Mr. Sam Huhn, National President, BVA

INTRODUCTION

Chairman Sanders, Chairman Miller, Ranking Members Senator Burr and Michaud, and other Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) and its membership, we appreciate this invitation to present our legislative priorities for 2013. BVA is the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. On March 28 of this year, the Association will turn 68 years old. As an increasing number of wounded service members continue to return from Operation Enduring Freedom, Afghanistan (OEF) after more than ten years of war, a new generation of the seriously eye injured is being added to the decades of combat wounded from previous wars and from the recently ended Operation Iraq Freedom (OIF) and Operation New Dawn (OND).

Improvised Explosive Device (IED) survivors face challenges ranging from the minor to the monumental: fractures, amputations, disfigurement, cognitive and motor impairments, emboli, headaches, personality changes, visual and auditory disturbances, altered effect, hypersensitivities, and dulled judgment. The mortality from blast violence has been reduced by the rapid frontline trauma interventions and rapid evacuation, but blast injuries by their nature usually include vision injuries, hearing loss, and brain trauma. Large numbers of the wounded returning home will need years of neurological, psychological, and ophthalmological long term 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, M.D., Ph.D. Dr. Subramanian, now an Associate Professor of neuro-ophthalmology at Wilmer Eye Institute, spent several years on staff at Walter Reed Army Medical Center in Washington, D.C., where he managed several polytrauma wounded warriors who had sustained serious head and eye combat injuries in OIF or OEF as a result of IEDs.

"Stop the bleeding, keep them breathing" is a key to saving a life on the battlefield, especially at a time in history when so many are being saved**.** For troops who sustain multiple injuries, a sober logic governs the sequence of interventions: "In combat theater, surgeons apply the '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. "Many would arrive at Walter Reed in severe shock because of blood loss or a closed head injury."

As survival occurs more than ever before amid multiple injuries, the establishment of the Vision Center of Excellence (VCE) for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries (authorized by the Fiscal Year 2008 National Defense Authorization Act, Public Law 100-180, Section 1623) becomes more vital. The Hearing Center of Excellence (HCE) and Traumatic Extremity and Amputation Center of Excellence (EACE) were mandated in the FY 2009 National Defense Authorization Act (Public Law 110-417). Congress established these three centers of excellence with the intention that they be joint Department of Defense (DoD) and Department of Veterans Affairs (VA) programs. Their purpose was to improve the care of wounded or injured service members and veterans affected by combat eye, hearing, and limb extremity/amputee trauma, and to improve clinical coordination between DOD and VA for the treatment of wounded service members suffering from these specialized kinds of injuries. These centers are also tasked with developing joint clinical registries containing up-to-date information on the diagnosis, treatment, vision research, and outcomes for the injuries. Unfortunately, these registries are still not fully functional even after being mandated more than three years ago.

Despite a legislative mandate and Secretary William Gates' inclusion of these three centers as a top priority in the February 2010 Quadrennial Defense Report (QDR), bureaucratic problems, limited oversight, some initial confusion over governance, and limited budgets have all hindered significant progress toward the establishment of the VCE, HCE, and EACE. Although the VCE has a DoD Director, a

VA Deputy Director, and 13 other full-time staff appointed to support it, a majority of the current staff is DoD contract personnel and only three are VA personnel. Compounding the organizational challenges is recently news that VCE Director Colonel Don Gagliano, M.D., was informed that on March 30, 2013 he is facing mandatory retirement at a critical juncture in the operational establishment of the VCE. Rather than extend his active duty orders for two years so that he can continue to direct the VCE, DoD has decided to retire him and not allow a waiver for him to remain on active duty. Of note also is that the HCE and EACE are still lacking full-time VA personnel, thus hampering their key missions and the meeting of their mandated objectives.

The DoD Armed Forces Surveillance Center report of May 2011, **Eye Injuries, Active Component, U.S. Armed Force, 2000-2010** indicates that during an 11-year surveillance period there were 186,555 eye injuries worldwide in the military medical facilities within its data. VA also notes that of the OEF/OIF/OND veterans diagnosed with eye conditions, including visual problems as a result of a Traumatic Brain Injury (TBI), upwards of 75 percent of them experience short- or long-term visual dysfunction, including double vision, sensitivity to light, and inability to read print, among other cognitive problems. The total number of veterans with TBI visual disturbances was 37,376. Some moderate to severe eye-injured OIF and OEF service members have not always been centrally tracked, making the implementation of the Defense Veterans Eye Injury Vision Registry (DVEIVR) extremely critical to improve coordination of care and ensure access to the full continuum of VA Eye Care Services, Blind Rehabilitation Service (BRS), and Low-Vision outpatient programs that these committees have helped establish over the years.

We draw attention to the overall cost impact of these eye injuries from OIF and OEF. In May 2012, the National Alliance Eye Vision Research (NAEVR) released its first-ever **Cost of Military Eye Injury and Blindness study**, prepared by Kevin Frick, Ph.D. (Johns Hopkins Bloomberg School of Public Health). Based on published data from 2000 to 2010 and recognizing a range of injuries from superficial to bilateral blindness, as well as visual dysfunction from TBI, the annual incident cost has been $2.3 billion, yielding a total cost to the economy over this timeframe of $25.1 billion–a large portion of which is the present value of future costs such as VA and Social Security benefits, lost wages, and family care.

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 them 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.

PEER REVIEWED MEDICAL RESEARCH AND RESEARCH FUNDING

BVA, along with nine other Veterans Service Organizations, signed a joint letter supporting the programmatic request to continue directed funding in FY 2014 for the **Peer Reviewed Medical Research-Vision (PRMR-Vision Trauma Research Program) extramural research line item.** The request is for $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, the level of funding was $3.75 million while in FY 2011 it was at $4 million even. Then, in FY 2012, it was even less at only $3.2 million, making eye injuries one of the lowest funded of all deployment injuries funded by the CDMRP. This resulted in a lack of funding for several eye trauma research grants. Defense-related vision trauma research warrants a more vigorous investment, especially since Secretary of Defense Panetta identified research into Deployment Sensory Injury –Vision and Hearing Injury requesting $14,790,000 as level for research funding in response to a question from Senator Durbin at a June 13, 2012 Senate Appropriations Committee hearing.

Today, battlefield conditions have resulted in a high percentage of penetrating eye injuries and TBI-related visual system dysfunction among those wounded/evacuated due to IED blast forces. With the continued presence of the U.S. in Afghanistan, coupled with other global threats, eye injuries will continue to be a challenge. 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. We stress the following numbers as we have in the past: 4,970 moderate-to-severe penetrating combat eye injuries, 10,458 retinal and choroidal hemorrhage injuries (including retinal detachment), 2,593 optic nerve injuries, and 6,926 corneal eye injuries.

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. In light of the data above, research within defense appropriations must be increased for the Vision Trauma Research Program (VTRP) within the Congressionally Directed Medical Research Program (CDMRP). We appreciated the bipartisan support last July 17 of Congressman Tim Walz (D. MN.) in an amendment supported by Congressman Jim Moran (D. VA.) to provide an additional $5 million to the VTRP level approved by the House Appropriations Committee-Defense of $5 million--for total of $10 million for FY 2013. We request that his level be kept in the final FY 2013 appropriations.

We point out that translational deployment eye injury research provides combat surgeons with new treatments that will preserve vision. A PRMR-Vision line item 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 (NIH) and is not done within VA Research and Development. This is unlike other CDMRP research for various cancer and general medical conditions in which there are many other sources of private foundations and over 40 large cancer state funded centers. DoD does engage representatives of VA and the National Eye Institute (NEI) in programmatic review of the vision trauma research grants it receives. For FY 2012, more than 25 eye trauma research grants could not be funded because of the limited CDMRP of $3.2 million for vision research—all despite the identification by DoD of research gaps in both eye trauma and TBI vision programmatic research that must be filled.

SHARING OF BLAST TRAUMA RESEARCH AND IED EVENT DATA

Members of this Committee were among a strongly bi-partisan group of 92 Members of Congress, including those who signed a letter last June to President Obama coordinated by the Global Campaign against IEDs. The letter called on VA and DoD to develop a strategy that partnered with Veterans Service Organizations and other appropriate entities to identify the long-term physical and psychological-social effects of IED related injuries. It also asked DoD to share blast related medical research findings with appropriate other federal agencies and with university researchers investigating such injuries. Today, blast trauma related medical research is being conducted by the DoD. Lamentably, it is not shared with VA researchers using the excuse it is all classified data. This refusal to share information adversely impacts the development of treatments needed for our veterans of all eras.
BVA learned from partnering with the Global Campaign against Improvised Explosive Devices that IED casualties for our service members and veterans date back to all of our nation’s conflicts. Although a significant number occurred in Vietnam, incidents in Afghanistan and Iraq have become more widely known. IEDs are the number one cause of casualties for our military forces. This is very likely to continue in all conflicts for the foreseeable future. While the number killed in action by IEDs has decreased in recent years, the number wounded who must live with the physical and psychological scars, either on active duty or as veterans, is both greater and ever increasing. With or without physical wounds, IEDs have a severe psychological impact, contributing to PTSD and then playing a major contributing role in active duty and veteran suicides.

TRAUMATIC BRAIN INJURY VISION SYSTEM DYSFUNCTION

The following figures, provided by the Defense Veterans Brain Injury Center, represent numbers of medical diagnoses of TBI collected from around the world from 2000 to the third quarter of FY 2012.[9]

Penetrating	4,174
Severe	2,663
Moderate	45,676
Mild	200,076
Not Classifiable	9,476
Total - All Severities	**262,065**

Concussion/Mild TBI is characterized by the following**:** A confused or disoriented state which lasts less than 24 hours; loss of consciousness for up to 30 minutes; memory loss lasting less than 24 hours; and structural brain imaging (MRI or CT scan) yielding normal results. **Moderate TBI** is characterized by the following**:** A confused or disoriented state which lasts more than 24 hours; loss of consciousness for more than 30 minutes, but less than 24 hours; memory loss lasting greater than 24 hours but less than seven days; and structural brain imaging yielding normal or abnormal results. **Severe TBI** is characterized by the following**:** A confused or disoriented state which lasts more than 24 hours; loss of consciousness for more than 24 hours; memory loss for more than seven days; and structural brain imaging yielding normal or abnormal results. **Penetrating TBI** is characterized by the following: A head injury in which the dura mater, the outer layer of the meninges, is penetrated.

In the past year in Afghanistan, IED blasts caused 78 percent of all battle injuries but, in Iraq, the same blasts caused 84 percent of all eye injuries. With increased visual screenings, VA providers are diagnosing increasingly higher numbers of vision system dysfunction and impairments from IED blasts. Although TBIs rarely result in legal blindness, researchers have found rising numbers of TBI cases with visual system dysfunction. The four VA Polytrauma Centers in Palo Alto, Richmond, Minneapolis, and Tampa have all reported that 70 percent of all TBI patients have complained of visual symptoms related to the blast exposure they experienced. VA found that 2,593 enrolled OIF/OEF veterans had ICD-9 code with disorders of the optic nerve and visual pathways related to TBI. 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. VA found the following visual complications diagnosed in OIF/OEF veterans: corneal damage, 6,926; traumatic cataracts, 13,293; angle recession glaucoma, 16.204; retinal injury, 10,458. These complications now found in young service members are especially alarming. We stress that these veterans are at high risk of progressive visual impairments if not diagnosed and treated early and then closely followed for decades.

BVA requests that efforts continue to improve the continuing education on the importance of visual screening, treatment, and rehabilitation of these visual complications. Servicemembers who have mild, moderate, or severe TBI with visual system impairment, or a penetrating eye injury, must be tracked in the Defense Veterans Eye vision Injury Registry, 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.

DOD-VA HEARING CENTER OF EXCELLENCE

During present-day combat, a single exposure to the impulse noise of an IED can cause immediate noise-induced 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. 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 223,000 OIF and OEF service members and veterans are service-connected for tinnitus and some 187,000 have various levels of hearing loss.

The HCE has a staff of two Air Force officers assigned in San Antonio's Wilford Hall. There is no full- time VA staffing. Two other problems are low programmatic line item funding and a clear lack of governance from the Health Executive Council and Joint Executive Council. We point to the GAO 11-114, January 31, 2011 Report that 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. The invisible wounds of hearing and visual impairments do not seem to result in equal budgets for the deployment of the trauma research that results for other injuries. Hearing deployment trauma research, for example, has had virtually no line item in the CDMRP for research.

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 2016. 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).

SECTION 508 VA INFORMATION TECHNOLOGY COMPLIANCE

Section 508 of the Rehabilitation Act requires federal agencies to ensure that all electronic and information technology developed, procured, maintained, or used in the federal environment provide equal access for federal employees and members of the public. The 2012 Department of Justice (DOJ) report identifies continued challenges with Section 508 implementation and management. The report makes recommendations for training, policy, and better collaboration. The DOJ Section 508 compliance survey completed in the summer of 2012, however, found widespread problems and lack of accessible electronic and information technology at federal sites.

BVA has repeatedly requested in its annual resolutions that VA IT be compliant with Section 508 of the Americans with Disabilities Act. We appreciate the fact that both of these committees have requested VA briefings and required updates on the status of its efforts to comply with 508 Access. This problem of lack of compliance, however, has still not been fixed either in Veterans Health Administration or the Veterans Benefits Administration and 184 IT program barriers were found in 2012 testing. 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 that Congress continue its strong oversight to ensure that VA adequately funds its Information Technology programs and meets timelines for fixing the inaccessible websites. We are concerned that the progress being made on electronic and information technology program timelines for implementing changes could be disrupted with the departure of VA Assistant Secretary for Information and Technology/Chief Information Officer Roger Baker. In the past year BVA appreciates that Mr. Baker has made these timelines for change an internal priority and has dedicated more personnel, funding, and contractor support to fix these long standing problems. We ask congressional members to continue strong oversight of the EIT system and insist that VA meet its obligations to comply with Section 508 compliance in all internet programs.

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 Veterans Integrated Service Network (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 new 113th Congress, ensuring that VHA cover such travel costs by changing Title 38 Section 111 to require VA to provide transportation costs for travel by airfare, train, or bus or other methods to a special rehabilitation program serving blinded veterans or the spinal cord injured for either inpatient or HOPTEL program medical care.

BVA thanks Senator Jon Tester for introducing S. 1755 and the Senate Committee on Veterans Affairs for including the bill in the hearing last June 27. We request that this vital legislation be introduced again. We also express appreciation to Congressman Mike Michaud for introducing H.R. 3687, the companion House bill legislation for disabled spinal cord injured and blinded veterans who are currently ineligible for

travel benefits. This bill would assist low-income and disabled veterans by removing the financially burdensome travel expenses needed to access vital care that improve independence and quality of life.

It makes little sense to have developed, over the past decade, outstanding blind rehabilitation services with high quality inpatient and outpatient specialized training, only to tell catastrophically disabled blinded or SCI 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. 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 25 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. States and private agencies are not the answer either since they do not usually 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. We question why Congress would consider enacting legislation to require VA to fund grants to service dog and guide dog programs at a cost of $30,000 per dog but refuse to provide a blinded veteran, who needs rehabilitation training to learn the skills to live independently at home, a $350 airline ticket to get to a BRC.

FUNDING VHA BLIND REHABILITATION SERVICE

Integrated among OIF and OEF veterans with eye injuries is an aging veteran population that can be characterized by a growing prevalence of age-related degenerative visual impairments. This group constitutes one of the major challenges of 2014 and far beyond. During FY 2011, there were 50,304 blinded veterans enrolled in BRS with care. VA research studies estimate that there are 156,854 legally blinded veterans. Epidemiological projections indicate that there are another 1,160,407 low-vision impaired veterans in the United States with visual acuity of 20/70 or worse. Considering the large number of veterans who may seek these services, making certain that each VA VISN Director continues to fully fund BRCs must necessarily be 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.

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, radiology support services, along with the subspecialty surgery specialists, to provide the clinical care necessary for the newly complex psychological trauma of the war wounded 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). 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.

VISUAL IMPAIRMENT SERVICES TEAMS AND BLIND REHABILITATION OUTPATIENT SPECIALISTS

The Visual Impairment Service Team (VIST) system now employs 123 full-time Coordinators and 38 who work part-time. VIST Coordinators nationwide serve as the critical key case managers. There are also 81 full-time Blind Rehabilitation Outpatient Specialists (BROS). As state governments slash social services budgets, additional blind and low-vision veterans could be drawn into the VA 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.

Congress included a provision in the Caregiver Act (S. 1963) passed in May 2010 that VA be required to develop a scholarship program for prospective BROS, thanks in large part to the efforts of Senator Sherrod Brown. The program has still not been fully implemented although VHA continues to administer identical scholarship programs for other allied health occupations. We ask Congress to request a timetable for the BROS scholarship program. Developing candidates for these positions would assist VA in delivering, to a much greater extent, more accessible, cost-effective, and top-quality outpatient blind rehabilitation services. BVA and other endorsers of VSOIB FY 2014 that to strengthen the ability of VHA to recruit and retain VHA health care professionals they must have access to Continuing Medical Education CME conferences and updates on emerging research and professional development education to meet licensure and certification standards.

While we agree with the need for oversight to prevent wasteful spending as a result of recent scrutiny of extremely large VA conferences involving thousands VA employees, we find troubling the recent drastic cuts to all professional medical conferences and outright cancellation of nearly all VA medical CEU conferences. The annual 185-participant VIST and BROS conference, previously an annual event, is now permanently canceled, making it impossible for staff to earn the educational credit hours necessary to improve their performance. Further, VA has created complex and bureaucratic administrative processes in their internal reviews by several layers. For any conference, there is an arbitrary limitation of attendance to not exceed 50 employees. Vital joint DoD and VHA medical conferences on subjects such as TBI, vision and spinal cord injury rehabilitation, prosthetics research, and audiology have all been canceled. VA has even canceled travel to non-VA sponsored professional medical or academy association conferences for physicians. We ask Congress to revisit this issue and request a more balanced approach. Please investigate what can be done to reverse this by determining the types of training programs and meetings that will be most effective in supporting employee professional development.

CONVERSION OF EYE TECHNICIANS WITHIN VA TO TITLE 38 USC, EMPLOYMENT STATUS

BVA was supportive of the section in the Caregivers and Veterans Omnibus Health Services Act (Public Law 111-163) that provided VA with the authority to extend Title 38 USC employment status to certain employees within VHA. Since enactment of the law in May 2010, VHA has worked to convert eye technicians from their current non-specific health technician status into a Title 38 hybrid series specific for them. This has been done to improve VA recruitment and retention of these qualified technicians. Unfortunately, the process has taken far longer than expected.

As discussed elsewhere in this testimony, with the current aging population of veterans with the degenerative eye diseases of macular degeneration, glaucoma, diabetic retinopathy, and cataracts, eye technicians have a cost effective impact on improving VA Eye Clinic access for care and reducing waiting times. The eye care workload within the VA system for FY 2011 was 1,526,000 veteran encounters, an increase of 73 percent since FY 2001.[22] The demand is expected to continue to rise with both the aging population of veterans and the younger OIF and OEF veterans needing eye care services. VA

ophthalmology providers have reported that just the loss of one eye technician in a busy clinic can negatively impact 1,300 veteran visits in that clinic. We understand that Under Secretary for Health Dr. Robert Petzel signed a memorandum of approval on June 6 of last year asking that Title 38 change the status of these eye technicians. The memorandum is still pending approval in Human Resources. We ask Members of the Committee that authorized this change for eye technicians to demand a timetable for approval to avoid further retention problems for these VA eye clinic employees.

WORK OPPORTUNITY TAX CREDIT (WOTC)

In August 2011, about three million U.S. veterans, or 14 percent of the total number worldwide, reported having a service-connected disability. The number could be higher since some veterans did not report at all. Veterans with a service-connected disability are assigned a disability rating by VA or DoD. Ratings range from 0 to 100 percent, in increments of 10 percentage points, depending on the severity of the condition (see Table 6.)

Among veterans with a service-connected disability, about 4 in 10 reported a disability rating of less than 30 percent, while about 3 in 10 had a rating of 60 percent or higher. At that same time, 60.3 percent of veterans with a service-connected disability rating of less than 30 percent were in the labor force, compared with 26.6 percent for those with a rating of 60 percent or higher.

In 1981, the first tax credit for private employers who hire veterans and other chronically unemployed workers was signed into law by President Reagan. Because higher unemployment is the lot of persons with an actual or perceived deficiency, such as a disability or a perception of having few civilian skills, these individuals have less chance than the average worker of being hired. This lack equality of opportunity in the labor market is an affront to our country's founding principles and explains why Congress enacted a hiring incentive to increase job opportunities for veterans, the disabled, and others unable to find jobs in good times and in bad times.

In designing the present-day Work Opportunity Tax Credit (WOTC), Congress took steps to ensure that the credit functioned through the private marketplace, where workers could be regular employees at regular wages and have the same opportunity as others to learn and advance. Congress also capped its contribution to the labor cost of each new hire, so the Treasury loses no more than approximately $1,100 per hire on average, according to Joint Committee on Taxation data—the lowest cost of any Federal jobs program; the employer pays the remainder of compensation for the entire duration of the job. Congress also mandated that each worker's status as a veteran or other target group be certified by the State Workforce Agency upon valid documentation and verified by IRS during audits. Because of these safeguards, there has never been a significant instance of fraud or abuse in WOTC.

In Fiscal Year 2011, the last year for which data is available, WOTC resulted in 1,160,523 jobs for members of all target groups, of which welfare and food stamp recipients comprised the largest. Of these nearly 1.2 million WOTC jobs, Department of Labor statistics show veterans accounted for a total of 17,712, of which 3,117 were disabled veterans. As in past wars, recently returning veterans suffer the highest unemployment rates—as of December 2012, of the 2.5 million Gulf War Era II veterans (those who served from 9/11 to the present), 1,874,000 were employed and 226,000 unemployed, with an unemployment rate of 10.8 percent. Of these unemployed, 180,000 are men with an unemployment rate of 9.9 percent and 46,000 are women with an unemployment rate of 15.7 percent. Clearly, women veterans who want to work are having serious difficulty finding jobs.

Moreover, between the end of 2011 and 2012, 200,000 post 9/11 veterans were released and almost all entered the workforce. The prospect is for this number to accelerate due to withdrawal from Afghanistan and budgetary stringency at DoD. As a minimum, it is estimated that 300,000 more of these veterans will be added this year. Therefore, the challenge of employing them is growing. In 2011, President Obama recommended and Congress amended WOTC in the VOW To Hire Heroes Act to increase the benefit for

unemployed veterans, with the largest benefit of $9,600 for hiring a disabled veteran. We therefore expect to see improvement in veterans hiring in the 2012 data.

Small and medium-sized enterprises (SMEs) are not participating in WOTC because the program will expire at the end of the year. If WOTC were made permanent, promoted to SMEs, and expanded to private non-profit employers such as hospitals and colleges, a world of well-paying jobs would open up to veterans in health care, life sciences, business services, education, and manufacturing where participation is now low. At present, SMEs cannot and will not bear the cost of changing their hiring practices to draw in veterans if the program is short-term.

CHAINED CPI'S NEGATIVE IMPACT ON DISABLED VETERANS

BVA and several other Veterans and Military Service Organizations are opposed to recent proposals that a "Chained Consumer Price Index" be used for determining yearly inflationary costs instead of the usual CPI for the disabled veteran Cost of Living Adjustment (COLA). The chained CPI, which many describe as a very minor change, would alter the method by which inflation is measured. It would reduce Social Security and VA disability benefits by cutting the annual COLA. It would also increase taxes by slowing the rate at which tax brackets rise.

The "Chained CPI" has been on the table in deficit reduction talks for months. BVA opposes it for the following reasons:

- **Social Security is the largest program serving veterans and their families.**

- **The chained CPI will be a double benefit cut for veterans who receive both Social Security and VA benefits. More than** nine million, mostly elderly, veterans receive Social Security benefits. This amounts to four in ten veterans. By contrast, in 2010, 4.1 million veterans received VA benefits. The exact number of veteran Social Security beneficiaries that also receive VA benefits is unknown but 771,000 of the veterans receiving Social Security benefits are receiving disability benefits.

- **VA benefits are already modest.** There are two principal VA benefits programs that go to veterans: disability compensation and pension benefits. The former are for veterans with service-connected disabilities, and the latter are for non-service-connected disabled veterans or elderly veterans with income below the poverty level. In 2011, poor senior veterans received $11,830 in annual pension benefits in 2011.

- **A veteran with average earnings who retires at age 65 would get a benefit cut of $577 at age 75 and $1,006 at age 85**. A 100 percent service connected 30-year-old OIF disabled veteran will have his/her benefit reduced by $1,376 at age 45, $1,821 at age 55, and $2,260 at age 65 under chained CPI.

- **For the currently elderly, disabled, nonservice-connected veterans living on Social Security, in increases in annual health care inflation and increased co-payments for Medicare premiums and medications must be factored into the equation**. The resulting chained CPI reductions would force them to live below poverty levels in their remaining years of life. For 313,000 elderly veterans living on small VA pensions, for widows of veterans, and for service-connected veterans, the chained CPI is the wrong way to deal with the problem.

BVA contends that Social Security and VA benefits should be based on a formula that takes into account these higher health care costs. This formula, developed by the Bureau of Labor Statistics, is called the CPI-E. The CPI-E rises at a slightly faster rate than the formula currently used to calculate the COLA and the proposed chained CPI, providing a modestly more generous COLA for seniors and people with disabilities.

BVA and other Veterans Service Organizations and Military Service Organizations ask that members of this Committee weigh into the debate and find alternative methods to fix the budget problems beyond that

of balancing them onto our elderly, service-connected disabled veterans, or on veterans' widows who already suffer because of the long standing Survivor Benefits Plan and Dependency and Indemnity Compensation offset.

GUIDE DOG AND SERVICE DOG POLICY

BVA has perhaps more experience with guide dogs than most Veterans Service Organizations or Military Service Organizations. For 67 years, BVA has worked with both VA and the original guide dog training programs to ensure that any blinded veteran who wishes to have a guide dog can obtain one for free! 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 guide dog.

Suddenly, however, about three years ago, DoD, VA, and Congress were inundated with information that blinded and severely injured veterans were being charged upwards of $25,000-$35,000 for service dogs and guide dogs. The inaccurate news was set in motion when families and organizations associated with OIF/OEF veterans reported they were unable to pay that amount of money for a service or therapy dog and began inquiring about the possibility of VA providing a dog to any disabled veteran with a physical or mental health condition. The implication was that Congress appropriate funds for these service dogs. The demands grew rapidly for expansion of this benefit, which would come from VA Prosthetics. Calls for VA to cover the costs of service dogs, guide dogs, and therapy dogs became commonplace.

Members of Congress must understand that the private sector is virtually unregulated and that 49 states, California being the exception, have no state laws concerning licensure, nor are there certification requirements for instructors or trainers. BVA contends that while there are some who try to point to the voluntary 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 programs. ADA rules are only about public access to facilities for the disabled with a marked "service animal." The statute is silent on state licensure, national accreditation, or certification for these service dog programs.

On the website of the International Association of Assistance Dogs Partners (IAADP) is the following statement: "CERTIFICATION is not required in the USA." Most states therefore lack programs to establish licensure standards. The Department of Justice decided to foster "an honor system," making 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 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. We see that VA is now caught, forced to develop service dog regulations and provide, through Prosthetics Services, all future costs associated with providing service animals. While many Members of Congress point out that there is no funding for other programs, they are still willing to commit $15 million for service dogs over the next five years. Physicians and nurses have absolutely no academic university training in service dogs or guide dogs and no ophthalmology residency program provides even one hour of course training on guide dogs. Who then decides if a veteran should have any kind of service animal—only the veteran and the service animal provider?

Some service dogs are being trained in six weeks while the well-established guide dog programs have averaged well over 120 hours of training over a nine-month period. The programs with a long and proven history will match the guide dog with a veteran's lifestyle, activity, occupation, and family needs. Some current advertising on the Internet indicates that a service dog costs $35,000. It also indicates that a certificate of compliance with Americans with Disabilities Act access standards is sufficient proof that the dog has been adequately and thoroughly trained. 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 service or guide dog that is insufficiently trained, placing them in great danger in a host of situations.

We strongly caution Members of this Committee to reassess this situation for the protection of disabled veterans, the strong potential risk of fraud, misleading advertising, and VA liability for large future expenditures. Please consider also the current lack of state licensure and certification standards 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 that our views be heard in any future hearings on this issue.

CONCLUSION

Once again, Chairman Sanders, Chairman Miller, and all Members, BVA thanks you for your efforts on behalf of all veterans and their families. 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

- Congress must ensure that the full establishment of 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. We request oversight hearings on the three DoD-VA Centers for Vision, Hearing, and Limb Extremity.

- BVA supports research funding through the dedicated Peer Reviewed Medical Research-Vision Trauma Research Program be a line item in DoD's Congressionally Directed Medical Research Program funding $10 million in FY 2014 defense appropriations to meet the demands.

- Guide Dogs for blinded veterans have been provided free for decades. BVA cautions that credentialing, certification, licensure, and lack of industry standards for training service dogs and therapy dogs could result in veterans receiving unqualified service dogs. Authorizing VA to grant payments of $35,000 to these programs will add substantially to VA prosthetics budgets and increase the risk of fraud.

- 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 travel for disabled veterans determined to benefit from specialized rehabilitation services.

- If the Work Opportunity Tax Credit (WOTC) were made permanent and then expanded to cover Small and Medium-sized Enterprises (SMEs) and even private non-profit employers such as hospitals and colleges, a world of well-paying jobs would open up to veterans in health care, life sciences, business services, education, and manufacturing. Veteran participation is currently low in SMEs they cannot and will not bear the cost of changing their hiring practices to draw in veterans if the program is short-term.
- Congress must ensure that DoD implement effective processes to share IED and blast trauma related medical research and data with VA, other federal agencies, and appropriate non-governmental organizations or entities.

- Congress must ensure that VA implement 508 compliance for all electronic information technology and that it set timelines for changes. Emphasis must be placed on funding and staffing.

Congress should revisit the issue of ensuring that VHA provided medical educational conferences to meet recruitment, retention, licensure, certification, and professional development necessary for well qualified VHA work force are done in cost effective method without eliminating these vital conferences.

Mr. Sam Huhn, National President, BVA

INTRODUCTION

Chairman Sanders, Chairman Miller, Ranking Members Senator Burr and Michaud, and other Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) and its

membership, we appreciate this invitation to present our legislative priorities for 2013. BVA is the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. On March 28 of this year, the Association will turn 68 years old. As an increasing number of wounded service members continue to return from Operation Enduring Freedom, Afghanistan (OEF) after more than ten years of war, a new generation of the seriously eye injured is being added to the decades of combat wounded from previous wars and from the recently ended Operation Iraq Freedom (OIF) and Operation New Dawn (OND).

Improvised Explosive Device (IED) survivors face challenges ranging from the minor to the monumental: fractures, amputations, disfigurement, cognitive and motor impairments, emboli, headaches, personality changes, visual and auditory disturbances, altered effect, hypersensitivities, and dulled judgment. The mortality from blast violence has been reduced by the rapid frontline trauma interventions and rapid evacuation, but blast injuries by their nature usually include vision injuries, hearing loss, and brain trauma. Large numbers of the wounded returning home will need years of neurological, psychological, and ophthalmological long term 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, M.D., Ph.D. Dr. Subramanian, now an Associate Professor of neuro-ophthalmology at Wilmer Eye Institute, spent several years on staff at Walter Reed Army Medical Center in Washington, D.C., where he managed several polytrauma wounded warriors who had sustained serious head and eye combat injuries in OIF or OEF as a result of IEDs.

"Stop the bleeding, keep them breathing" is a key to saving a life on the battlefield, especially at a time in history when so many are being saved**.** For troops who sustain multiple injuries, a sober logic governs the sequence of interventions: "In combat theater, surgeons apply the '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. "Many would arrive at Walter Reed in severe shock because of blood loss or a closed head injury."

As survival occurs more than ever before amid multiple injuries, the establishment of the Vision Center of Excellence (VCE) for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries (authorized by the Fiscal Year 2008 National Defense Authorization Act, Public Law 100-180, Section 1623) becomes more vital. The Hearing Center of Excellence (HCE) and Traumatic Extremity and Amputation Center of Excellence (EACE) were mandated in the FY 2009 National Defense Authorization Act (Public Law 110-417). Congress established these three centers of excellence with the intention that they be joint Department of Defense (DoD) and Department of Veterans Affairs (VA) programs. Their purpose was to improve the care of wounded or injured service members and veterans affected by combat eye, hearing, and limb extremity/amputee trauma, and to improve clinical coordination between DOD and VA for the treatment of wounded service members suffering from these specialized kinds of injuries. These centers are also tasked with developing joint clinical registries containing up-to-date information on the diagnosis, treatment, vision research, and outcomes for the injuries. Unfortunately, these registries are still not fully functional even after being mandated more than three years ago.

Despite a legislative mandate and Secretary William Gates' inclusion of these three centers as a top priority in the February 2010 Quadrennial Defense Report (QDR), bureaucratic problems, limited oversight, some initial confusion over governance, and limited budgets have all hindered significant progress toward the establishment of the VCE, HCE, and EACE. Although the VCE has a DoD Director, a VA Deputy Director, and 13 other full-time staff appointed to support it, a majority of the current staff is DoD contract personnel and only three are VA personnel. Compounding the organizational challenges is recently news that VCE Director Colonel Don Gagliano, M.D., was informed that on March 30, 2013 he is facing mandatory retirement at a critical juncture in the operational establishment of the VCE. Rather than extend his active duty orders for two years so that he can continue to direct the VCE, DoD has decided to retire him and not allow a waiver for him to remain on active duty. Of note also is that the HCE and EACE

are still lacking full-time VA personnel, thus hampering their key missions and the meeting of their mandated objectives.

The DoD Armed Forces Surveillance Center report of May 2011, **Eye Injuries, Active Component, U.S. Armed Force, 2000-2010** indicates that during an 11-year surveillance period there were 186,555 eye injuries worldwide in the military medical facilities within its data. VA also notes that of the OEF/OIF/OND veterans diagnosed with eye conditions, including visual problems as a result of a Traumatic Brain Injury (TBI), upwards of 75 percent of them experience short- or long-term visual dysfunction, including double vision, sensitivity to light, and inability to read print, among other cognitive problems. The total number of veterans with TBI visual disturbances was 37,376. Some moderate to severe eye-injured OIF and OEF service members have not always been centrally tracked, making the implementation of the Defense Veterans Eye Injury Vision Registry (DVEIVR) extremely critical to improve coordination of care and ensure access to the full continuum of VA Eye Care Services, Blind Rehabilitation Service (BRS), and Low-Vision outpatient programs that these committees have helped establish over the years.

We draw attention to the overall cost impact of these eye injuries from OIF and OEF. In May 2012, the National Alliance Eye Vision Research (NAEVR) released its first-ever **Cost of Military Eye Injury and Blindness study**, prepared by Kevin Frick, Ph.D. (Johns Hopkins Bloomberg School of Public Health). Based on published data from 2000 to 2010 and recognizing a range of injuries from superficial to bilateral blindness, as well as visual dysfunction from TBI, the annual incident cost has been $2.3 billion, yielding a total cost to the economy over this timeframe of $25.1 billion–a large portion of which is the present value of future costs such as VA and Social Security benefits, lost wages, and family care.

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 them 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.

PEER REVIEWED MEDICAL RESEARCH AND RESEARCH FUNDING

BVA, along with nine other Veterans Service Organizations, signed a joint letter supporting the programmatic request to continue directed funding in FY 2014 for the **Peer Reviewed Medical Research-Vision (PRMR-Vision Trauma Research Program) extramural research line item.** The request is for $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, the level of funding was $3.75 million while in FY 2011 it was at $4 million even. Then, in FY 2012, it was even less at only $3.2 million, making eye injuries one of the lowest funded of all deployment injuries funded by the CDMRP. This resulted in a lack of funding for several eye trauma research grants. Defense-related vision trauma research warrants a more vigorous investment, especially since Secretary of Defense Panetta identified research into Deployment Sensory Injury –Vision and Hearing Injury requesting $14,790,000 as level for research funding in response to a question from Senator Durbin at a June 13, 2012 Senate Appropriations Committee hearing.

Today, battlefield conditions have resulted in a high percentage of penetrating eye injuries and TBI-related visual system dysfunction among those wounded/evacuated due to IED blast forces. With the continued presence of the U.S. in Afghanistan, coupled with other global threats, eye injuries will continue to be a challenge. 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. We stress the following numbers as we have in the past: 4,970 moderate-to-severe penetrating combat eye injuries, 10,458 retinal and choroidal hemorrhage injuries (including retinal detachment), 2,593 optic nerve injuries, and 6,926 corneal eye injuries.

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. In light of the data above, research within defense appropriations must be increased for the Vision Trauma Research Program (VTRP) within the Congressionally Directed Medical Research Program (CDMRP). We appreciated the bipartisan support last July 17 of Congressman Tim Walz (D. MN.) in an amendment supported by Congressman Jim Moran (D. VA.) to provide an additional $5 million to the VTRP level approved by the House Appropriations Committee-Defense of $5 million--for total of $10 million for FY 2013. We request that his level be kept in the final FY 2013 appropriations.

We point out that translational deployment eye injury research provides combat surgeons with new treatments that will preserve vision. A PRMR-Vision line item 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 (NIH) and is not done within VA Research and Development. This is unlike other CDMRP research for various cancer and general medical conditions in which there are many other sources of private foundations and over 40 large cancer state funded centers. DoD does engage representatives of VA and the National Eye Institute (NEI) in programmatic review of the vision trauma research grants it receives. For FY 2012, more than 25 eye trauma research grants could not be funded because of the limited CDMRP of $3.2 million for vision research—all despite the identification by DoD of research gaps in both eye trauma and TBI vision programmatic research that must be filled.

SHARING OF BLAST TRAUMA RESEARCH AND IED EVENT DATA

Members of this Committee were among a strongly bi-partisan group of 92 Members of Congress, including those who signed a letter last June to President Obama coordinated by the Global Campaign against IEDs. The letter called on VA and DoD to develop a strategy that partnered with Veterans Service Organizations and other appropriate entities to identify the long-term physical and psychological-social effects of IED related injuries. It also asked DoD to share blast related medical research findings with appropriate other federal agencies and with university researchers investigating such injuries. Today, blast trauma related medical research is being conducted by the DoD. Lamentably, it is not shared with VA researchers using the excuse it is all classified data. This refusal to share information adversely impacts the development of treatments needed for our veterans of all eras.
BVA learned from partnering with the Global Campaign against Improvised Explosive Devices that IED casualties for our service members and veterans date back to all of our nation's conflicts. Although a significant number occurred in Vietnam, incidents in Afghanistan and Iraq have become more widely known. IEDs are the number one cause of casualties for our military forces. This is very likely to continue in all conflicts for the foreseeable future. While the number killed in action by IEDs has decreased in recent years, the number wounded who must live with the physical and psychological scars, either on active duty or as veterans, is both greater and ever increasing. With or without physical wounds, IEDs have a severe psychological impact, contributing to PTSD and then playing a major contributing role in active duty and veteran suicides.

TRAUMATIC BRAIN INJURY VISION SYSTEM DYSFUNCTION

The following figures, provided by the Defense Veterans Brain Injury Center, represent numbers of medical diagnoses of TBI collected from around the world from 2000 to the third quarter of FY 2012.[9]

Penetrating	4,174
Severe	2,663
Moderate	45,676
Mild	200,076
Not Classifiable	9,476
Total - All Severities	**262,065**

Concussion/Mild TBI is characterized by the following**:** A confused or disoriented state which lasts less than 24 hours; loss of consciousness for up to 30 minutes; memory loss lasting less than 24 hours; and structural brain imaging (MRI or CT scan) yielding normal results. **Moderate TBI** is characterized by the following**:** A confused or disoriented state which lasts more than 24 hours; loss of consciousness for more

than 30 minutes, but less than 24 hours; memory loss lasting greater than 24 hours but less than seven days; and structural brain imaging yielding normal or abnormal results. **Severe TBI** is characterized by the following**:** A confused or disoriented state which lasts more than 24 hours; loss of consciousness for more than 24 hours; memory loss for more than seven days; and structural brain imaging yielding normal or abnormal results. **Penetrating TBI** is characterized by the following: A head injury in which the dura mater, the outer layer of the meninges, is penetrated.

In the past year in Afghanistan, IED blasts caused 78 percent of all battle injuries but, in Iraq, the same blasts caused 84 percent of all eye injuries. With increased visual screenings, VA providers are diagnosing increasingly higher numbers of vision system dysfunction and impairments from IED blasts. Although TBIs rarely result in legal blindness, researchers have found rising numbers of TBI cases with visual system dysfunction. The four VA Polytrauma Centers in Palo Alto, Richmond, Minneapolis, and Tampa have all reported that 70 percent of all TBI patients have complained of visual symptoms related to the blast exposure they experienced. VA found that 2,593 enrolled OIF/OEF veterans had ICD-9 code with disorders of the optic nerve and visual pathways related to TBI. 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. VA found the following visual complications diagnosed in OIF/OEF veterans: corneal damage, 6,926; traumatic cataracts, 13,293; angle recession glaucoma, 16.204; retinal injury, 10,458. These complications now found in young service members are especially alarming. We stress that these veterans are at high risk of progressive visual impairments if not diagnosed and treated early and then closely followed for decades.

BVA requests that efforts continue to improve the continuing education on the importance of visual screening, treatment, and rehabilitation of these visual complications. Servicemembers who have mild, moderate, or severe TBI with visual system impairment, or a penetrating eye injury, must be tracked in the Defense Veterans Eye vision Injury Registry, 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.

DOD-VA HEARING CENTER OF EXCELLENCE

During present-day combat, a single exposure to the impulse noise of an IED can cause immediate noise-induced 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. 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 223,000 OIF and OEF service members and veterans are service-connected for tinnitus and some 187,000 have various levels of hearing loss.

The HCE has a staff of two Air Force officers assigned in San Antonio's Wilford Hall. There is no full- time VA staffing. Two other problems are low programmatic line item funding and a clear lack of governance from the Health Executive Council and Joint Executive Council. We point to the GAO 11-114, January 31, 2011 Report that 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. The invisible wounds of hearing and visual impairments do not seem to result in equal budgets for the deployment of the trauma research that results for other injuries. Hearing deployment trauma research, for example, has had virtually no line item in the CDMRP for research.

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 2016. 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).

SECTION 508 VA INFORMATION TECHNOLOGY COMPLIANCE

Section 508 of the Rehabilitation Act requires federal agencies to ensure that all electronic and information technology developed, procured, maintained, or used in the federal environment provide equal access for federal employees and members of the public. The 2012 Department of Justice (DOJ) report identifies continued challenges with Section 508 implementation and management. The report makes recommendations for training, policy, and better collaboration. The DOJ Section 508 compliance survey completed in the summer of 2012, however, found widespread problems and lack of accessible electronic and information technology at federal sites.

BVA has repeatedly requested in its annual resolutions that VA IT be compliant with Section 508 of the Americans with Disabilities Act. We appreciate the fact that both of these committees have requested VA briefings and required updates on the status of its efforts to comply with 508 Access. This problem of lack of compliance, however, has still not been fixed either in Veterans Health Administration or the Veterans Benefits Administration and 184 IT program barriers were found in 2012 testing. 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 that Congress continue its strong oversight to ensure that VA adequately funds its Information Technology programs and meets timelines for fixing the inaccessible websites. We are concerned that the progress being made on electronic and information technology program timelines for implementing changes could be disrupted with the departure of VA Assistant Secretary for Information and Technology/Chief Information Officer Roger Baker. In the past year BVA appreciates that Mr. Baker has made these timelines for change an internal priority and has dedicated more personnel, funding, and contractor support to fix these long standing problems. We ask congressional members to continue strong oversight of the EIT system and insist that VA meet its obligations to comply with Section 508 compliance in all internet programs.

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 Veterans Integrated Service Network (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 new 113th Congress, ensuring that VHA cover such travel costs by changing Title 38 Section 111 to require VA to provide transportation costs for travel by airfare, train, or bus or other methods to a special rehabilitation program serving blinded veterans or the spinal cord injured for either inpatient or HOPTEL program medical care.

BVA thanks Senator Jon Tester for introducing S. 1755 and the Senate Committee on Veterans Affairs for including the bill in the hearing last June 27. We request that this vital legislation be introduced again. We also express appreciation to Congressman Mike Michaud for introducing H.R. 3687, the companion House bill legislation for disabled spinal cord injured and blinded veterans who are currently ineligible for travel benefits. This bill would assist low-income and disabled veterans by removing the financially burdensome travel expenses needed to access vital care that improve independence and quality of life.

It makes little sense to have developed, over the past decade, outstanding blind rehabilitation services with high quality inpatient and outpatient specialized training, only to tell catastrophically disabled blinded or SCI 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. 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 25 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. States and private agencies are not the answer either since they do not usually 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. We question why Congress would consider enacting legislation to require VA to fund grants to service dog and guide dog programs at a cost of $30,000 per dog but refuse to provide a blinded veteran, who needs rehabilitation training to learn the skills to live independently at home, a $350 airline ticket to get to a BRC.

FUNDING VHA BLIND REHABILITATION SERVICE

Integrated among OIF and OEF veterans with eye injuries is an aging veteran population that can be characterized by a growing prevalence of age-related degenerative visual impairments. This group constitutes one of the major challenges of 2014 and far beyond. During FY 2011, there were 50,304 blinded veterans enrolled in BRS with care. VA research studies estimate that there are 156,854 legally blinded veterans. Epidemiological projections indicate that there are another 1,160,407 low-vision impaired veterans in the United States with visual acuity of 20/70 or worse. Considering the large number of veterans who may seek these services, making certain that each VA VISN Director continues to fully fund BRCs must necessarily be 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.

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, radiology support services, along with the subspecialty surgery specialists, to provide the clinical care necessary for the newly complex psychological trauma of the war wounded 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). 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.

VISUAL IMPAIRMENT SERVICES TEAMS AND BLIND REHABILITATION OUTPATIENT SPECIALISTS

The Visual Impairment Service Team (VIST) system now employs 123 full-time Coordinators and 38 who work part-time. VIST Coordinators nationwide serve as the critical key case managers. There are also 81 full-time Blind Rehabilitation Outpatient Specialists (BROS). As state governments slash social services budgets, additional blind and low-vision veterans could be drawn into the VA 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.

Congress included a provision in the Caregiver Act (S. 1963) passed in May 2010 that VA be required to develop a scholarship program for prospective BROS, thanks in large part to the efforts of Senator Sherrod Brown. The program has still not been fully implemented although VHA continues to administer identical scholarship programs for other allied health occupations. We ask Congress to request a timetable for the BROS scholarship program. Developing candidates for these positions would assist VA in delivering, to a much greater extent, more accessible, cost-effective, and top-quality outpatient blind rehabilitation services. BVA and other endorsers of VSOIB FY 2014 that to strengthen the ability of VHA to recruit and retain VHA health care professionals they must have access to Continuing Medical Education CME conferences and updates on emerging research and professional development education to meet licensure and certification standards.

While we agree with the need for oversight to prevent wasteful spending as a result of recent scrutiny of extremely large VA conferences involving thousands VA employees, we find troubling the recent drastic cuts to all professional medical conferences and outright cancellation of nearly all VA medical CEU conferences. The annual 185-participant VIST and BROS conference, previously an annual event, is now permanently canceled, making it impossible for staff to earn the educational credit hours necessary to improve their performance. Further, VA has created complex and bureaucratic administrative processes in their internal reviews by several layers. For any conference, there is an arbitrary limitation of attendance to not exceed 50 employees. Vital joint DoD and VHA medical conferences on subjects such as TBI, vision and spinal cord injury rehabilitation, prosthetics research, and audiology have all been canceled. VA has even canceled travel to non-VA sponsored professional medical or academy association conferences for physicians. We ask Congress to revisit this issue and request a more balanced approach. Please investigate what can be done to reverse this by determining the types of training programs and meetings that will be most effective in supporting employee professional development.

CONVERSION OF EYE TECHNICIANS WITHIN VA TO TITLE 38 USC, EMPLOYMENT STATUS

BVA was supportive of the section in the Caregivers and Veterans Omnibus Health Services Act (Public Law 111-163) that provided VA with the authority to extend Title 38 USC employment status to certain employees within VHA. Since enactment of the law in May 2010, VHA has worked to convert eye technicians from their current non-specific health technician status into a Title 38 hybrid series specific for them. This has been done to improve VA recruitment and retention of these qualified technicians. Unfortunately, the process has taken far longer than expected.

As discussed elsewhere in this testimony, with the current aging population of veterans with the degenerative eye diseases of macular degeneration, glaucoma, diabetic retinopathy, and cataracts, eye technicians have a cost effective impact on improving VA Eye Clinic access for care and reducing waiting times. The eye care workload within the VA system for FY 2011 was 1,526,000 veteran encounters, an increase of 73 percent since FY 2001.[22] The demand is expected to continue to rise with both the aging population of veterans and the younger OIF and OEF veterans needing eye care services. VA ophthalmology providers have reported that just the loss of one eye technician in a busy clinic can negatively impact 1,300 veteran visits in that clinic. We understand that Under Secretary for Health Dr. Robert Petzel signed a memorandum of approval on June 6 of last year asking that Title 38 change the status of these eye technicians. The memorandum is still pending approval in Human Resources. We ask

Members of the Committee that authorized this change for eye technicians to demand a timetable for approval to avoid further retention problems for these VA eye clinic employees.

WORK OPPORTUNITY TAX CREDIT (WOTC)

In August 2011, about three million U.S. veterans, or 14 percent of the total number worldwide, reported having a service-connected disability. The number could be higher since some veterans did not report at all. Veterans with a service-connected disability are assigned a disability rating by VA or DoD. Ratings range from 0 to 100 percent, in increments of 10 percentage points, depending on the severity of the condition (see Table 6.)

Among veterans with a service-connected disability, about 4 in 10 reported a disability rating of less than 30 percent, while about 3 in 10 had a rating of 60 percent or higher. At that same time, 60.3 percent of veterans with a service-connected disability rating of less than 30 percent were in the labor force, compared with 26.6 percent for those with a rating of 60 percent or higher.

In 1981, the first tax credit for private employers who hire veterans and other chronically unemployed workers was signed into law by President Reagan. Because higher unemployment is the lot of persons with an actual or perceived deficiency, such as a disability or a perception of having few civilian skills, these individuals have less chance than the average worker of being hired. This lack equality of opportunity in the labor market is an affront to our country's founding principles and explains why Congress enacted a hiring incentive to increase job opportunities for veterans, the disabled, and others unable to find jobs in good times and in bad times.

In designing the present-day Work Opportunity Tax Credit (WOTC), Congress took steps to ensure that the credit functioned through the private marketplace, where workers could be regular employees at regular wages and have the same opportunity as others to learn and advance. Congress also capped its contribution to the labor cost of each new hire, so the Treasury loses no more than approximately $1,100 per hire on average, according to Joint Committee on Taxation data—the lowest cost of any Federal jobs program; the employer pays the remainder of compensation for the entire duration of the job. Congress also mandated that each worker's status as a veteran or other target group be certified by the State Workforce Agency upon valid documentation and verified by IRS during audits. Because of these safeguards, there has never been a significant instance of fraud or abuse in WOTC.

In Fiscal Year 2011, the last year for which data is available, WOTC resulted in 1,160,523 jobs for members of all target groups, of which welfare and food stamp recipients comprised the largest. Of these nearly 1.2 million WOTC jobs, Department of Labor statistics show veterans accounted for a total of 17,712, of which 3,117 were disabled veterans. As in past wars, recently returning veterans suffer the highest unemployment rates—as of December 2012, of the 2.5 million Gulf War Era II veterans (those who served from 9/11 to the present), 1,874,000 were employed and 226,000 unemployed, with an unemployment rate of 10.8 percent. Of these unemployed, 180,000 are men with an unemployment rate of 9.9 percent and 46,000 are women with an unemployment rate of 15.7 percent. Clearly, women veterans who want to work are having serious difficulty finding jobs.

Moreover, between the end of 2011 and 2012, 200,000 post 9/11 veterans were released and almost all entered the workforce. The prospect is for this number to accelerate due to withdrawal from Afghanistan and budgetary stringency at DoD. As a minimum, it is estimated that 300,000 more of these veterans will be added this year. Therefore, the challenge of employing them is growing. In 2011, President Obama recommended and Congress amended WOTC in the VOW To Hire Heroes Act to increase the benefit for unemployed veterans, with the largest benefit of $9,600 for hiring a disabled veteran. We therefore expect to see improvement in veterans hiring in the 2012 data.

Small and medium-sized enterprises (SMEs) are not participating in WOTC because the program will expire at the end of the year. If WOTC were made permanent, promoted to SMEs, and expanded to private non-profit employers such as hospitals and colleges, a world of well-paying jobs would open up to veterans in health care, life sciences, business services, education, and manufacturing where participation is now low. At present, SMEs cannot and will not bear the cost of changing their hiring practices to draw in veterans if the program is short-term.

CHAINED CPI'S NEGATIVE IMPACT ON DISABLED VETERANS

BVA and several other Veterans and Military Service Organizations are opposed to recent proposals that a "Chained Consumer Price Index" be used for determining yearly inflationary costs instead of the usual CPI for the disabled veteran Cost of Living Adjustment (COLA). The chained CPI, which many describe as a very minor change, would alter the method by which inflation is measured. It would reduce Social Security and VA disability benefits by cutting the annual COLA. It would also increase taxes by slowing the rate at which tax brackets rise.

The "Chained CPI" has been on the table in deficit reduction talks for months. BVA opposes it for the following reasons:

- **Social Security is the largest program serving veterans and their families.**

- **The chained CPI will be a double benefit cut for veterans who receive both Social Security and VA benefits. More than** nine million, mostly elderly, veterans receive Social Security benefits. This amounts to four in ten veterans. By contrast, in 2010, 4.1 million veterans received VA benefits. The exact number of veteran Social Security beneficiaries that also receive VA benefits is unknown but 771,000 of the veterans receiving Social Security benefits are receiving disability benefits.

- **VA benefits are already modest.** There are two principal VA benefits programs that go to veterans: disability compensation and pension benefits. The former are for veterans with service-connected disabilities, and the latter are for non-service-connected disabled veterans or elderly veterans with income below the poverty level. In 2011, poor senior veterans received $11,830 in annual pension benefits in 2011.

- **A veteran with average earnings who retires at age 65 would get a benefit cut of $577 at age 75 and $1,006 at age 85**. A 100 percent service connected 30-year-old OIF disabled veteran will have his/her benefit reduced by $1,376 at age 45, $1,821 at age 55, and $2,260 at age 65 under chained CPI.

- **For the currently elderly, disabled, nonservice-connected veterans living on Social Security, in increases in annual health care inflation and increased co-payments for Medicare premiums and medications must be factored into the equation**. The resulting chained CPI reductions would force them to live below poverty levels in their remaining years of life. For 313,000 elderly veterans living on small VA pensions, for widows of veterans, and for service-connected veterans, the chained CPI is the wrong way to deal with the problem.

BVA contends that Social Security and VA benefits should be based on a formula that takes into account these higher health care costs. This formula, developed by the Bureau of Labor Statistics, is called the CPI-E. The CPI-E rises at a slightly faster rate than the formula currently used to calculate the COLA and the proposed chained CPI, providing a modestly more generous COLA for seniors and people with disabilities.

BVA and other Veterans Service Organizations and Military Service Organizations ask that members of this Committee weigh into the debate and find alternative methods to fix the budget problems beyond that of balancing them onto our elderly, service-connected disabled veterans, or on veterans' widows who already suffer because of the long standing Survivor Benefits Plan and Dependency and Indemnity Compensation offset.

GUIDE DOG AND SERVICE DOG POLICY

BVA has perhaps more experience with guide dogs than most Veterans Service Organizations or Military Service Organizations. For 67 years, BVA has worked with both VA and the original guide dog training programs to ensure that any blinded veteran who wishes to have a guide dog can obtain one for free! 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 guide dog.

Suddenly, however, about three years ago, DoD, VA, and Congress were inundated with information that blinded and severely injured veterans were being charged upwards of $25,000-$35,000 for service dogs and guide dogs. The inaccurate news was set in motion when families and organizations associated with OIF/OEF veterans reported they were unable to pay that amount of money for a service or therapy dog and began inquiring about the possibility of VA providing a dog to any disabled veteran with a physical or mental health condition. The implication was that Congress appropriate funds for these service dogs. The demands grew rapidly for expansion of this benefit, which would come from VA Prosthetics. Calls for VA to cover the costs of service dogs, guide dogs, and therapy dogs became commonplace.

Members of Congress must understand that the private sector is virtually unregulated and that 49 states, California being the exception, have no state laws concerning licensure, nor are there certification requirements for instructors or trainers. BVA contends that while there are some who try to point to the voluntary 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 programs. ADA rules are only about public access to facilities for the disabled with a marked "service animal." The statute is silent on state licensure, national accreditation, or certification for these service dog programs.

On the website of the International Association of Assistance Dogs Partners (IAADP) is the following statement: "CERTIFICATION is not required in the USA." Most states therefore lack programs to establish licensure standards. The Department of Justice decided to foster "an honor system," making 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 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. We see that VA is now caught, forced to develop service dog regulations and provide, through Prosthetics Services, all future costs associated with providing service animals. While many Members of Congress point out that there is no funding for other programs, they are still willing to commit $15 million for service dogs over the next five years. Physicians and nurses have absolutely no academic university training in service dogs or guide dogs and no ophthalmology residency program provides even one hour of course training on guide dogs. Who then decides if a veteran should have any kind of service animal—only the veteran and the service animal provider?

Some service dogs are being trained in six weeks while the well-established guide dog programs have averaged well over 120 hours of training over a nine-month period. The programs with a long and proven history will match the guide dog with a veteran's lifestyle, activity, occupation, and family needs. Some current advertising on the Internet indicates that a service dog costs $35,000. It also indicates that a certificate of compliance with Americans with Disabilities Act access standards is sufficient proof that the dog has been adequately and thoroughly trained. 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 service or guide dog that is insufficiently trained, placing them in great danger in a host of situations.

We strongly caution Members of this Committee to reassess this situation for the protection of disabled veterans, the strong potential risk of fraud, misleading advertising, and VA liability for large future expenditures. Please consider also the current lack of state licensure and certification standards 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 that our views be heard in any future hearings on this issue.

CONCLUSION

Once again, Chairman Sanders, Chairman Miller, and all Members, BVA thanks you for your efforts on behalf of all veterans and their families. 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

- Congress must ensure that the full establishment of 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. We request oversight hearings on the three DoD-VA Centers for Vision, Hearing, and Limb Extremity.

- BVA supports research funding through the dedicated Peer Reviewed Medical Research-Vision Trauma Research Program be a line item in DoD's Congressionally Directed Medical Research Program funding $10 million in FY 2014 defense appropriations to meet the demands.

- Guide Dogs for blinded veterans have been provided free for decades. BVA cautions that credentialing, certification, licensure, and lack of industry standards for training service dogs and therapy dogs could result in veterans receiving unqualified service dogs. Authorizing VA to grant payments of $35,000 to these programs will add substantially to VA prosthetics budgets and increase the risk of fraud.

- 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 travel for disabled veterans determined to benefit from specialized rehabilitation services.

- If the Work Opportunity Tax Credit (WOTC) were made permanent and then expanded to cover Small and Medium-sized Enterprises (SMEs) and even private non-profit employers such as hospitals and colleges, a world of well-paying jobs would open up to veterans in health care, life sciences, business services, education, and manufacturing. Veteran participation is currently low in SMEs they cannot and will not bear the cost of changing their hiring practices to draw in veterans if the program is short-term.
- Congress must ensure that DoD implement effective processes to share IED and blast trauma related medical research and data with VA, other federal agencies, and appropriate non-governmental organizations or entities.

- Congress must ensure that VA implement 508 compliance for all electronic information technology and that it set timelines for changes. Emphasis must be placed on funding and staffing.

Congress should revisit the issue of ensuring that VHA provided medical educational conferences to meet recruitment, retention, licensure, certification, and professional development necessary for well qualified VHA work force are done in cost effective method without eliminating these vital conferences.