of service members and veterans.

The VHA Director of BRS, we feel, must have more central control over blind center resources and funding levels. With the implementation of the Full Continuum of Care model announced by VHA, we again reiterate that greater emphasis should be placed on complementing the outpatient programs while ensuring adequate staffing at the BRCs. Some VISN directors might force

medical centers or attempt to mandate that BRC directors cut the inpatient staff and BRC training inherent to the success in these highly specialized rehabilitative programs.

BVA found in 2009 a DOD earmark for a private blind agency trying to initiate a new pilot program for the newly combat blinded, wasting $800,000 and adding more confusion and potential to disrupt the transition between DOD and VA care. We caution that private agencies for the blind do not have the full specialized nursing, physical therapy, pain management, audiology and speech pathology, pharmacy services, neuro-radiology support services, along with the subspecialty surgery specialists, to provide the clinical care necessary for the newly complex, polytrauma war wounded. The lack of electronic health care records is also major problem when veterans return to DOD or VA for follow-up care.

BVA requests that all private agencies be required to demonstrate peer reviewed quality outcome measurements that are a standard part of VHA BRS and that they must also be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Blind Instructors should be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). Agencies should also have the specialized medical staffing necessary for complex wounds. Additionally, no private agency should be used for newly war blinded service members or veterans unless it can provide clinical outcome studies, evidence-based practice guidelines, and joint peer-reviewed vision research

BENEFICIARY TRAVEL FOR BLINDED VETERANS

For veterans who are currently ineligible for travel benefits, the law does not cover the cost of travel to a BRC, thus adding to disabled veterans' financial burdens. Veterans who must currently shoulder this hardship, which often involves airfare, can be discouraged by these costs to travel to a BRC. The average age of veterans attending a BRC is 67 because of the high prevalence of degenerative eye diseases in this age group. BVA urges that these travel costs be covered by the VISN from which the veteran is referred and not be an added burden for the disabled blinded veteran obtaining the crucial rehabilitation training needed to gain independence through VA BRS. BVA therefore requests introduction of legislation in the 112th Congress, ensuring that VHA cover such travel costs by changing Title 38 Section 111 to ensure that VA provided public transportation costs for travel by airfare, train, or bus to a special rehabilitation program serving blinded veterans.

It makes little sense to have developed, over the past decade, an outstanding blind rehabilitative service, with high quality inpatient and outpatient specialized services, only to tell catastrophically disabled blinded veterans they must pay their own travel expenses. To put this dilemma in perspective, a large number of our constituents are living below the poverty line. None, of course, can drive themselves. BVA estimates that to provide air travel or other means of travel assistance for blinded veterans, it would cost $10,000 per center each year ($120,000 for 12 centers) to meet this demand. VA utilization data revealed that one in three veterans enrolled in VA health care was defined as a rural resident or a highly rural resident. The data also points to the fact that blinded veterans in rural regions have significant financial barriers to traveling without utilization of public transportation.

To elaborate on the challenges of travel without financial assistance, the data found that for most health characteristics examined, enrolled rural and highly rural veterans were similar to the general population of enrolled veterans. The analysis also confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between 55 and 64. Similarly, approximately twenty-five percent of all enrolled veterans fell into this age group. In FY 2007, rural veterans had a median household income of $19,632, 4 percent lower than the household income of urban veterans ($20,400) . The median income of highly rural veterans showed a larger gap at $18,528 adding significant barriers to paying for air travel or other public transportation to enter a VA BRC or other rehabilitation program. More than 70 percent of highly rural veterans have to drive more than four hours to receive tertiary care from VA and states and private agencies do not operate blind services in rural regions. In fact, almost all private blind outpatient agency services are located in large urban cities. With the current economic problems with state budgets clearly in view, we expect further cuts to these social services that will bring even more challenges to the disabled in rural regions.

VISUAL IMPAIRMENT SERVICES TEAMS AND BLIND REHABILITATION OUTPATIENT SPECIALISTS

The mission of each Visual Impairment Service Team (VIST) program is to provide blinded veterans with the highest quality of blind rehabilitation training. To accomplish this mission, VIST has established mechanisms to maximize the identification of blinded veterans and to offer a review of benefits and services for which they are eligible. VIST Coordinators are in a unique position to provide comprehensive case management and Seamless Transition services to returning OIF/OEF service personnel for the remainder of their lives. They can assist not only newly blinded veterans but can also provide their families with timely and vital information that facilitates psychosocial adjustment.

The VIST system now employs 112 full-time Coordinators and 43 who work part-time. VIST Coordinators nationwide serve as the critical key case managers. As 29 state governments slash social services budgets, these actions could draw more blind and low-vision veterans into the system for care. Given the demographic projections of visually impaired and blinded veterans, BVA believes and has always maintained that any VA facility with 150 or more blinded veterans on its rolls should have a full-time VIST Coordinator. Veterans attending BRCs often require additional training later due to changes in adaptive equipment or technology advances. VISTs and BROS ensure that such training occurs.

Congress included a provision in the Caregiver Act S 1963 last May that VA be required to develop a scholarship program for Blind Rehabilitation Outpatient Specialists (BROS) thanks to Senator Brown (D. OH). The program has still not been implemented although VHA continues to administer identical scholarship programs for nursing students and those in other allied health occupations. We ask Congress to request a timetable for the BROS scholarship program. Developing candidates for these positions would assist VA to deliver, to a much greater extent, more accessible, cost-effective, and top-quality outpatient blind rehabilitation services.

ADVANCED BLIND REHABILTATION PROGRAMS

Pre-admission home assessments, individualized evaluations, and outpatient training, all of which are complemented by a post-completion home follow-up, are part of the new three year expansion of VA's Advanced Outpatient Blind programs. These programs have been referred to historically as VISOR (Visual Impairment Services Outpatient Rehabilitation Program). They consist of an outpatient, nine-day rehabilitation experience, offering Living Skills Training, Orientation and Mobility, and Low-Vision Adaptive Devices Therapy with appropriate prosthetics. A VIST Coordinator with low-vision credentials manages the program. Other key staff members consist of certified BROS, Orientation and Mobility Specialists, Rehabilitation Teachers, Low-Vision Therapists, and Low-Vision Ophthalmologists. These programs improve access, provide new rehabilitation services of the highest quality, and reduce the waiting times.

INTERMEDIATE LOW-VISION OPTOMETRY PROGRAMS: VICTORS

Another important model of service delivery that does not fall under VA BRS is the Visual Impairment Center to Optimize Remaining Sight (VICTORS), an innovative program operated by VA Optometry Service. It consists of special services to low-vision veterans who, although not legally blind, suffer from severe visual impairments. Veterans must usually have a visual acuity of 20/70 through 20/200 to be considered for this service. The program, entirely outpatient, typically lasts three days. Veterans undergo a comprehensive, low-vision optometric evaluation and then are prescribed low-vision prosthetics devices. The Low-Vision Optometrists employed in Intermediate programs are ideal for the highly specialized skills necessary for the assessment, diagnosis, treatment, and coordination of services for returnees with TBI visual system dysfunction who require low-vision services to improve their functional status at home or work.

GUIDE DOG AND SERVICE DOG POLICY

BVA has perhaps more experience with guide dogs than most Veterans Service Organizations or Military Service Organizations. For 66 years, the Association has worked with both VA and the original guide dog training programs to ensure that veterans who want a guide dog can obtain one. For decades, hundreds of blinded veterans have received guide dogs from a handful of well-known programs that never charged a veteran to receive a dog.

Suddenly, however, about three years ago, DOD, VA, and Congress were inundated with information that blinded and severely injured veterans were being charged up to $25,000 for a service dog. The inaccurate news was set in motion when families and organizations associated with OIF veterans, unable to pay that amount of money for a dog, began inquiring about the possibility of VA providing a dog to any disabled veteran with any physical or mental health condition. The demands grew rapidly for big expansion in this new benefit from VA Prosthetics and that VA would cover the costs of service dogs.

Members of Congress should understand that the private sector is virtually unregulated and that 49 states have no laws concerning licensure of the service dog programs, no certification requirements for instructors or trainers. BVA points out that while there are some who try to use the International Association of Assistance Dog Partners (IAADP) or the Americans with Disabilities Act as international service animal standards, there are clearly no federal statutory standards for the service animal programs. ADA rules are only about public access to facilities

for the disabled with a marked "service animal," but the statute is silent on licensure or certification for the service dog program.

On the IAADP website, please note the following statement: "CERTIFICATION is not required in the USA." Most states therefore lack programs to certify dogs if they did not go through that program's training course. The Department of Justice decided to foster "an honor system," making the tasks the dog is trained to perform on command or cue to assist a disabled person the primary way to differentiate between a service animal and a pet rather requiring a certification ID from a specific program. This opened the door for people to train their own assistance dogs, usually with the help of an experienced trainer, if a program dog is unavailable.

Only nine service dog programs voluntarily cooperate with the IAADP standards while 86 programs do not participate in these standards. VA is now caught, forced to develop service dog regulations and provide through prosthetics all future costs associated with providing service animals. Physicians and nurses have absolutely no academic university training in service dogs or Guide Dogs. No ophthalmology residency program anywhere provides even one hour of course training on Guide Dogs.

Another major danger is "service dogs being trained in six weeks" while the well-established guide dog programs have averaged well over 120 hours of training for months and match the guide dog with the veterans needs. Currently, advertising on the Internet indicates that a service dog costs $45,000 and that one can "train you're his/her own service dog and receive in the mail a Certificate sufficient for ADA access standards." Some organizations have turned this issue into a crusade with Congress and VA without informing Members that this is largely an unregulated and unlicensed field. The real danger for blinded veterans is that they may obtain a guide dog that is insufficiently trained, placing them in great danger, as a pedestrian, of being injured or killed in a crosswalk with a poorly trained service dog.

We strongly caution Members of this Committee to reassess this situation for the protection of disabled veterans, the potential risk of fraud, misleading advertising, and VA liability for expenditures, as well as the need to have state licensure of service dog programs. While a great deal of pressure has been applied to Members to expand the service dog program, BVA requests further consideration of the current problems outlined above and would request our views on any future hearings in this issue.

CONCLUSION

Once again, Madam Chair, Chairman Miller, and all members, BVA thanks you for your efforts on behalf of all veterans and their families. We look forward to working with all Members to ensure that the three DOD-VA Defense Centers of Excellence have the needed resources in a timely manner for the remainder of FY 2011 and for FY 2012 so that they have the programmatic/operational management support necessary for these wounded warriors entering both systems. Thank you for the opportunity to present BVA's legislative priorities before you today. I will now gladly answer any questions you may have concerning our testimony.

RECOMMENDATIONS

• Ensure that the new veterans health care "Advance Funding" model provide not only adequate funding to meet the demands on the health care system but also that VHA be held accountable For transparency regarding how and where the appropriations are being used. BVA strongly endorses the VSO Independent Budget recommendation regarding the new advance funding for veterans health care for FY 2012. We question why medical centers have vacant clinical positions while the VISN and VHA have added hundreds of administrative FTEE.

• Congress must ensure that the full establishment and Programmatic Operational Management (POM) budget requested by DOD for FY 2011 for the Vision Center of Excellence (VCE) and Defense Veterans Eye Injury Registry (DVEIR) be operational. Availability of joint DOD/VA staffing resources is critical for its success. BVA requests that DOD appropriations POM include $15 million in FY 2012. The Health Executive Council (HEC) must provide Congress with quarterly updates on all three DOD-VA Centers for Vision, Hearing, and Limb Extremity.

• As Congress works to finalize the FY 2011 appropriations funding, each of these specialized wounded warrior centers should be provided the resources necessary to meet and succeed in their missions of coordinating care between DOD and VA, and establishing war injury registries as mandated in the NDAAs. The following needed funding levels for the Centers of Excellence have been identified for POM FY 2011: $5 million for the Limb Extremity Center, $9.5 million for the VCE and $10 million for the HCE.

• Congress should mandate, with time benchmarks, a single, bi-directional, electronic health care records system for a truly efficient Seamless Transition. DOD and VA must also implement a mandatory, single-separation physical examination as a pre-requisite to prompt completion of the military separation process. Disabled service-connected veterans, who, at the time of rating, qualify for special adaptive housing grants, or auto grants, should have such certificates of eligibility issued at the time of the rating. This would reduce the claims backlogs.

• BVA firmly supports position that extramural vision research funding through the dedicated Peer Reviewed Medical Research-Vision line item in DOD's Congressionally Directed Medical Research Program (PRMRP) is essential. BVA urges that PRMR-Vision be funded at $10 million in FY 2012 defense appropriations to meet the demands for more eye trauma research.

• BVA believes that catastrophically disabled blinded veterans who are accepted at one of the VA special Blind Rehabilitation Services programs should be eligible for travel benefits associated with travel for the cost of airline or public transportation for services offered by VA.

• Congress should authorize, and VA should provide, a full range of medical, psychological, financial, and social support services to family caregivers of veterans, especially when the latter have been diagnosed with brain and catastrophic physical and polytrauma injuries. Committees should closely oversee VA's full implementation of Caregiver benefits authorized by P. L. 111-163 for all severely disabled veteran generations.

• BVA requests that these Committees enact H.R 117, the "Housing, Employment, and Living Programs Act of 2011" in order to correct the Special Adaptive Housing standard to 20/200 or 20 degrees of visual field loss or less, and to remove the 5/200 standard currently used by VBA. The

subsistence allowance for Vocational Rehabilitation students must also be increased to encourage participation in this program.

• Beneficiary travel to VA Blind Rehabilitation Centers (BRCs) should be provided by amending Title 38 of U.S.C. Section 111. VA should provide airfare or other modes of commercial travel for catastrophically disabled veterans determined to benefit from rehabilitation services.

• BVA supports the statement from this year's Independent Budget that VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality rehabilitative care, especially for those returning wounded with complex health problems such as blindness, multiple amputations, spinal cord injury, or TBI with mental health problems.