DR. ROY KEKAHUNA, NATIONAL PRESIDENT, BVA

BLINDED VETERANS ASSOCIATION

TESTIMONY
PRESENTED BY

DR. ROY KEKAHUNA
BVA NATIONAL PRESIDENT

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

MARCH 4, 2010

INTRODUCTION

Chairman Akaka, Chairman Filner, Ranking Members Senator Burr, Congressman Buyer, and all Members of the House and Senate Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA), "Aloha" and we appreciate this opportunity to present our legislative priorities for 2010. BVA is the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. This month, BVA will celebrate an important milestone with its 65th anniversary on March 28 of continuous service for our nation's blinded veterans. As another newer generation of seriously eye injured service-members return from Operation Iraqi Freedom (OIF) and now an increase in wounded from Operation Enduring Freedom (OEF) in Afghanistan, our combined efforts will be extraordinarily important in ensuring that these new combat blinded veterans, and those from previous conflicts and wars, have the full continuum of high-quality care and benefits they have earned from the VA.

BVA would greatly appreciate strong bipartisan action of Members of Congress in ensuring that the Secretary of Defense and Secretary of the VA fully implement, with adequate funding from Congress, the joint full staffing for the National Defense Authorization Act (NDAA) FY 2008, Section 1624 (DoD-VA "Vision Center of Excellence" (VCE) and Eye Trauma Registry. Since enactment of NDAA more 24 months ago, there were long delays in DoD funding being identified, complete lack of joint staffing for over a year, then reversed decisions on the organizational structure, and a Memorandum of Understanding (MOU) was never signed until

October 8, 2009. These issues have all caused unacceptable delays in starting mission operations for this critical center. The finger- pointing, bureaucratic gamesmanship and long delays in decision-making must all be stopped by these committees. BVA requests that the Chairmen and Ranking Members hold full Committee hearings and work with key members on Oversight of the House Armed Services Committee (HASC) and Senate Armed Services (SAC) to establish all three of the NDAA Defense Centers of Excellence for Vision, Hearing, and Limb Extremity Centers of Excellence.

SEAMLESS TRANSITION ISSUES

During the past year, BVA has worked with Members of these two Committees and tried to get the HASC to hold DoD accountable for the many organizational problems associated with the Seamless Transition process involving the battle eye-injured and those with visual complications associated with Traumatic Brain Injury (TBI). Many severely eye-injured OIF and OEF wounded service members are not centrally tracked, making the implementation of the Eye Trauma Registry important. This tracking failure negatively affects some in their access to the full continuum of VA Eye Care Service, Blind Rehabilitation Services (BRS), and Low-Vision outpatient programs that these committees helped establish. BVA again stresses that, according to Department of Defense (DoD) data compiled between March 2003 and December 2008, 10 percent of all combat-injured casualties evacuated from Iraq had associated eye injuries. Fortunately, due to advanced combat surgery teams, and the rapid evacuation military medical system, the severe eye injured in these wars have had their vision partially restored, but approximately 114 blinded have required treatment at one of the ten VA Blind Rehabilitation Centers (BRCs). There has been insufficient oversight of the VCE by the Joint Executive Council (JEC) and failure of both agencies to provide detailed budgets, full staffing, and the planned construction renovation for 3,870 square feet of office space for the VCE at the National Naval Medical Center in Bethesda is not expected to be completed until FY 2011. No further delays for the implementation plans for the VCE in FY 2010 are acceptable and should not be tolerated.

BVA points to the frustrating fact that despite the MILCON/VA Appropriations including $6.8 million for FY 2009 for VA implementation of its portion of the VCE initiative, as of January 29, 2010, the VA had a total of one part-time staff member appointed and had reprogrammed the funds over five years instead of utilizing the funds to urgently start the VCE operations. BVA requests that Congress include $ 8.5 million in Defense appropriations for FY 2011 and require that the VHA report quarterly on its staffing plans, the status of the Eye Trauma Registry, and expenditures of the MILCON/VA appropriations provided.

BVA believes that the VCE and its Eye Trauma Registry is where improved coordination to ensure availability of eye care and vision rehabilitation services, best outcome practices, and evidence- based clinical measures can be developed and refined for the TBI-wounded who face vision dysfunction. Research coordinated with the Defense Veterans Brain Injury Centers DVBIC and Defense Intrepid Center of Excellence (NICOE) for TBI, along with all 22 VA Polytrauma Network sites, can be facilitated, data analyzed documentation of the findings, and publishing of plans to improve both acute injury care and long term vision rehabilitation. We predict that the number of TBI-injured will continue to rise as a result of the troop surge into Afghanistan throughout the rest of this year.

Worse, BVA now is finding other earmarked centers of excellence and private agencies trying to initiate new independent programs to "manage these combat wounded" adding to the confusion, and negatively impacting transition between DoD and VA. 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). The Defense Veterans Brain Injury Center reports that an analysis of the first 433 TBI-wounded found that 19 percent had concomitant amputation of an extremity. Mild TBI was found in 44 percent of these 433 patients and 56 percent were diagnosed with moderate-to-severe TBI. Some 12 percent of those with moderate to severe TBI had penetrating brain trauma. Only VA Blind Rehabilitative Centers 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. They need the specialized VA mental health services with coordinated multidisciplinary care that the VA medical centers are capable of providing.

We caution that private agencies for the blind do not have the full specialized nursing, physical therapy, pain management, speech pathology, pharmacy services, Lab or radiology support services, along with subspecialty surgery specialists to provide the clinical care necessary for these wounded. The lack of electronic health care records in the private agencies would make things worse when veterans returned into DoD or VA medical services. BVA requests that any private agencies should demonstrate peer reviewed quality outcome measurements that are standard part of VHA BRS and should it ever be necessary to refer a visually impaired or blinded veteran to a non VA BRC, that any Non VA BRC should be accredited by either (NAC) the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped or CARF, the Commission For Accreditation of Rehabilitation Facilities, and that the employed Blind Rehabilitation Specialists be Certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

BVA believes that the DoD-VA Seamless Transition process for eye trauma cases must include the sharing of outcome studies, clinical guidelines, and joint peer reviewed research projects on vision care and vision loss prevention through the exchange of electronic medical records and clinical specialized consultation and these are not present in private agencies for the blind.

TRAUMATIC BRAIN INJURY

The Veterans Health Administration (VHA) reports ever increasing numbers of TBI cases being found as more screening occurs, with 22,000 confirmed to have TBI. Improvised Explosive Device (IED) blasts contributed to more than 65 percent of these injuries. As of January 30, 2010, a total of 42,113 service members had been wounded or injured in either OIF or OEF wars. Added to the number of penetrating battle eye injuries are the 63 percent of moderate to severe TBI service members who have suffered visual dysfunction. The data now comes from various VA research findings based on individuals tested by neuro-ophthalmologists or low-vision optometrists. With increased visual screenings they are diagnosing high percentages with Post Traumatic Vision Syndrome (PTVS).

Although TBIs rarely result in legal blindness, researchers have found rising numbers with "TBI functional blindness" and other manifestations diagnosed as Post-Traumatic Vision Syndrome (PTVS). The VA Polytrauma Center in Palo Alto, Hines VAMC, Tampa VAMC, all have reported that 80 percent of all TBI patients have complained of visual symptoms as a result of their blast exposure. VA research has further revealed that approximately 65 percent of those with diagnosis of visual dysfunction have at least one, and often three of the following associated visual disorders including diplopia, convergence disorder, photophobia, ocular-motor dysfunction, color blindness, and an inability to interpret print. One research study that examined 25 TBI veterans found none of the following visual complications during the normal medical evacuation process; corneal damage 20%, cataracts 28%, angle recession glaucoma 32%, retinal injury 22%, these all would place these individuals at high risk of progressive visual impairments if not diagnosed and treated early.

BVA commends VA its for increased efforts recently to improve the continuing education of all clinical VA staff on the identification, diagnosis, and appropriate consultative management of TBI veterans, with specific recent new VHA policy on TBI visual screening. Recently VA hosted in December, 2009 a TBI Visual Consequences medical conference in Chicago with over 500 DoD and VA staff. But critical to this vision-related TBI screening and diagnosis is the development immediately of the NDAA mandated Eye Trauma Registry data base to include all visually impaired veterans or service members who have sustained a mild, moderate, or severe TBI with visual impairment diagnosis or a penetrating eye injury. We request that Army National Guard or Army Reserve leadership must ensure and facilitate the reporting of all eye wounded to the Eye Trauma Registry. BVA is finding increasing numbers of visually impaired service members in the reserves injured two or more years ago, now complaining of significant visual impairments. 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.

VA FUNDING FOR FY 2011-2012

BVA commends both Chairmen Filner and Akaka and the many bipartisan sponsors of the Veterans Health Care Budget Reform and Transparency Act of 2009 (H.R. 1016 and S. 423, respectively) introduced one year ago and enacted last November is truly historic legislation that will provide VA with timely, sufficient, and hopefully predictable budgets in the future years. The confusion created by Continuing Resolutions, supplemental appropriations, and constant tinkering to adjust for increasing numbers of war veterans entering the system we hope are long gone. We request careful oversight though of this new process and we ask that the implementation of this is transparent as intended for this new health care funding methodology.

PEER REVIEWED MEDICAL RESEARCH-VISION FUNDING

BVA, along with other veteran service organizations dedicated to serving our nation's veterans, are pleased to join in supporting the programmatic request of continuing directed funding in Fiscal Year (FY) 2011 for the Peer Reviewed Medical Research-Vision (PRMR-

Vision) extramural research line item, funding it at $10 million. This program, which is managed by the Department of Defense's (DoD) Telemedicine and Advanced Technology Research Center (TATRC), was initially created by Congress in FY2009 appropriations and funded at $4 million. In FY2010, it was funded at an even lower level of $3.75 million. Defense-related vision trauma research warrants a more vigorous investment, especially since Defense Secretary Robert Gates has identified research into Restoration of Sight and Eye-care as one of four top priorities for funding, along with Post Traumatic Stress Disorder, Traumatic Brain Injury (TBI), and Prosthetics.

Today, battlefield conditions have resulted in 10 percent of all those wounded/evacuated having penetrating eye injuries and TBI-related visual dysfunction due to blast forces. With the U.S expanded presence in Afghanistan, that number is rising even greater. Serious combat eye trauma from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) is now the second most common injury and trails only hearing loss, according to an Office of VA Research & Development article published in October 2008. The November 2008 Medical Surveillance Defense Monthly Report from the Armed Forces Health Center reported that, over the past ten years and of the 188,828 ocular injuries reported, there were 4,970 moderate-to-severe penetrating combat eye injuries, 8,441 retinal and choroidal hemorrhage injuries (including retinal detachment), 686 optic nerve injuries, and 4,294 chemical and thermal eye burn injuries.

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

BVA strongly supports the National Alliance for Eye Vision Research's (NAEVR) position that eye and vision research within defense appropriations be increased for PRMR-Vision program within the Congressionally Directed Medical Research Program (CDMRP). While there were more than 120 pre-proposal grant applications received for FY 2009, the program received barely enough funding for 3-4 research projects. We request, for FY 2011, $10 million as a dedicated line item for PRMR-Vision and point out that traumatic eye injury research provides combat surgeons with new treatments that will preserve vision. We also wish to emphasize that the PRMR-Vision line item in defense appropriations is a dedicated funding source for extramural research into immediate battlefield needs which is not conducted by the VA nor the National Eye Institute (NEI) within the national Institutes of Health (NIH), although TATRC ensures to engage representatives of the VA and NEI (as well as the FDA) in programmatic review of the vision research grants it receives.

VA RESEARCH

Adequate funding for research is critical for the Rehabilitation Research and Development Service, one of the four components of the Office of Research and Development within VA that

directly impacts blinded veterans. In FY 2010, Congress increased the amount to $580 million. This year the VA budget request for FY 2011 is not adequate and we ask for $700 million in FY 2011 Disabled service members returning from the war zones need the very finest in research, training, and rehabilitation care. Ensuring adequate funding for such research is crucial. Future research could potentially preserve sight, restore lost functions, and/or prevent further deterioration and we request increase in FY 2011 to $700 million.

ELIMINATING DISABLED VETERAN CO-PAYMENTS S 1963

We want to thank all those members who supported H.R. 6445 introduced by Congresswoman Halvorson and passed with full bipartisan support of the House VA Committee during the 111th Congress and Senator Sanders for S 801. The bill provided for the elimination of co-payments by disabled veterans in the event of a need for admission to inpatient rehabilitation programs. Many older blinded veterans with age-related degenerative eye disease blindness cannot afford the co-payments required to attend a BRC. Under the current system, veterans are required to pay both the Social Security Administration co-payment and a daily per diem rate during the rehabilitation period, resulting in a co-payment of $1,500 for a blinded veteran admission at BRC. BVA again thanks both Senator Sanders and Representative Halvorson for introducing this legislation in the 111th Congress, and we call for immediate passage of S 1963 where this important section waits for final action.

BENEFICIARY TRAVEL

For veterans who are currently ineligible for travel benefits, the law also 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 air transportation, can be discouraged by these costs to travel to a BRC. The average age of veterans attending a BRC is 67 years old because of high prevalence of degenerative eye diseases in this age group. BVA urges that these travel costs should be provided by the VISN network where the veteran is referred from, and not be an added burden for disabled blinded veteran obtaining the crucial rehabilitation training needed to gain independence through the VA rehabilitation services. We request of both Committees that this legislation be introduced during the second session of the 111th Congress to ensure that VHA cover the travel costs to these blind centers.

BLIND VETERANS FAIRNESS ACT HR 3485

New York, New Jersey, Pennsylvania, and Massachusetts currently provide a yearly annuity for blinded veterans who have sustained a total loss of sight as a result of service in any war. All blinded veterans in New York, both service-connected and Non-Service-Connected (NSC), currently receive an annual payment of $1,101. The figure is $750 in New Jersey, $1,800 in Pennsylvania, and $2,000 in Massachusetts for service connected blinded veterans. Under current law, however, NSC blinded veterans actually lose their VA pension benefits for receiving this modest annuity from the NY state. In the future, any state where the annuity is currently being considered will face this same problem unless corrected. A blinded veteran's VA pension should not be offset when such state annuities have been instituted.

BVA appreciates that Congressman Brian Higgins (D NY) introduced HR 3485 last July and that Chairman Hall held a hearing on this issue last October in First session of 111th Congress. Similar to H.R. 3997, enacted in the 110th Congress, it included a section stating that blinded veteran annuities from any state "not be considered for purposes of Social Security Income" and that annuities paid by states to blinded veterans be disregarded in determining Social Security Income benefits. The same should apply to VA pension income and we point out that the VBA witness testified before the subcommittee on Benefits in favor of this bill last October. Veterans currently receiving these small state annuities often have extremely low incomes. To penalize blinded veterans in this category by offsetting their VA pensions is entirely unfair to those who selflessly served the Nation and we ask for this bill to be passed in the 111th congress and for a senate companion bill.

CURRENT SPECIALLY ADAPTED HOUSING SERVICES

The current SAH requirement from the Veterans' Housing Opportunity and Benefits Improvement Act of 2006 (P.L. 109-233), June 15, 2006 still used blindness acuity of 5/200 and requirements of loss of use of both hands and it should be modified to permanent service connected blindness of 20/200 or less, or loss of peripheral visual fields to 20 degrees or less. The current standards now listed below for this restricts helping those returning OIF and OEF functionally TBI blinded veterans with visual impairments requiring assistance and adaptive technology because they would never qualify for this current stricter 5/200 current standard leaving them with no grant to adapt a home.

The Special Home Adaptation (SHA) grant, on the other hand, helps service-connected veterans with specific mobility problems within the home. The SHA grant is for $12,756. The disability must be permanent and total due to:

- Blindness in both eyes with a 5/200 visual acuity or less, or
- Anatomical loss or loss of both hands and extremities below the elbow.

In addition to change of visual acuity to 20/200 or 20 degrees loss of visual fields, BVA supports the VSOIB recommendation that Congress increase the Specially Adapted Housing SAH grant from $63,780 and the Special Home Adaptation (SHA) amount from $12,756 both levels up to meet the average national renovation cost, according to construction experts for adaptive accessible housing renovations.

VBA CLAIMS BACKLOGS REMAIN HIGH

A core mission of the VA Veterans Benefits Administration (VBA) is to provide financial disability compensation, Dependency and Indemnity Compensation, and disability pension benefits to veterans and their dependent family members and survivors. As of January 30, 2009, there was a persistently high backlog of rating claims, with most cases waiting more than 180 days for decisions. These payments are intended by law to relieve the economic effects of disability (and death) on veterans and to compensate their families for loss. For these payments to effectively fulfill their intended purpose, VA must deliver them promptly and base such deliveries on accurate adjudications.

Waiting for action by VA on their pending claims, veterans and their families often suffer financial hardships, resulting from protracted delays as claims are denied and remanded for more

evidence. BVA supports the VSO Independent Budget recommendation that Congress should consider amending title 38, United States Code § 5103A(d)(1), to provide that when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request such evidence from a VA health care facility examination. The language we suggest adding to section 5103A (d) (1), would not, however, require VA to accept private medical evidence if, for example, VA finds that the evidence is not credible and therefore not adequate for VA rating purposes. BVA has examples of highly qualified neuro-ophthalmology exams being ignored while veterans wait for routine compensation examiner to repeat tests again. Disabled veterans should not wait years for the process to determine the rating for obvious injuries, especially recently injured who served in Iraq and Afghanistan.

New and improved information technology should be utilized to fix this problem. BVA requests that VA Information Technology be compliant with Section 508 of the American Disabilities Act. 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 recommend to reduce the claims back log some, that when a disabled veteran is rated that VBA issue certificate of eligibility for the adaptive housing and automobile grants at the same time. Why force a VA rated permanent disabled Service Connected veteran to file three new claims for each of these benefit programs when VBA could certify them and issue eligibility at the time of the initial rating decision for the adaptive housing, auto grant, and life insurance programs.

VA CONTRACTED CARE AND PROJECT HERO

The Veteran Service Organization Independent Budget (VSOIB) stresses how important and critical it is that VA solve the growing problem of contracted care from the old fee basis services system into a more coordinated, high quality care system with improved access, and cost effective delivery of those services for veterans. Along with this, any contracted care must mandate the full development of bidirectional compatible Electronic Health Record (EHR) where any VA clinicians can immediately access all contracted care clinical notes or diagnostic services provided by contractors. These changes will improve the coordination of care plans between VA and private providers. BVA also believes that contracted care must not negatively impact current VA clinical capacity or existing specialized rehabilitative or academic affiliated training programs. The VA track record on the fee basis billing has not been good and we point to the recent VA OIG Report No 08-02901-185 released August 3, 2009 “Audit of Veterans Health Administration’s Non-VA Outpatient Fee Care Program” as evidence of the problems associated with the current contract system.

During 4-year period of fiscal years FY 2005-2008, outpatient Fee Care Program costs have more than doubled from $740 million to over $1.6 billion and in FY 2008 VA paid about 3.2 million out-patient fee claims. VA Inspector General Office reports “ VA made significant number of improper payments (37% of paid claims reviewed), such as duplicate claim payments, and incorrect payment amounts.” If the current contracted Fee programs have these issues, BVA requests assurances that the diversion of funds into the ongoing HERO project has full transparency and accounting of the total costs. Of concern is reports from local VA medical facilities of complaints that VA centers are having budgetary related staffing problems today,

even after the large increases provided by this congress. One fear is expansion of contracted services hurts VA internal staffing more as more care is outsourced. While we appreciate that VHA business office staff have provided regular briefings to the VSOs about the status of Project HERO, there has certainly been concerns on information regarding what the total costs, types of healthcare provided to veterans ranging diagnostic services verses specialist care or surgery, and what will determine which veterans are further enrolled (other than four VISN networks general geography being the deciding point). There should be further questions of VA about how Project HERO is going to evolve in the next year both in total costs and impact on medical centers in the four VISN networks staffing. Some should ask why is VA simply still paying for individual fee for each procedure or diagnostic service in Project HERO instead of bundled or packaged services for real comparison purposes of access, quality outcomes, clinical care costs, and meeting VA contract goals? VHA started the contract of outsourcing services for Project HERO with Humana in 2007 with this five year pilot now half way completed with some questions about if this meets the needs of VA for contracted care for evaluation purposes and we thank Chairman Michaud for holding the Health subcommittee hearing on January 20, and ask for more full committee hearings on both HERO and Fee Basis Care.

VOCATIONAL REHABILITATION SERVICES

In FY 2009, VR&E was authorized 1,105 FTEs. As endorser with IBVSOs BVA is concerned along with some members of the committees when informed that this number has been "frozen" due to the unknown impact the implementation of chapter 33 benefits will have on the VR&E program. Last year, we recommended that total staffing be increased to manage the current and anticipated workload as stated in the Secretary's VR&E Task Force. VA currently has approximately 106,000 enrollees in Chapter 31. The IBVSOs believe that a ratio of 1:96 (which includes administrative support) is inadequate to provide the level of counseling and support that our wounded and disabled veterans need to achieve success in their employment goals. BVA supports the recommendation of the IBVSOs that Congress should authorize 1,375 total FTEs for the Vocational Rehabilitation and Employment Service for FY 2010.

FUNDING VHA BLIND REHABILITATION SERVICE

Combine with eye injuries in OIF and OEF is an aging veteran population with the growing prevalence of age-related visual impairment, and they are the challenge in 2010 and far beyond. The good news is the VA Visual Impairment Advisory Board (VIAB) has successfully implemented a uniform national standard for providing a full continuum of outpatient blind or low vision rehabilitation services. BVA is proud to report that since the announcement in January 2007 that VHA would dedicate $40 million over three years toward implementation of the continuum of care, huge progress has been made within the VA medical centers. Currently, 55 new outpatient VA programs with 157 new outpatient blind and low-vision VA personnel are now in place. They are improving local services, decreasing waiting times, and providing approximately 49,460 blinded veterans care now enrolled in Blind Rehabilitative Services (BRS) in FY 2009. These new programs have made significant positive changes in a system that as recently was 2004 had been having blinded veterans waiting over six months for a BRC admission, now the average is less than eight weeks at some VA centers, and for this we thank these committees for your support of the funding for these new programs. Studies reveal in America there are estimated 156,854 legally blinded veterans. Further epidemiological studies project there are another 1,160,407 low vision impaired veterans in the United States. Ensuring

that each VISN VA network director continues to fully fund these new outpatient and Blind Rehabilitative Centers is important considering the preceding numbers of veterans who may seek these services.

BLIND REHABILITATION CENTERS

After 60 years of existence and progress, VA Blind Rehabilitative Centers (BRCs) still provide the most ideal environment in which to maximize the rehabilitation of our Nation's blinded veterans. BRCs help them acquire the essential adaptive skills to overcome the many social and physical challenges of blindness. The high-quality services and opportunities provided by BRCs during FY 2009 resulted in 1,934 blinded veterans receiving full rehabilitative services and adaptive prosthetics prescribed by VA eye care specialists. Only the inpatient VA BRCs have all of the diverse, specialized nursing staff, and orthopedics, neurology, rehabilitative medicine, occupational and physical therapy, pharmacy services, radiology, and lab services to treat the complex wounds of these service members.

VHA Director of Blind Rehabilitation Service (BRS) should have more central control over blind center resources and funding levels. With the implementation of the Full Continuum of Care model announced by VHA, we again reiterate that greater emphasis should be placed on complementing the outpatient programs while ensuring continued full staffing at the BRCs. The new Advanced outpatient blind and Intermediate Low Vision programs again are improving services for veterans, however some of the VISN directors, might force some medical centers or attempt to mandate that BRC directors cut the inpatient staff, reduce the number of beds, or limit the time of the individualized training inherent to the success in these highly specialized rehabilitative programs. We ask for some Oversight & investigation of these BRCs to ensure they maintain high quality services.

VISUAL IMPAIRMENT SERVICES TEAMS AND BLIND REHABILITATION OUTPATIENT SPECIALISTS

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

The VIST system now employs 112 full-time Coordinators and 43 who work part-time. The average caseload is 375 blinded veterans. VIST Coordinators nationwide serve as the critical key case managers for some 49,269 blinded veterans, a number that is projected to increase to 52,000 within couple of years. VA should therefore increase the number of full-time VIST Coordinators

if any VA center has more than 150 blinded veterans enrolled. The VIST/BROS teams are able to provide improved local services when a veteran requires them. 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 have a full-time VIST Coordinator. Veterans attending BRCs often require additional training later due to changes in adaptive equipment or technology advances. VISTs and BROS ensure that such training occurs. VA BRS established new BROS positions during FY 2009 in facilities throughout the system bringing the total of BROS now to 73 full time, triple the number from 2004. The creation of the positions placed VA in a better position to deliver accessible, cost-effective, top-quality outpatient blind rehabilitation services.

ADVANCED BLIND REHABILTATION PROGRAMS

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

INTERMEDIATE LOW-VISION OPTOMETRY PROGRAMS: VICTORS

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

HR 4360 NAMING of LONG BEACH VA BLIND CENTER

Finally, the Blinded Veterans Association (BVA) today is asking for your support along with the entire California congressional delegation of 52 co-sponsors in supporting passage of H.R. 4360 to name the currently being constructed Department of Veterans Affairs Blind Rehabilitation Center in Long Beach, after the late Major Charles R. Soltes (Rob), Jr. O.D. introduced by

Congressman Campbell. The legislation, introduced by Representative John Campbell (R-CA-48) as H.R. 4360, would honor Dr. Soltes for his dedicated service to the nation as an Army Reserve Medical Officer working in the field of military optometry. He was the first military optometrist to be killed in action.

Dr. Soltes was called to active duty in July 2004 at the age of 36 and deployed to Iraq just two months later. On October 13 of that same year, a truck carrying an improvised explosive device drove into his convoy vehicle and detonated. A second soldier was also killed in the convoy. Dr. Soltes was a graduate of the New England College of Optometry and subsequently completed a residency at Brooke Army Medical Center. He entered the U.S. Army Medical Service Corps in 1994 and provided eye care services to servicemen and women at home and abroad, with military assignments in Brook Army Medical Center, Texas, the Republic of Korea, and at the U.S. Military Academy at West Point. He earned adjunct faculty appointments at the University of Houston, College of Optometry, the State University of New York State College of Optometry, and the Northeastern State University College of Optometry. At West Point, Dr. Soltes served as Director of the Optometry Residency Program.

At the time of the attack that took his life, Dr. Soltes was serving as a Public Health Officer with the 426th Civil Affairs Battalion, U.S. Army Reserve, in Mosul, Iraq. His mission was to assist military commanders by working with local governments and civilians in the commander's area of operations, building and upgrading hospitals for the Iraqi people. His military specialty was listed as an optometrist, and he was returning from an Iraq civilian hospital visit when his convoy was hit and he was killed by IED blast. Dr. Soltes' widow, Sally Huong Dang, O.D. of Irvine, California, is also a practicing optometrist and was a professional practice partner with her late husband. She has recently volunteered to provide low-vision services and care to blinded veterans to fulfill a promise she made to her husband before he departed for Iraq to always care for our nation's veterans. BVA greatly appreciates the efforts of Representative Campbell, Representative Rohrabacher, and for the leadership support of House VA Committee Chairman Bob Filner as original sponsor, to honor Dr. Soltes, on behalf of Sally, and her three young children with this appropriate legislation we ask this legislation be enacted by the 111th congress by the house and senate.

CONCLUSION

Once again, Mr. Chairman, thank you very much for the opportunity to present the Blinded Veterans Association's legislative priorities for FY 2011 as we mark this milestone of 65 years of service for our nation's blinded veterans. The VCE should be funded, staffed, and the Registry functioning today. Thank you, I will gladly answer any questions you or other Members of these Committees may have concerning our testimony.

RECOMMENDATIONS

Ensure that the new veterans health care "Advance Funding" model provides not only adequate funding to meet the demands on the health care system but also VHA is held accountable and is transparent about where the appropriations are being used. BVA strongly endorses the VSO Independent Budget recommendation regarding the new advanced funding for veterans health care for FY 2011 and FY 2012.

Congress must ensure the full establishment and budget of the Vision Center of Excellence VCE and Eye Trauma Registry must become operational. Joint DoD/VA staffing resources be available now is critical for its success Request DoD appropriations include $8.5 million for Defense in FY 2011 for operations. Section 1624 of NDAA FY 2008 must be modified and specific organizational alignment for the VCE Director and VA Deputy Director should report to Assistant Secretary of Defense for Health Affairs and to the Under Secretary of Health VHA.

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

BVA firmly supports the National Alliance for Eye Vision Research's (NAEVR) position that extramural vision research funding through the dedicated Peer Reviewed Medical Research-Vision line item in the DOD's Congressionally Directed Medical Research Program (PRMRP) is essential. BVA urges that PRMR-Vision be funded at $10 million in FY2011 defense appropriations.

BVA believes that blinded veterans that get accepted to one of the VA special Blind Rehabilitative Centers programs, who are currently not eligible for travel benefits, that each VISN must provide for the cost of their airfare travel to attend one of the inpatient BRCs. This serves as a strong disincentive to not have access to rehabilitation services offered by VA.

Congress must repeal the inequitable requirement that the amount of an annuity under the Survivor Benefit Plan be reduced on account of, and by an amount equal to, the amount received by a veteran under Dependency and Indemnity Compensation.

VIST coordinators are key points of contact for any service member with blindness or low vision. VA Medical Centers with more than 150 blinded veterans should staff one full-time VIST Coordinator.

Congressman Higgins introduced H.R. 3485 "The Blind Veterans Fairness Act," in the first session of the 111th Congress in hearing last October VBA agreed this offset should be removed for blinded veterans. We request the Senate VA Committee introduce companion bill.

It is the recommendation of the IBVSOs that Congress enact legislation to increase the automobile allowance to 80 percent of the average cost of a new automobile $22,800 and then provide for automatic annual adjustments based on the rise in the cost of living.

We ask for passage of HR 4360 by both chambers to name the Long Beach Blind Center in memory of Dr Charles "Rob" Soltes Jr.