



**TESTIMONY  
PRESENTED BY**

**Thomas A. Zampieri, Ph.D.  
BVA NATIONAL PRESIDENT**

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



**February 26, 2020**

## INTRODUCTION

Chairman Moran, Chairman Takano, Ranking Member Tester, Ranking Member Roe, and distinguished Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) – and its membership – we appreciate this opportunity to present our legislative priorities for 2020. As the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our nation’s blinded veterans – and their families – BVA would like to highlight that “National Blind Veterans Day” occurs March 28, 2020 and marks the 75th anniversary of our organizations founding by World War II blinded army servicemembers at Old Avon Farms Convalescent Center in Connecticut.

It is our hope that this second session of the 116th Congress will proactively address the following critically important issues:

- I. Ensure that the Department of Veterans Affairs (VA) implements caregiver benefits for catastrophically disabled veterans of “ALL” war eras – mandating that eligibility criteria be inclusive of caregivers for blinded veterans;
- II. Enact H.R. 3504 modernizing VA’s Specially Adapted Housing (SAH) grant program – mandating eligibility criteria be inclusive of legally blind veterans;
- III. Enact H.R. 1199 mandating VA’s compliance with website accessibility as required by Section 508 of the Rehabilitation Act (29 United States Code §794d), as amended by the Workforce Investment Act of 1998 (Public Law 105-220);
- IV. Enact H.R. 4589 making permanent the authority of VA’s Secretary to award grants for the transportation of highly rural veterans to medical care;
- V. We support and urge swift Senate passage of H.R. 4920 continuing VA contracting with AbilityOne® programs that employ blinded and visually impaired veterans;
- VI. We support adequate funding of Veterans Health Administration (VHA) Blind Rehabilitation Services (BRS);
- VII. We support improving programs and services for women veterans;
- VIII. We support Fiscal Year 2021 (FY21) appropriations of \$30 million for the Department of Defense (DoD) Congressionally Directed Medical Research Program (CDMRP) Vision Research Program (VRP) strengthening the “ONLY” research program focused on prevention and treatment of combat-related ocular trauma and Traumatic Brain Injury (TBI) visual dysfunction;
- IX. We call upon Congress, VA, and DoD to request that the Assistant Secretary of Defense for Health Affairs (ASDHA) – working with our United Kingdom (UK) Defence Medical colleagues, Universities, and non-profit associations – to sign a five-year agreement establishing a Joint International Ocular Trauma Task Force;
- X. We urge Congress to mandate DoD Defense Health Agency (DHA) compliance with Section 703 of the National Defense Authorization Act (Public Law 114-328) for (FY17) requesting the designation of four ocular trauma centers.

### I. EXTENSION OF VA BENEFITS TO CAREGIVERS OF VETERANS FOR ALL WAR ERAS

Caregivers are the most important component of rehabilitation and maintenance for veterans with catastrophic injuries. While the Department of Veterans Affairs (VA) provides essential health care services to severely disabled veterans, for many it is caregivers who provide the day-to-day services and

support needed to sustain their well-being. The welfare of caregivers has a direct impact on the quality of care veterans receive and the quality of life they can sustain. Title 1 of Public Law 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, required VA to create a caregiver-support program for those veterans catastrophically injured as a result of their service. Currently, some 19,000 Post-9/11 era veterans access these services. In the years to come, as the VA MISSION Act provisions are enacted, an estimated 90,000 veterans are likely to begin utilizing these services.<sup>1</sup>

The task before VA is monumental. The Caregiver Support Program must correct current flaws while preparing to meet and serve a larger, older population of veterans that – in addition to their service-connected disabilities – have age-related conditions as well.<sup>2</sup> One of the factors that most commonly leads people over the age of 65 to seek admission into nursing homes is blindness. Such admissions are sought based on a false assumption that nursing homes are the only place where blind persons can obtain the support and assistance they need. However, there is ample evidence to indicate that paying for nursing home care is neither cost-effective for VA, nor in the best interest of most veterans. Rather, many such veterans can and should age in place, supported by one or more caregivers. VA support for these caregivers would require a fraction of the cost of nursing home care. The Blinded Veterans Association (BVA) concurs with the discussion and recommendations on this issue contained in the Independent Budget Veterans Service Organizations (IBVSO) for 2019.

Further, we caution members of Congress and VA officials to ensure that the measures in Public Law 161-163, which purport to expand benefits to caregivers of veterans who served in conflicts prior to 9/11, do not inadvertently deny some veterans access to this more cost-effective and quality-of-life enhancing alternative. By utilizing eligibility determination tools that result in inaccurate characterization of the catastrophic impact vision loss has on a veteran's life, these measures deny caregivers much needed benefits. As VA begins the phasing-in of these benefits to veterans of all eras, we urge members of the House and Senate Veterans' Affairs Committees to ensure that VA's implementing regulations do not define eligibility in a manner that measures need based exclusively on a veteran's ability to perform activities of daily living (ADL) involving non-sensory physical tasks, such as feeding and grooming oneself.

After a comprehensive review in 2017 and the issuance of Veterans Health Administration (VHA) Directive 1152(1), "Caregiver Support Program," the Independent Budget Veterans Service Organizations (IBVSOs) believe VHA has made consistent improvements, but BVA rejects any assessments based on ADL criteria alone, as they do not provide adequate means to measure the impact of "sensory disabilities."<sup>3</sup> Any VHA policy made to expand benefits for caregivers must be implemented in a manner that recognizes that "catastrophic disabilities" substantially affect a range of life activities – including neuro-sensory and cognitive functions – and fairly evaluates eligibility based on the severity of the disability and a veteran's demonstrated need for caregiver support.

## **II. MODERNIZING VA SPECIALLY ADAPTED HOUSING GRANT ELIGIBILITY FOR BLINDED VETERANS**

The Blinded Veterans Association (BVA) thanks Congresswoman Luria – and the House Veterans Affairs Committee (HVAC) – for passing H.R. 3504, the "Ryan Kules Specially Adaptive Housing Improvement

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<sup>1</sup> <http://www.independentbudget.org/pdf/funding.pdf> pg. 6

<sup>2</sup> <http://www.independentbudget.org/116-congress/> pg. 26

<sup>3</sup> Ibid, IBVSO Caregivers pg. 37

Act,” bipartisan legislation that would expand the pool of veterans eligible to receive Department of Veterans Affairs (VA) administered Specially Adaptive Housing (SAH) grants to include blinded veterans. Current eligibility requirements mandate that a blinded veteran also suffer from the loss, or loss of use, of an additional extremity.

Section 202 of Public Law 112-154 also provides that, in addition to those veterans currently eligible for SAH under 38 United States Code § 2101(a) (see 38 Code of Federal Regulations § 3.809), veterans who served on or after September 11, 2001, and who incurred a permanent – but not necessarily total – disability “due to the loss or loss of use of one or more lower extremities – which so affects the functions of balance or propulsion as to preclude ambulating without the aid of braces, crutches, canes, or a wheelchair” are eligible for the SAH benefit. Legal blindness, by itself, was not included as a qualifying disability under the existing language. This limitation precludes blinded veterans from adapting their homes with features capable of mitigating vision loss and restoring lost independence. Modern technologies are available that would enable blinded veterans to perform many of the tasks associated with independent living. Unfortunately, these technologies are expensive, and therefore, often beyond the reach of many blinded veterans. We urge swift passage of H.R. 3504 by the Senate.

### **III. MANDATING VA COMPLIANCE WITH EFFECTIVE COMMUNICATION REQUIREMENTS**

The Blinded Veterans Association (BVA) thanks Congresswoman Luria – and the House Veterans Affairs Committee (HVAC) – for passing H.R. 1199, the “VA Website Accessibility Act of 2019,” bipartisan legislation that would direct the Department of Veterans Affairs (VA) to report to Congress regarding the accessibility of VA websites (including attached files and web-based applications) to individuals with disabilities. The report would identify websites, files, and applications that are not accessible to such individuals and include the VA’s plan to make each of them accessible.

VA currently faces a myriad of challenges on multiple fronts, and many issues compete for the attention of its leaders. Not the least of these concern the capacity of VA’s Information Technology (IT) infrastructure to meet the demands resulting from ever-changing expectations regarding communications between federal government agencies and those who utilize their programs and services. Federal agencies are now expected to make ever-increasing amounts of information accessible through a rapidly growing number of media and devices, and VA has struggled to keep up with these demands. One area in which VA has struggled the most is the area of compliance with accessibility guidelines for the design and dissemination of electronic information.

A 2012 Department of Justice (DOJ) report indicated that although Section 508 was enacted in 1998, agencies across the federal government continue to fall short when it comes to the implementation and management of compliance with this provision, and regrettably, VA is no exception. Despite this report and several years of ongoing dialogue between VA’s senior IT officers and BVA’s national leadership, numerous websites and information technologies utilized by VA remain out of compliance with the most basic accessibility guidelines. In addition, VA has repeatedly compounded this problem by introducing new technologies that are not compliant and, in some cases, allowing upgrades that remove accessibility features that were once in place.

Guidelines and best practices for digital accessibility have existed for decades. The Website Content Accessibility Guidelines (WCAG), developed by the Worldwide Web Consortium, have been accepted as

the industry standard by both the private sector and the federal government for years. It is therefore time that government agencies comply as the federal courts have ruled.

In 2013, the Office of General Counsel (OGC) advised VA that by failing to send correspondence to claimants who were known to be blind – in formats they could read – VA was in violation of its statutory obligation to “send proper notice.” The OGC went on to point out that in cases where such improper notice was given, the claim must remain open until such time as the appropriate notice was given. It was noted that this includes claims where decisions have been rendered denying the claim. The OGC stated that in such cases notice of denial was improperly given and was therefore invalid, thus subjecting VA to possible litigation for retroactive benefits. If VA fails to serve proper notice in such cases, the amount of any retroactive benefits due to an applicant may continue to compound.

Under current Veterans Benefits Administration (VBA) regulations, notice by telephone is only provided to blinded veterans who have service-connected disabilities and who have previously received a rating of 70 percent or higher. Therefore, veterans who have visual impairments rated at less than 70 percent, whether the underlying disability is service-connected or not, do not qualify to receive phone calls to alert them of actions taken on their claims, let alone notices of those actions that are sent in a format the veteran can read, such as large print.

An ongoing concern involves VA’s Training, Responsibility, Involvement, and Preparations of Claims (TRIP) portal. Several years ago, prior to its deployment, BVA made repeated requests to VA staff asking for assurance that the portal be accessible, enabling blind Veteran Service Officers (VSOs) access to the training. The portal was released by VBA in 2018 – and to date – remains inaccessible to individuals requiring adaptive screen reader technologies. As is all too often the case, this situation could have been avoided if the site’s developers had followed industry-standard accessibility guidelines. Now, barriers to access via screen readers that were inadvertently built into the website’s design cannot be readily removed without requiring a major and expensive overhaul of the entire design.

Another challenge for blinded veterans in rural regions involves VA’s reliance on telehealth initiatives for the provision of mental health services. Unfortunately, much of this technology remains inaccessible to the blind, and more than a third (36 percent) of rural veterans lack access to the Internet at home, which further constrains VA’s ability to meet their needs. Thus, the web-based technologies routinely used to monitor and educate so many veterans cannot be accessed by this cohort.<sup>4</sup>

We recommend that Congress require VA to create an Information Accessibility Officer position in every Veterans Integrated Service Network (VISN) and VBA Regional Office. These Information Accessibility Officers would serve as liaisons to VA’s 508 Compliance Office. They would also be responsible for ensuring that every disabled veteran have access – and the necessary knowledge – to use VHA and VBA documents and websites. They would also educate veterans on how to navigate VA websites and notify VA of any barriers that may limit veterans’ access to information.

In addition to the countless DOJ and VA Office of Inspector General (OIG) warnings, the recent Supreme Court decision rendered October 7, 2019 should serve as a VA wakeup call. The Court declined to hear an appeal by Domino’s Pizza seeking to overturn an order from the Ninth Circuit requiring the company

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<sup>4</sup> Ibid, VSO Independent Budget pg. 71

to make their website accessible to people who have disabilities. The case was initiated by a blind individual who could not use Domino's website to place an order using his screen-reading software. The federal court ruled in his favor, stating that just as the Americans with Disabilities Act (ADA) requires businesses to ensure that people with disabilities have access to their buildings, goods, and services, businesses must also ensure that they can use their websites.

We believe these challenges will continue until the issue of accessible communications becomes a top IT system priority for VA's entire senior leadership. Failure to do so could result in our joining with various other stakeholders in finally filing a federal lawsuit forcing VA compliance. We believe that by directing the VA Secretary – via implementation and strong Congressional oversight of H.R. 1199 – would provide the impetus for VA's commitment to the addressing of these issues.

The following VA 508 compliance issues remain as outstanding BVA concerns:

- Continued reliance on inaccessible kiosks at VA Medical Centers (VAMCs), the use of which are required to check in for scheduled appointments. A recent Request for Information (RFI) issued by VA failed to notify prospective vendors of 508 requirements and, when asked by vendors for clarification prior to issuance of a formal Request for Proposals (RFP), VA officials appeared to lack understanding.
- Inaccessible Telehealth tools, namely the "Health Buddy" home monitoring station.
- VBA web pages containing e-Benefits information that are inaccessible to blinded veterans who use screen readers.
- The continuing accessibility barriers faced by VA employees with visual disabilities who are forced to use legacy systems that are largely incompatible with adaptive software in order to do their jobs.
- Inadequate staffing by VA to ensure its capacity to address internal and external accessibility issues.
- Lack of an enforcement mechanism or other means of addressing compliance issues so that if equipment, hardware, software, or a website are found to be noncompliant with accessibility standards, someone follows through and addresses the issues that are identified and thereby resolves the issue.
- Recent statements by CERNER representatives announcing waiver requests in advance of VA's new Electronic Health Record (EHR) system deployment.

#### **IV. OVERCOMING TRANSPORTATION BARRIERS FOR BLINDED RURAL VETERANS**

Barriers remain a persistent problem for blinded veterans who live in rural areas and have either no or very limited options for getting to and from medical appointments. Blinded veterans cannot drive themselves and for many, finding someone to drive them presents a major and frequent barrier to keeping their medical appointments. The Veterans Travel Program (VTP) provides transportation to medical appointments at Department of Veterans Affairs (VA) Medical Centers (VAMCs) for veterans with disabilities. VTP policies must ensure that blindness is included as a medical justification for VA to authorize the use of various modes of transportation so that veterans who are blind can get to local VAMCs and receive health care services.

VA currently operates 21 VAMCs – and an additional 350 Community Based Outpatient Clinics (CBOCs) – located in rural areas. Regrettably, access to health care for rural blinded veterans remains a major problem, particularly as these veterans age, become more disabled, or lose their family caregivers. Transportation has become one of the most pressing issues for blinded rural veterans. Beneficiary travel funds reimburse eligible veterans for part of their travel expenses, but the reimbursement depends upon the veteran finding an able and available driver and vehicle.

The Blinded Veterans Association (BVA) supports H.R. 4589 and S. 2966 amending Title 38 of the United States Code, making permanent the authority of VA’s Secretary to award grants for the transportation of highly rural veterans to medical care. Presently, only 90 VAMCs support the Veterans Transportation Services (VTS) due to uncertainty regarding yearly extension of the program. Making the VTS program permanent would allow local VA facilities to hire drivers and purchase vehicles to transport veterans as needed. It would also extend a grant that allows Veterans Service Organizations (VSOs) and State Veterans Service Agencies new approaches to providing transportation and/or travel assistance.

#### **V. PROTECTING ABILITYONE® EMPLOYMENT FOR BLINDED VETERANS**

Each year, the AbilityOne® Program provides employment opportunities for more than 45,000 people who are blind or severely disabled, including more than 3,000 wounded, ill, or injured disabled veterans. The Blinded Veterans Association (BVA) knows of no targeted efforts by Service-Disabled Veteran-Owned Small Businesses (SDVOSBs) that actively recruit blinded veterans into their workforce or provide the training and adaptive technology equipment necessary to employ blinded veterans that occurs within AbilityOne® agencies.

National Veterans Benefits Administration (VBA) data continues to demonstrate that veterans with higher ratings of catastrophic disabilities experience unemployment rates of 45 percent or greater. In the year 2017, an estimated 27.0 percent (plus or minus 0.72 percentage points) of non-institutionalized persons age 21 to 64 years with a visual disability in the United States were living below the poverty level. In other words, 1.3 million out of 3.7 million non-institutionalized persons aged 21 to 64 years with a visual disability in the United States were living below the poverty level in 2017.<sup>5</sup>

BVA points to the Veteran Service Organizations Independent Budget (VSOIB) evidence on employment challenges for veterans with the highest disability ratings as being even greater. Veterans who have a disability rating of less than 30 percent were about 40 percent more likely to be engaged in the workforce than veterans with a 60 percent or higher disability rating. Only about four in every 10 veterans with a 60 percent or higher disability rating participated in the labor force in 2017. This growing labor force participation disparity exists for Post-9/11 veterans who have served on active duty since September 2001. Bureau of Labor Statistics (BLS) data showed that Post-9/11 veterans without a disability were 12 percent more likely to be in the labor force than Post-9/11 veterans with disabilities.

We recognize the “Veterans First Contracting Program” (established by the Veterans Benefits, Health Care, and Information Technology Act of 2006) and the AbilityOne® Program (established through the JWOD Act, which serves people who are blind or have significant disabilities) serve different, but complementary missions. Both programs are important to creating employment for two populations while meeting their respective objectives. Congress has repeatedly affirmed its long-standing support of

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<sup>5</sup> <http://www.disabilitystatistics.org/reports/acs.cfm?statistic=2>

the AbilityOne® Program. Continuing the existing contracts from the Department of Veterans Affairs (VA) to AbilityOne® programs ensures employment opportunities for our blinded and disabled veterans, which are critical to increasing their economic independence.

BVA supports and urges swift Senate passage of H.R 4920, strong bipartisan legislation continuing VA contracting with AbilityOne® programs that employ blinded and visually impaired veterans. This legislation would simply amend Title 38 of the United States Code providing for an exception to certain small business contracting requirements applicable to VA's procurement of certain goods and services covered under the AbilityOne® Program. In short, this legislation would ensure that one of our nation's most socio-economically disadvantaged populations of veterans isn't further harmed.

#### **VI. FUNDING VHA BLIND REHABILITATION SERVICE (BRS)**

As of August 6, 2018, 42,583 veterans were on permanent Visual Impairment Service Team (VIST) Coordinator case management lists. Veterans' Health Administration (VHA) research studies estimate that there are 131,580 legally blinded veterans in the United States population. Epidemiological projections indicate that there are another 1.5 million low-vision veterans in the United States with visual acuity of 20/70 or worse.

The Department of Veterans Affairs (VA) currently operates 13 residential Blind Rehabilitation Centers (BRCs) across the country. These BRC's provide the ideal environment in which to maximize the rehabilitation of our nation's blinded veterans. Unfortunately, Veterans Integrated Service Network (VISN) and Veterans Affairs Medical Center (VAMC) directors at some sites housing BRC's are failing to replace BRC staff who retire or transfer to other facilities, claiming limited funding to support maintenance of staffing at previous levels. As a result, some BRCs now lack the staffing to help blinded veterans acquire the essential adaptive skills they need to overcome the many social and physical challenges of blindness. Without intervention, we fear that the number of BRCs in this position will grow.

The Blinded Veterans Association (BVA) requests that Congress provide oversight into how funds allocated to VA Blind Rehabilitation Services (BRS) are being used. VHA and VISNs should be required to explain how funds are allocated within and among BRC's. These centers need directed funding to bring staffing levels up to required levels. Directors should not be allowed to divert funds designated by the Veterans Equitable Resource Allocation (VERA) System for these rehabilitation admissions from the blind centers to other general medical operations. BVA is concerned that community care funding contracted under the auspices of the VA MISSION Act will take funds away from these VA rehabilitation centers. There should be no bed closings or hiring freezes on critical blind center staff positions because facilities also need to offer veterans more community care options. We point out that VHA must maintain the current bed capacity and full staffing levels in the BRCs that existed at the time of passage of the "Veterans' Health Care Reform Act of 1996" (Public Law 104-262).

We call on Congress to conduct oversight ensuring that VA is meeting capacity requirements within the recognized systems of specialized care in accordance with Public Law 104-262 and the "Continuing appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act of 2017," (Public Law 114-223). Despite repeated warnings about these capacity problems, Congress has conducted minimal oversight on VA's ability to deliver specialized health care services.



BVA requests that if VA does contract with private agencies to provide rehabilitation training to blinded veterans, VA should ensure that the private agencies with which it contracts have a demonstrated capacity to meet the peer reviewed quality outcome measurements that are a standard part of VHA BRS. We further recommend that VA require private agencies with which it contracts to be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Impaired (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Additionally, VA should require those agencies to provide veterans with instructors who are certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

No agency should be used to train newly blinded combat veterans unless it can provide clinical outcome studies, evidence-based practice guidelines, mental health care counseling, and joint peer reviewed vision research. BVA also supports the FY19 Independent Budget Veterans Service Organizations (IBVSO) recommendation mandating that competency standards for non-VA community providers be equivalent to standards expected of VA providers, and that non-VA providers meet continuing education requirements to fill gaps in knowledge about veteran specific conditions and military culture.<sup>6</sup>

Private agencies for the blind lack the necessary full specialized nursing, physical therapy, pain management, audiology, speech pathology, pharmacy, and radiology support services that are available at VA BRCs because they are located adjacent to VAMCs. Also, most private agencies are outpatient centers located in major cities, making access for blinded veterans from rural areas difficult, if not impossible. In many rural states there are no private inpatient blind training centers at all. Therefore, the availability of an adequately funded and staffed VA BRC is the only option. These veterans should not be forced to utilize alternative facilities when VHA BRS has the capacity to ensure that they have access to a program at a facility that is adequately staffed and funded.

## **VII. ADDRESSING ISSUES FACING WOMEN VETERANS**

The Blinded Veterans Association (BVA) looks forward to working with the Department of Veterans Affairs (VA) and members of Congress to improve programs and services for women veterans. It is our hope that some of the concerns that women veterans face, which were highlighted during hearings held by Congress, will be acted upon sooner rather than later. For instance, there is a continuing need for gender-specific health care services at VA Medical Centers (VAMCs) across the country. We urge Congress to give VA the resources it needs to address these issues in a timely and comprehensive manner.

Although it is not exclusively a women's issue, Military Sexual Trauma (MST) is an issue that commonly affects women servicemembers and veterans. It is also one that has been swept under the rug for too long. We urge members of Congress to continue their vigilant monitoring of VA's handling of MST claims to ensure that they are handled with sensitivity and fairness, as well as promptness. We also support passage of H.R. 1092, the bipartisan "Servicemember and Veterans' Empowerment and Support Act of 2019," which expands the definition of MST to ensure that servicemembers and veterans who experience sexual harassment can access VA counseling and benefits. It also codifies a lower burden of proof so that more survivors are eligible for trauma and mental health care related to MST, even if they didn't feel comfortable reporting the event to their chain of command while in service.

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<sup>6</sup> <http://www.independentbudget.org/116-congress/> pg. 15

BVA fully supports the FY20 Independent Budget Veterans Service Organizations (IBVSO) section on women veterans calling for advance appropriations of \$540 million designated for gender-specific health care for women veterans. In addition to this amount, we recommend Congress direct \$75.8 million in increased funding to hire an additional 200 new physicians as designated women’s health providers; train 700 designated women’s health providers (conduct mini residencies—including a specific women’s health mini residency training program on-site for rural communities); hire 800 additional employees, to include: nurses, women veteran program managers, care coordinators (for preventative screening services such as pap smears, mammography, maternity care ,and other gender-specific services), clerks, and other support staff, to account for attrition in staff serving on women veteran’s clinical teams and continued growth and demand for services; and hire and provide specialized training for 100 women veteran peer support specialists for placement in primary care clinics and mental health care teams to assist with more complex patients and suicide prevention efforts in high-risk patients. Finally, additional resources are needed to fund expansion of successful and ongoing pilot programs, including women-only therapeutic nature retreats and child care pilots.<sup>7</sup>

#### **VIII. BVA URGES CONGRESS TO FUND THE FY21 DoD VISION RESEARCH PROGRAM (VRP) AT \$30 MILLION**

The Vision Research Program (VRP) was established by Congress in FY09 to fund impactful military-relevant vision research that has the potential to significantly improve the health care and well-being of servicemembers, veterans, their family members and caregivers, and the American public. The VRP’s program area aligns with the Sensory Systems task area of the Clinical and Rehabilitative Medicine Research Program, a core research program of the Defense Health Agency (DHA).

Eye injury and visual dysfunction resulting from battlefield trauma affects many servicemembers and veterans. Surveillance data from the Department of Defense (DoD) indicates that eye injury accounts for approximately 14.9 percent of all injuries from battlefield trauma sustained during the wars in Afghanistan and Iraq, resulting in more than 182,000 ambulatory patients and 4,000 hospitalizations between 2000 and 2011. In addition, Traumatic Brain Injury (TBI), which affects more than 413,898 servicemembers between 2000 and 2019, can have significant impact on vision – even when there is no injury to the eye.

Research sponsored by the Department of Veterans Affairs (VA) showed that as many as 75 percent of servicemembers who had suffered a TBI had visual dysfunction. The VA Office of Public Health has reported that for the period October 2001 through June 30, 2015, the total number of Operation Enduring Freedom (OEF) / Operation Iraqi Freedom (OIF) / Operation New Dawn (OND) veterans enrolled in VA with visual conditions was 211,350; including 21,513 retinal and choroid hemorrhage injuries (including retinal detachment); 5,293 optic nerve pathway disorders; 12,717 corneal conditions; and 27,880 with traumatic cataracts.<sup>8</sup> VA continues to see increased enrollment of this generation with various eye and vision disorders resulting from complications of frequent blast-related injuries.

VA data also revealed a rising number of total Post-9/11 veterans with TBI visually impaired “ICD-10 Codes” enrolled in the Veterans Health Administration (VHA) system. In FY13 there were 39,908

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<sup>7</sup> <http://www.independentbudget.org/pdf/FY22IB> pg. 7

<sup>8</sup> VHA Office of Public Health OIF/OEF/OND Veterans Medical Encounters for Disorders Eye and Vision, FY 2002 to June 30, 2015 Enrollment Code data report.

enrollees identifying with symptoms of visual disturbances, and by FY15 those numbers increased to 66,968. Based on recent data (2000-2017) compiled by the TBI Defense Veterans Brain Injury Center (DVBIC), the reported incidence of TBI without eye injury but clinical visual impairment is estimated to be 76,900.

A January 2019 Military Medicine journal article, based on a 2018 study by the Alliance for Eye and Vision Research that used prior published data during 2000-2017, has estimated that deployment-related eye injuries and blindness have cost the U.S. \$41.5 billion in that timeframe, with \$40.2 billion of that cost reflecting present value of a lifetime of long-term benefits, lost wages, and family care.

On April 3, 2019, former DHA Director Vice Adm. Raquel Bono testified before the House Subcommittee on Defense (HACD), stressing the need for “specific research programs supporting efforts in combat casualty care, Traumatic Brain Injury, psychological health, extremity injuries, burns, vision, hearing and other medical challenges that are militarily relevant and support the warfighter. This budget request proposes increased funding for battlefield injury research and establishes a permanent baseline for our mission-essential research.”

Of note, the Congressionally Directed Medical Research Program (CDMRP) appropriations that fund this critical extramural vision research into deployment-related vision trauma is not currently conducted by VA, elsewhere within DoD – including the Joint DoD/VA Vision Center of Excellence (VCE), or the National Eye Institute (NEI) within the National Institutes of Health (NIH). Additionally, DoD continues to identify gaps in its ability to treat various ocular blast injuries. Thus, this funding is critical to meeting those challenges.

In its history, the VRP has funded two types of awards: hypothesis-generating, which investigates the mechanisms of corneal and retinal protection, corneal healing, and visual dysfunction resulting from TBI; and translational/clinical research, which facilitates development of diagnostics, treatments and therapies—especially designed for rapid battlefield application. Research funded by the VRP has produced:

- 15 patents, patent applications, or provisional patents.
- 8 clinical trials funded by VRP and/or based on results of VRP-funded projects.
- 163 peer-reviewed publications in highly respected scientific journals.

VRP funding has also supported the development of:

- A portable, handheld device to analyze the pupil’s reaction to light, enabling rapid diagnosis of TBI-related visual dysfunction.
- An “ocular patch,” which is a nanotechnology-derived reversible glue that seals lacerations and perforations of the eye on the battlefield, protecting it while a soldier is transported to a more robust medical facility where trained ocular surgeons can properly suture the globe.
- A validated computational model of the human eye globe to investigate injury mechanisms of a primary blast wave from an Improvised Explosive Device (IED), which has accounted for 70 percent of the blast injuries in Iraq and Afghanistan. The model determines the stresses on and deformations to the eye globe and surrounding supporting structures to enable DoD to develop more effective eye protection strategies.

- A vision enhancement system that uses modern mobile computing and wireless technology, coupled with novel computer vision (that is, object recognition programs) and human-computer interfacing strategies, to assist visually impaired veterans undergoing vision rehabilitation to navigate, find objects of interest, and interact with people.

The Blinded Veterans Association (BVA) believes the priority in DoD research is to “Save Life, Limb, and Eyesight,” which has been the motto of military medicine for decades. Therefore, along with other Veterans Service Organizations (VSOs) and Military Service Organizations (MSOs), we respectfully request that your support of the DoD/VRP Peer Reviewed Medical Research Program for extramural translational battlefield vision research be funded in the amount of \$30 million for FY21.

#### **IX. ESTABLISHING A JOINT INTERNATIONAL OCULAR TRAUMA TASK FORCE**

In 2017, Assistant Secretary of Defense for Health Affairs McCaffery signed a Joint United States (US) - United Kingdom (UK) Task Force Charter establishing an international partnership to advance interoperability between the allied military medical services. This reaffirmed the partners’ commitment to mutually advancing medical care in defense of global interests by sharing information and developing opportunities for combined training and collaborative research. The Blinded Veterans Association (BVA) subsequently met with senior UK Defence medical officials in London – and the British Embassy – who expressed a keen desire to officially establish a dedicated Joint Ocular Trauma Task Force to advance combat ocular trauma care and research under this partnership. The US response, however, has thus far, been noncommittal. BVA requests that Members of Congress express their staunch support for this strategic initiative between allies in order to preserve sight.

Ocular casualties account for approximately 14.9 percent of combat casualties, with a higher incidence during increased combat activity. Moreover, the Department of Veterans Affairs (VA) reports that upwards of 70 percent of Traumatic Brain Injury (TBI) patients suffer from visual symptoms. The legendary British-American military cooperation developed over a century of shared battlefield experience has led to a unique level of interoperability and familiarity. This extends to ocular casualty care, beginning with early battlefield treatment guidance provided by the UK in World War I – and blind rehabilitation programs at St. Dunstan’s – for US casualties. This level of cooperation continues today but largely through individual, unofficial efforts. For example, several key publications reflect joint authorship; prior research symposia included joint participants; and, during a 2019 six-month partnership, a UK-US ophthalmology team delivered ocular trauma care in Afghanistan, offering one of the most active clinical specialties. Nevertheless, ocular care is routinely overlooked at official Department of Defense (DoD) / Defense Health Agency (DHA) policy levels. For example, neither the 2011-2014 Joint Task Force on Wounded, Ill, and Injured Servicemembers nor the 2012 Dismounted Complex Blast Injury Task Force reports mention military ocular trauma care or research, much to our disappointment. Similarly, the current Task Force Partnership Agreement neglects ocular trauma – despite the critical importance of sight to combat effectiveness and personal welfare – and the increasing incidence of eye injuries in the past 100 years of warfare.

The 2019 John S. McCain National Defense Appropriations Act (NDAA), Public Law 115-232, requires DoD to provide a Strategic Medical Research Plan that describes its medical research focus areas and medical research projects; details coordination processes across defense medical research and development (R&D) to ensure alignment with mission, promote synergy, address gaps, and minimize

duplication. Public Law 115-232 also outlines efforts to coordinate with other departments and agencies of the federal government. DoD's response was sent to Congressional committees on April 8, 2019.

In summary, the report identifies the need for agility and responsiveness across all levels and types of medical care, requires an R&D strategy that is nimble, responsive, and attuned to emerging needs of the warfighter. The report is nested within national strategic guidance and capitalizes on opportunities in science and medical technology. It also requires partnerships at home and abroad. This strategy offers a common framework to ensure that DoD continues to discover, develop, and deliver the medical capabilities required today – and in the future. It provides the basis on which to optimize infrastructure, coordination, and information exchange among the Services and defense agencies across DoD, Federal Interagency, and the civilian sector to continue to be responsive to both contemporary medical readiness requirements and future needs of the warfighter. While the Strategic Plan does not specifically mention ocular issues, the US Army Medical Research and Materiel Command (USAMRMC) maintains an ocular health research portfolio, the goal of which is to “improve the health and readiness of military personnel affected by ocular injuries and vision dysfunction by identifying clinical needs and addressing them through directed joint medical research.” Specific topics of interest include:

- Validated models to inform deployment treatment of blast ocular injury and TBI vision system injuries.
- Prolonged field-care and critical-care capabilities.
- Portable diagnostic tools.
- Decision aids for unit-level, MEDEVAC en-route, and MTF care.
- Deployable ocular trauma medical treatment packages.
- Research vision prosthetics and vision restoration devices.
- Regenerative medical techniques.

Most of these goals are germane to international military forces and would benefit from combat experience and cooperative research with our British allies and colleagues. A specific goal of the Joint Ocular Trauma Task Force will be reporting on these initiatives at the Schepens 7th Military Vision Symposium “Future Military Conflicts and Civilian Mass Casualties Events.” The symposium, which will bring together international ocular trauma experts and vision researchers, is scheduled for March 5-6, 2021 in Boston.

A Joint Ocular Trauma Task Force should be officially established now, with specific objectives to collaboratively identify opportunities for enhancing interoperability between the US and UK in ocular combat casualty care. The Task Force would improve the prevention, diagnosis, mitigation, treatment, and rehabilitation and reintegration of ocular injuries and TBI-associated vision loss. It would also enhance vision research exchange. This initiative also seeks to improve civilian ocular trauma care through migration of military lessons learned, particularly regarding issues facing first responders and non-ophthalmic providers in civilian disasters or acts of terrorism, resulting in improved emergency medical services and vision trauma outcomes.

We call upon Congress, VA, and DoD to request that the Assistant Secretary of Defense for Health Affairs (ASDHA) and Secretary of Veterans Affairs – working with their UK Defence Medical colleagues – sign an agreement to establish this Joint Ocular Trauma Task Force for five years.

## **X. MANDATING THE DESIGNATION OF FOUR OCULAR TRAUMA CENTERS**

The FY17 National Defense Appropriations Act (NDAA) was enacted and Section 703 authorized the Secretary of Defense (SECDEF) to “...designate a medical center as a regional center of excellence for unique and highly specialized health care services...” Although ocular injuries clearly meet that definition, no ocular injury Military Treatment Facilities (MTFs) were ever identified by the Defense Health Agency (DHA) as designated specialized care centers to provide for improved eye injury care. The current result is that there are no Department of Defense (DoD) requirements for eye injuries to be referred to specialty treatment centers for evaluation, treatment, care coordination, vision research, or rehabilitation for our military wounded personnel.

Designating four ocular trauma centers should have been accomplished more than two years ago as mandated – with strengthening clinical coordination between DoD and the Veterans Health Administration (VHA). These ocular trauma centers should be mandated to develop bidirectional, longitudinal vision joint clinical injury registries with up-to-date information on the diagnosis, treatment, and follow-up evaluations for wounded personnel.

Ocular injuries are characterized by complex poly-trauma wherein multiple delicate eye structures are injured and remain at long-term risk. These injuries are best treated by a coordinated team of highly trained ocular subspecialists and require close follow-up, particularly when they accompany other systemic polytraumas. The Blinded Veterans Association (BVA) calls upon Congress to require the SECDEF to designate four ocular trauma centers.

### **CONCLUSION**

Once again, Chairman Moran, Chairman Takano, Ranking Member Tester, Ranking Member Roe, and all Members, thank you for the opportunity to present BVA’s legislative priorities before you today.

### **BVA SUPPORTED LEGISLATION**

H.R. 100 “Veteran Overmedication and Suicide Prevention Act of 2019”

A bill to direct the Secretary of Veterans Affairs to conduct an independent review of the deaths of covered veterans by suicide during the last five years, and for other purposes.

Rep. Vern Buchanan (FL-16-R)

S. 2991 “Veteran Overmedication and Suicide Prevention Act of 2019”

A bill to direct the Secretary of Veterans Affairs to conduct an independent review of the deaths of covered veterans by suicide during the last five years, and for other purposes.

Sen. Dan Sullivan (AK-R)

H.R. 4920 “Department of Veterans Affairs Contracting Preference Consistency Act”

A bill to amend title 38, United States Code, to provide for an exception to certain small business contracting requirements applicable to the Department of Veterans Affairs’ procurement of certain goods and services covered under the AbilityOne® program, and for other purposes.

Rep. Mark Takano (CA-41-D)

H.R. 4524 “Rural Veterans Travel Enhancement Act of 2019”

A bill to amend title 38, United States Code, to make permanent the authority of the Secretary of Veterans Affairs to transport individuals to and from facilities of the Department of Veterans Affairs in connection with rehabilitation, counseling, examination, treatment, and care, and for other purposes.  
Rep. Rick Larsen (WA-2-D)

S. 450 “Veterans Improved Access and Care Act of 2019”

A bill to require the Secretary of Veterans Affairs to carry out a pilot program to expedite the onboarding process for new medical providers of the Department of Veterans Affairs, to reduce the duration of the hiring process for such medical providers, and for other purposes.  
Sen. Cory Gardner (CO-R)

S. 746 “Department of Veterans Affairs Website Accessibility Act of 2019”

A bill to require the Secretary of Veterans Affairs to conduct a study on the accessibility of websites of the Department of Veterans Affairs to individuals with disabilities, and for other purposes.  
Sen. Robert P. Casey Jr. (PA-D)

S. 785 “Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019”

A bill to improve mental health care provided by the Department of Veterans Affairs, and for other purposes.  
Sen. Jon Tester (MT-D)

S. 850 “Highly Rural Veteran Transportation Program Extension Act”

A bill to extend the authorization of appropriations to the Department of Veterans Affairs for purposes of awarding grants to veteran service organizations for the transportation of highly rural veterans.  
Sen. Dan Sullivan (AK-R)

S. 1154 “Department of Veterans Affairs Electronic Health Record Advisory Committee Act”

A bill to amend title 38, United States Code, to establish an advisory committee on the implementation by the Department of Veterans Affairs of an electronic health record.  
Sen. Jon Tester (MT-D)

S. 1648 “Supporting Veteran Caregivers Act of 2019”

A bill to reinstate and compensate family caregivers who were improperly removed from the family caregiver program of the Department of Veterans Affairs, or whose benefits were reduced, and to ensure that all veteran caregivers receive the support and assistance for which they are eligible in a fair and consistent manner, and for other purposes.

Sen. Robert P. Casey Jr. (PA-D)

H.R. 1749 “PFC Joseph P. Dwyer Peer Support Program Act”

A bill to authorize the Secretary of Veterans Affairs to make grants to state and local entities to carry out peer-to-peer mental health programs.

Rep. Lee M. Zeldin (NY-1-R)

S. 1835 “21st Century Assistive Technology Act”

A bill to reauthorize the Assistive Technology Act of 1998, and for other purposes.

Sen. Robert P. Casey Jr. (PA-D)

S. 2022 “Paul Benne Specially Adaptive Housing Improvement Act of 2019”

A bill to amend title 38, United States Code, to provide for improvements to the specially adapted housing program of the Department of Veterans Affairs, and for other purposes.

Sen. Jerry Moran (KS-R)

H.R. 3504 “Ryan Kules Specially Adaptive Housing Improvement Act of 2019”

A bill to amend title 38, United States Code, to provide for improvements to the specially adapted housing program and educational assistance programs of the Department of Veterans Affairs, and for other purposes.

Rep. Gus M. Bilirakis (FL-12-R)

H.R. 3640 “Housing Access for Blind Veterans Act”

A bill to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to assist blind veterans who have not lost use of a leg in acquiring specially adapted housing, and for other purposes.

Rep. Elaine G. Luria (VA-2-D)

H.R. 3636 “Caring For Our Women Veterans Act”

A bill to require the Secretary of Veterans Affairs to submit to Congress certain reports relating to the health care and treatment provided by the Department of Veterans Affairs to women veterans, and for other purposes.

Rep. Lauren Underwood (IL-14-D)

H.R. 4451 “S.O.S. Veterans Caregivers Act”

A bill to amend title 38, United States Code, to clarify that caregivers for veterans with serious illnesses are eligible for assistance and support services provided by the Secretary of Veterans Affairs, and for other purposes.

Rep. Raul Ruiz (CA-36-D)

S. 1881 “VETS Safe Travel Act”

A bill to provide PreCheck to certain severely injured or disabled veterans, and for other purposes.

Sen. Todd Young (IN-R)

H.R. 2620 “Faster Treatments and Cures for Eye Diseases Act”

A bill to advance treatment and cures for blindness and other retinal conditions and to promote competitiveness in the United States through a pilot program to increase funding for translational research, and for other purposes.

Rep. Sanford D. Bishop Jr. (GA-2-D)

H.R. 4589 “No Title”

To make permanent the authority of the Secretary of Veterans Affairs to make grants for the transportation of highly rural veterans to medical care.

Rep. TJ Cox (CA-21-D)

H.R. 3356 “VETS Safe Travel Act”

A bill to provide PreCheck to certain severely injured or disabled veterans, and for other purposes.

Rep. Paul A. Gosar (AZ-4-R)



S. 191 “Burn Pits Accountability Act”

A bill to direct the Secretary of Defense to include in periodic health assessments, separation history and physical examinations, and other assessments an evaluation of whether a member of the Armed Forces has been exposed to open burn pits or toxic airborne chemicals, and for other purposes.

Sen. Amy Klobuchar (D-MN)

H.R. 663 “Burn Pits Accountability Act”

A bill to direct the Secretary of Defense to include in periodic health assessments, separation history and physical examinations, and other assessments an evaluation of whether a member of the Armed Forces has been exposed to open burn pits or toxic airborne chemicals, and for other purposes.

Rep. Tulsi Gabbard (D-HI-02)

H.R. 1199 “VA Website Accessibility Act of 2019”

A bill to direct the Secretary of Veterans Affairs to conduct a study regarding the accessibility of websites of the Department of Veterans Affairs to individuals with disabilities.

Rep. Elaine G. Luria (D-VA-02)

S. 669 “The Air Carrier Access Amendments Act of 2019”

To protect the rights of passengers with disabilities in air transportation, and for other purposes.

Sen. Tammy Baldwin (D-WI)

## **Dr. Thomas Zampieri Biography**

### **BVA National President**

Dr. Zampieri served on active duty as an Army Medic from September 1972 until September 1975. He completed this service at the rank of Sergeant. He graduated from Hahnemann Medical University's Physician Assistant Program in June 1978 and enlisted in July 1978 in the Army National Guard. He retired in 2000 as a Major after 21 years of honorable service. His service includes 13 years as a Military Aeromedical Flight Surgeon, logging more than 600 hours of flight operations.

As a civilian, he obtained a Bachelor of Science Degree from the State University of New York, a Master's Degree in Political Science from University of St. Thomas in Houston, Texas, and a Political Science Ph.D. at Lacrosse University. He was selected as the Director of Government Relations for BVA in 2005, presenting testimonies before U.S. Congressional Committees on a variety of veterans' issues prior to his retirement on November 22, 2013.

He was appointed in 2014 to serve on the Association's Board of Directors as District Director of the Texas region, and was elected as Vice President of BVA in 2018. On January 29, 2019, he assumed the office of President and in August 2019, he was elected as National President of the BVA. He is also the chairman of the Government Relations & Legislative Committee for BVA and a member of the Academy of Political Science.

Dr. Zampieri has 5 percent vision in both eyes resulting from degenerative retinal disease. He has volunteered since 2010 in cultivating an award-winning international exchange program with the Blind Veterans UK, known as Project Gemini. He has organized briefings with senior defense medical officials concerning military eye injuries, blast Traumatic Brain Injuries with vision dysfunction, defense vision trauma research program, and rehabilitation services with DOD, VA, and UK officials.