SAM HUHN, NATIONAL PRESIDENT, BVA

BLINDED VETERANS ASSOCIATION

TESTIMONY
PRESENTED BY

SAM HUHN
BVA NATIONAL PRESIDENT

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

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INTRODUCTION

Madame 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), I express appreciation for this invitation to present our legislative priorities for 2012. BVA is the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. The Association has worked to improve the lives of blinded veterans throughout the 67 years of its service. As more wounded service members continue to return after more than ten years of Operation Enduring Freedom (OEF), the recently terminated Operation Iraqi Freedom (OIF), and Operation New Dawn (OND), a new generation of seriously eye injured is being added to the decades of combat wounded from previous wars. It is vital that we ensure that these newly injured combat veterans, and all veterans from previous wars, have the full continuum of high-quality vision care and benefits they have earned from the Department of Veterans Affairs (VA) and through the actions of this Congress.

CENTERS OF EXCELLENCE

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 Extremity Trauma and Amputee Center (LEIC) were established in the FY 2009 NDAA (Public Law 110-417). Congress established these three

Centers of Excellence (COEs) three years ago. The intent was that all three be joint initiatives of the Department of Defense (DoD) and VA. The overall objective was 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. These three Centers are also tasked with developing clinical registries containing up-to-date information on the diagnosis, treatment, surgical procedures, and follow-up examinations for the injuries experienced by our nation's military personnel.

Despite the legislative mandate to the contrary, the Defense Department-Veterans Affairs Centers of Excellence have generally struggled to meet even their start-up goals. In the case of the Hearing Center of Excellence and the DoD –VA Extremity Trauma and Amputee COE, at this time there are fewer than half a dozen employees between them organizationally even though DoD operates three amputee clinical centers.

Former Defense Secretary Robert Gates included the three Centers as his second top priority in the February 2010 Quadrennial Defense Report (QDR). Bureaucratic issues, governance questions, and limited budgets have all hindered significant progress toward the full operational establishment of the Vision Center of Excellence, the Hearing-Audiology Center of Excellence, and the Extremity Trauma and Amputee Center of Excellence. While we can report some progress during the past year with VCE now having employed a DoD Director, a VA Deputy Director, and 11 full-time support staff, the other two Centers still lack necessary personnel, thus hampering their progress. They also continue waiting for Memos of Understanding and Operational Agreements. These three Defense Centers of Excellence now face additional major challenges in meeting their mandated objectives without strong governance oversight and sufficient funding levels.

DoD and VA Information Technology, along with contractor assistance, have developed the Defense Veterans Eye Injury and Vision Registry (DVEIVR) as the very first clinical electronic health registry having the ability to exchange with VA providers all eye-injury clinical notes, diagnostic records, and surgical records from the battlefield. DVEIVR was tested this past year and began extracting information from the Joint Trauma Tracking Registry (JTTR) and Armed Forces Health Surveillance Center on vision injured. During the next six months DVEIVR will enter into its second stage of the pilot testing of data exchange. Later, information technology data extractors will take approximately 59,000 records of eye-injured personnel in Military Treatment Facilities (MTFs) and VA Medical Centers (VAMCs.) The data extractors will then securely download them into the DVEIVR in the next several months. Despite this plan, cuts to DoD Information Technology could slow or even stop this joint effort.

BVA requests that Congress appropriate $10 million for the VCE operations budget FY 2013 and it require DoD and the VA Veterans Health Administration (VHA) to report quarterly on their functional plans for DVEIVR. BVA also requests status updates for HCE and LEIC. We believe that within the framework of VCE and DVEIVR, Seamless Transition of eye care and vision rehabilitation services, as well as veteran and family education, can be developed and refined to improve long-term care of veterans.

SEAMLESS TRANSITION

During the past three years, BVA has worked with Members of these VA Committees, in addition to both the House Armed Services Committee (HASC) and Senate Armed Services Committee (SAC). We have explained the need to hold both DoD and VA jointly accountable for the many organizational problems associated with the Seamless Transition process that have so much affected the battle eye-injured and those with visual system dysfunction complications associated with Traumatic Brain Injury (TBI). VA last reported that DoD had the ICD-9 diagnostic code information for 58,000 eye-injured service members and that VA had it for 46,000. Within those numbers 16 percent of all evacuated wounded had sustained eye trauma. Specific numbers from December 2010 data are as follows:

- Department of Veterans Affairs 46,000*
- DoD Vision Center Excellence 58,000
- Optic nerve injury 1,200
- Retinal injuries 8,441
- Chemical/ thermal burns 4,294
- Orbital blast injuries globe 4,970

*Includes mild, moderate, severe eye injuries.

Of the eye injured, 2,089 are reported by VHA to have a diagnosis of low vision and 190 have been blinded, requiring treatment for both groups at one of the 12 then existing VA Blind Rehabilitation Centers (BRCs), or at low-vision clinics. 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, and depression (affecting 22 percent of those diagnosed with TBI). The Defense and Veterans Brain Injury Center (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.

IED BLAST SURVIVAL

Improvised Explosive Device (IED) survivors face challenges that range from the minor to the monumental: fractures, amputations, disfigurement, sensory deficits, cognitive and motor impairments, dysphagia, emboli and stroke, headaches, personality changes, visual and auditory disturbances, altered affect, hypersensitivities and dulled judgment.5 The mortality from blast violence has been reduced by rapid medical interventions but blast injuries, by their nature, usually include eye, ear and brain trauma. The resulting trauma is sufficiently great that service members returning home will need years of neurological, psychological, otolaryngological, and ophthalmologic follow-up.

“The majority of soldiers we saw were injured by a blast of some sort, rather than, for example, a gunshot wound,” said Prem S. Subramanian, MD, PhD. Dr. Subramanian, now an associate professor of neuro-ophthalmology at Wilmer Eye Institute, spent several years on staff at Walter Reed Medical Center in Washington, D.C., where he managed many polytrauma patients who had sustained serious head and eye combat injuries in Iraq or Afghanistan.

Stop the bleeding, keep them breathing. For troops who sustain multiple injuries, this is a sober logic that governs the sequence of interventions. “In combat theater, surgeons and medics apply

the medical priority of 'Save Life, Limb and Eyesight' approach to prioritizing injuries, with limbs and eyes earning equal attention, and both of those deferring to life-threatening injuries," Dr. Subramanian said. "If patients had a severe intra-cerebral hemorrhage, for example, or subdural or subarachnoid hemorrhage, causing brain herniation or depression of their vital signs, obviously that would command the greatest precedence. Many would arrive at Walter Reed in severe shock because of blood loss or a closed head injury." BVA urges Members of Congress to support all battlefield research funding.

TBI vision dysfunction was noted in a New England Journal of Medicine study performed by doctors practicing at the Palo Alto VA Polytrauma Center. The doctors had studied polytrauma patients diagnosed with TBI who had no knowledge of an eye injury or who had not previously reported eye injury (eyes with open injury were excluded from analysis). Upon comprehensive eye exams, 43 percent of the polytrauma patients had a closed eye injury in at least one location. These data, combined with the 16 percent of those with known, or open, vision injuries, imply that approximately 200,000 veterans may be experiencing mild, moderate, or severe neurological vision dysfunction.

Added to the number of penetrating eye injuries are the 75 percent of mild, moderate-to-severe TBI service members who have suffered visual system dysfunction. The data now come from various VA research findings based on veterans tested by neuro-ophthalmologists or low-vision optometrists. With increased visual screenings, each month they are diagnosing higher numbers of 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 reported that 75 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, in the percentages indicated, none of the following visual complications diagnosed early in the normal medical evacuation process: 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.

Service members 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.

PEER REVIEWED VISION TRAUMA RESEARCH PROGRAM (VTRP)

BVA, along with six other Veterans Service Organizations dedicated to serving our Nation's veterans, are joined in supporting the programmatic request of continuing directed funding in FY 2013 for the for the Peer Reviewed Vision Trauma Research Program (VTRP) extramural research line item, funding requested at $10 million for core vision/eye research. This programmatic line item, 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 2012, it was funded at the lowest level of $3.25 million in the past four years, resulting in lack of funding for several vital deployment related eye trauma research grants. Defense-related vision trauma research warrants a far more vigorous investment, especially since TATRC and DoD experts identified vital research gaps into restoration of sight and eye care as a priority for funding.

Today, battlefield conditions in OEF have resulted in the classification of 10 percent of all eye wounds as severe global injuries. In addition, and more generally, among those wounded and evacuated, 48 percent of the eye injured have wounds of a higher level of penetration and include TBI-related visual system dysfunction. This is due to service members' exposure to the blasts when dismounting from vehicles and being subjected to the full force of IEDs. According to DoD, serious combat eye trauma from OIF and OEF was the fourth most common injury (58,000 injuries) and trails behind only TBI (229,106) PTSD (estimated at 300,000), and hearing loss (198,921). The majority of the wounded have also suffered from polytrauma.

The November 2008 Medical Surveillance Defense Monthly Report from the Armed Forces Health Center reported that a ten-year active duty eye injury review from 1998 to December 2007 revealed a total of 188,828 ocular injuries. While 63 percent of the injuries were mild, there were; 8,441 retinal and choroidal hemorrhage injuries (including retinal detachment), 686 optic nerve injuries, and 4,294 chemical and thermal eye burn injuries.

BVA demands to know why the Peer Reviewed Vision Trauma Research Program is the lowest funded of all of CDMRPs for battlefield research. Vision TBI screening programs and accompanying research are vital to ensuring more front line deployment screening and treatment options for these visual complications. Not unlike the existing specialized research programs on burns, blood transfusions, limb extremity, and spinal cord injuries, a more vigorously funded VTRP extramural research program will enable the exploration of new and promising research opportunities that directly meet battlefield needs. In light of this urgent need, BVA strongly disagrees with the determination of Congress to cut the Defense VTRP by 20 percent, down from $4 million in 2011 to $3.2 million for FY 2012.

BVA requests that eye and vision trauma research within defense appropriations be increased for the Vision Trauma Research Program VTRP within the Congressionally Directed Medical Research Program (CDMRP). We request, for FY 2013, $10 million as a dedicated line item for Vision Trauma Research Program and point out that eye injury research provides combat surgeons with new treatments that will preserve vision. We also emphasize that the PRMR-Vision line item in defense appropriations is a dedicated funding source for extramural research into immediate battlefield needs. Although we were repeatedly told there was no funding for FY 2012 and that tough choices therefore had to be made, we point to a Floor statement on December 15 by Senator John McCain: "Mr. President, the Armed Services Committee

authorized, and the Congress will soon appropriate, some $290 million for research into post-traumatic stress disorder, prosthetics, blast injury, and psychological health. These are critical to improving actual battlefield medicine. Yet, once again, the appropriators inserted unrequested funding for medical research, this time to the tune of $600 million. Let me remind my colleagues that these unrequested projects are funded at the expense of other military priorities."

This type of eye trauma research for wounded warriors is not conducted by the National Eye Institute (NEI) within the National Institutes of Health (NIH) and is not funded by VA or other agencies. DoD engages representatives of VA and NEI in a 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. Despite the identification by TATRC of the urgent need to fill the vision trauma battlefield research gaps in both eye trauma and TBI vision programmatic research, Congress substantially reduced vision funding for FY 2012. Although the VCE Director reviews defense vision trauma research grants that can facilitate data-analyzed documentation of the findings and the publication of combat translational clinical plans to improve both acute eye injury care and the long-term vision rehabilitation outcomes, VCE has no internal DoD research funding.

We urge members of congress to review the GAO Report GAO-12-342SP, Section 14, 2012. The majority of federal funding for health research and related activities is spent by the National Institutes of Health (NIH), within the Department of Health and Human Services (HHS), the Department of Defense (DOD), and the Department of Veterans Affairs (VA). In fiscal year 2010, NIH, DOD, and VA obligated about $40 billion, $1.3 billion, and $563 million, respectively, for activities related to health research. While other federal funds may provide research to wide variety of medical conditions listed in the CDMRP, battlefield deployment research should be considered vital to DoD budgets and taken into strong consideration with traumatic injury research programs receiving priority funding to save life, limb and eye sight.

DoD-VA HEARING CENTER OF EXCELLENCE AND RESEARCH

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. Nevertheless, rarely do Members of these Committees receive testimony regarding the third most common injury from the wars. The figure now stands at 198,921 for OIF and OEF service members with service-connected hearing loss. Another 214,428 have been rated for tinnitus.

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. 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 Air Force Director of HCE Colonel Mark Packer, MD, more than 233,000 active duty OIF and OEF service members have now documented various levels of hearing loss.

HCE has a staff of one Air Force officer assigned in San Antonio's Wilford Hall. There is no full-time VA staffing. While BVA appreciates that total funding for HCE operations is $5 million for FY 2012, there is a clear lack of strong oversight from the DoD-VA Health Executive Committee (HEC). A January 31, 2011 Government Accountability Office Report (11-114) on Hearing Programs found that while hearing loss is a major physical injury from the wars, the progress on starting a hearing injury registry to track and develop coordinated care between the two health care systems lags far behind. BVA has become increasingly frustrated that the two major sensory injuries from the wars, vision and hearing, are the least funded for research. The high numbers of invisible wounds that result in hearing and visual impairments, and that negatively affect ability to function in society, are the least funded when it comes to research budgets related to other injuries. BVA supports the Defense Health Programs (DHP) DoD request of Sensory Injury Research FY 2013 for $14,796,000 for hearing, vision, and gait injuries to meet this challenge.

Translated into other financial terms, the government paid out approximately $1.1 billion in VA disability compensation for tinnitus in 2010. 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). The number of veterans affected is not small either—as of the end of the second quarter of FY 2011, there were 198,921 from OIF and OEF operations with a service connected hearing loss.

BENEFICIARY TRAVEL FOR BLINDED VETERANS: H.R. 3687 AND S. 1755

BVA thanks Congressman Michaud, and Senator Tester for introducing legislation for disabled SCI and blinded veterans who are currently ineligible for travel benefits, thus assisting low income and disabled veterans' the travel 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 Blind Rehabilitation Service (BRS). BVA therefore requests enactment of HR 3687ensuring that VHA cover such travel costs by changing Title 38 Section 111 to ensure that VA provided public transportation costs for travel to special rehabilitation program.

It makes little sense to have developed, over the past decade, an outstanding blind rehabilitative service, with high quality inpatient specialized services, only to tell low income, disabled blinded veterans that they must pay their own travel expenses. To put this dilemma in perspective, a large number of our constituents are living at or below the poverty line but the VA Means threshold for travel assistance sets $14,340 as the income mark for eligibility to receive the benefit. The Congressional Budget Office scored the cost that would result from S. 1755—$2 million for FY 2013 and $4 million each year thereafter to travel for admission to either a Spinal Cord Injury Center or a BRC. VA utilization data revealed that one in three veterans enrolled in VA health care was defined as either a rural resident or a highly rural resident. The data also indicate 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 must drive more than four hours to receive tertiary care from VA. Additionally, 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.

VETERANS PROGRAMS IMPROVEMENT ACT OF 2011, S. 914

The current Special Adaptive Housing (SAH) requirement has a 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 a loss of peripheral visual fields to 20 degrees or less. The Veterans Benefits Administration testified before the VA Subcommittee on Economic Opportunity in June 2010, expressing support for this change since the 5/200 visual acuity standard is not used to deliver any other VBA benefits. In addition, VHA has a visual acuity standard of 20/200 or less for legal blindness. BVA was grateful that H.R. 5290 was passed by the House VA Committee with full bipartisan support and then approved on the House Floor in September 2010. We also thank Senator Begich and other Members for including this legislation in Section 306 of S. 914, the Veterans Programs Improvement Act of 2011.

If accessible housing grants and beneficiary travel assistance is not allowed so that disabled veterans can live independently at home, the alternative high cost of institutional care in nursing homes will become the much less desirable alternative. According to a 2008 MetLife survey, 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). Even assisted living center charges of $3,031 per month ($36,372 annually) rose another 2 percent in 2008. These options are far more costly and considerably less attractive than for VA to provide adaptive housing grants for veterans to remain in their homes and function there with some independence. In the United States, the fifth most common cause of admission to nursing homes is blindness.

BLIND REHABILITATION CENTERS (BRCs)

After more than 64 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 must have more central control over blind center resources and funding levels. The full Continuum of Care model by VHA should ensure that both the outpatient programs and inpatient BRCs have adequate staffing. Some VISN directors might attempt to force medical centers or BRC directors to cut the staff and the BRC training that is inherent in the success of these highly specialized rehabilitation programs.

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 a 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.

FUNDING VHA BRS

BVA supports the VSO Independent Budget (IB) for FY 2013 and the IB's Advance Appropriations budget for FY 2014. This document was sent to Congress earlier this year. The section of greatest interest, however, and which most affects our membership, is the one dedicated to VA BRS. The FY 2012 budget for BRS was $126 million. For FY 2013, it would increase to $134 million. Advance Appropriations for FY 2014 would bring another increase, this one to $143 million. The VA budget for BRS covers 13 BRCs and 45 outpatient programs. Currently, 50,574 blinded veterans are now enrolled in BRS with specialized care at those sites and within those programs. 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 Blind Rehabilitation Clinics and BRCs is a high priority for BVA. We urge members to protect VHA funding special disability programs from cuts.

VISUAL IMPAIRMENT SERVICES TEAMS (VIST) AND BLIND REHABILITATION OUTPATIENT SPECIALISTS (BROS)

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, the VIST program 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 program now employs 115 full-time Coordinators and 43 who work part-time. VIST Coordinators nationwide serve as the critical key case managers. As 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. Although VISTs and BROS ensure that rehabilitation training occurs, some medical center directors are delaying for months the filling of vacant positions for these key personnel. We ask for stronger oversight and authority from VA BRS to ensure that positions are filled. We ask Congress to request a timetable for the BROS scholarship program that was included in S 1963 more than a year ago.

GUIDE DOG AND SERVICE DOG POLICY

BVA has more experience with guide dogs than most Veterans Service Organizations. For 67 years, BVA 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 high quality programs that never charged a veteran to receive a dog. The demand, however, is now growing rapidly for expansion of this new benefit from VA Prosthetics so that VA would cover all the costs associated with all service dogs.

When it comes to service dogs for disabled veterans, Members of Congress should understand that the private sector is virtually unregulated. There are 49 states that have no laws concerning licensure of service dog programs and no certification requirements for instructors or trainers. BVA points out that while some advocates of these programs attempt to use the International Association of Assistance Dog Partners (IAADP) or the Americans with Disabilities Act (ADA) as enforcement and regulatory mechanisms, the international service animal standards are totally voluntary and there are no clear 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 the licensing or certification of 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 the IAADP 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 than requiring yearly certification for programs. This opened the door for people to train their own assistance dog. Only nine service

dog programs voluntarily cooperate with the IAADP standards while 86 programs do not participate in these standards. Although we hear about cost concerns regarding nearly everything else, we have not heard that covering all future costs associated with service animals. Furthermore, Physicians, Nurses, Occupational Therapists, and Physical Therapists also lack knowledge and training in this area to determine prescribing of service dog.

All factors considered, we ask: Who within VA will "prescribes" and decide if a service dog is necessary? Will it be only the veteran and the service dog program? With other VA benefits, the providers must prescribe devices or prosthetics. What then will occur with this policy?

We strongly caution Members to reassess this situation for the protection of disabled veterans against the potential risk of fraud and poor training, and to consider the potential cost to VA. BVA requests further consideration of the aforementioned problems. We request that our views be considered in any future hearings on this issue.

CONCLUSION

On behalf of BVA, thank you for your efforts on behalf of all veterans and their families. We look forward to working with all Members of Congress in an effort to better serve our brave men and women who have sacrificed on the battlefield and who are now seeking care within the DoD and VA systems. We hope to also continue our dedicated service to the veterans of previous generations to whom we also owe our freedom. I will now gladly answer any questions you may have concerning our testimony.

RECOMMENDATIONS

• BVA endorses the VSO Independent Budget recommendation regarding the advance funding for veterans health care for FY 2013-2014. We again question why medical centers often have vacant clinical positions while the VISNs and VHA have added administrative FTEEs.

• Congress must ensure full establishment and Programmatic Operational Management (POM) of the budget requested by DoD for FY 2013 for the Vision Center of Excellence (VCE) and Defense Veterans Eye Injury Registry (DVEIR). DoD/VA staffing resources are critical to the success of each Center of Excellence. The Health Executive Council (HEC) must provide Congress with quarterly updates on all three DoD-VA Centers of Excellence for Vision, Hearing, and Limb Extremity Injuries.

• The following needed funding levels for the Centers of Excellence have been identified for POM for FY 2013: $5 million for the Defense Department-Veterans Affairs Extremity Trauma and Amputee Center of Excellence, $10 million for VCE, and $5 million for HCE.

• BVA firmly supports the position that extramural vision research funding through the dedicated Peer Reviewed Vision Trauma Research Program VTRP is critical. BVA urges that VTRP be funded at $10 million in FY 2013 for vision/eye research.

• BVA requests passage of S. 914 legislation to correct the Special Adaptive Housing standard for

legal blindness, the Veterans Benefits Administration must use legal standard 20/200 or less, or 20 degrees of visual field loss or less.

• Beneficiary travel to VA Blind Rehabilitation Centers (BRCs) should be provided by amending Title 38 of U.S.C. Section 111. BVA requests support of S. 1755 and H.R. 3687 to cover any modes of commercial travel for blind or spinal cord injured disabled veterans for admission to inpatient rehabilitation services.

• 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.

• BVA supports FY 2013 Sensory System Injury programmatic request from Defense Health Program (DHP) for $14,796,000 for all sensory deployment injury research to meet this vital need.

• 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. Recently, 50 percent of the IT budget to meet compliance was cut within VA IT. 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. We request oversight for compliance with this program.