DR. NORMAN JONES, JR., BLINDED VETERANS ASSOCIATION, NATIONAL PRESIDENT

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TESTIMONY
PRESENTED BY

DR. NORMAN JONES, JR.
BVA NATIONAL PRESIDENT

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

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INTRODUCTION

Mr. Chairman and Members of the House and Senate Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present our legislative priorities. 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. Later this month, BVA will celebrate its 64th anniversary of continuous service to this most unique group of Americans. As a new generation of seriously eye injured service members return from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom, Afghanistan (OEF), our combined efforts will be extraordinarily important in ensuring that these new veterans and those from previous conflicts and wars have the full continuum of high-quality care and benefits they have earned. BVA would greatly appreciate strong bipartisan support of Members of Congress in ensuring that the Pentagon implement, with adequate funding and staffing, the National Defense Authorization Act (NDAA) of FY 2008, Section 1624 (joint DoD-VA "Vision Center of Excellence" (VCE) and Eye Trauma Registry. Since enactment of NDAA more 13 months ago, funding for this critical center has been a persistent issue. BVA requests that the Chairmen and Ranking Members hold full Committee hearings and work with the Armed Services Committees to establish all of the required NDAA Defense Centers of Excellence for both Hearing and Vision.

SEAMLESS TRANSITION ISSUES

During the past year, BVA has worked with Members of these two Committees and the Armed Services Committees regarding the many 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 returning 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, and Low-Vision outpatient programs. BVA again stresses that, according to Department of Defense (DoD) data compiled between March 2003 and December 2007, a full 13 percent of all combat-injured casualties evacuated from Iraq had associated eye injuries. Fortunately, due to advanced combat surgery teams, the total blinded is approximately 130 and most have already benefited from treatment at one of the ten VA Blind Rehabilitation Centers (BRCs). These are the only locations at which multidisciplinary professional medical, surgical, and psychiatric personnel are all located onsite to facilitate comprehensive services for all injuries. Cooperation between DoD Medical Treatment Facilities (MTFs) and VHA in the reporting of eye injury cases is slowly improving. The cooperation will ensure that the care from professionals in DoD and VA Medical Centers continues to be excellent. Although BVA believes that the Vision Center of Excellence and Registry legislation within NDAA ensures real Seamless Transition for the eye wounded, we request that the Secretary of Defense and the Secretary of VA both report to this Committee as to the specific plans for funding and staffing VCE. These plans and the reports thereof are also required by NDAA itself.

Since many of the eye-wounded suffer from other serious injuries (studies indicate that 44 percent, for example, have Post-Traumatic Stress Disorder), they will need the specialized mental health services with coordinated multidisciplinary care that VA is capable of providing. We caution that private agencies for the blind do not have the full specialized physical therapy staffing, pharmacy services, radiology personnel, and psychology specialists to provide this type of care. The inherent lack of computerized health care records in private agency care would only make things worse in the sharing of health care data among DoD, VA, and the aforementioned agencies. BVA believes that the DoD-VA Seamless Transition process for eye trauma cases must include the sharing of outcome studies, clinical guidelines, and joint research projects on vision care and vision loss prevention through the exchange of electronic medical records.

TRAUMATIC BRAIN INJURY

As of September 2008, the Veterans Health Administration (VHA) reported 8,747 diagnosed TBI cases with another approximately 7,500 in diagnostic testing for possible TBI. Improvised Explosive Device (IED) blasts contributed to more than 64 percent of these injuries. As of January 30, 2009, a total of 43,993 service members had been wounded or injured in Iraq. The number of hostile wounded requiring air medical evacuation from Iraq between March 19, 2003 and January 30, 2009 was 9,375, of which an estimated 1,500 had sustained combat eye trauma. The number of direct battle eye injuries does not include the estimated 63 percent of all moderate

to severe TBI service members or veterans who have suffered visual dysfunction. The estimate comes from VA research based on individuals tested by neuro-ophthalmologists or low-vision optometrists. We stress that only 4 percent of these persons meet the definition of legal blindness despite the dysfunction they now experience. Veterans with neurological vision dysfunction resulting from moderate to severe TBI will require long-term VA eye care follow-up in low vision clinics.

BVA believes that VCE and Eye Trauma Registry is where vital research, best practices, and outcome measures can be developed and refined for the TBI-wounded who face vision dysfunction. It is where research coordinated with the Defense Veterans Brain Injury Centers and Defense Centers of Excellence for TBI can be facilitated. We predict that the number of TBI-injured will continue to rise as a result of the upcoming troop surge in Afghanistan.

POST-TRAUMATIC VISION SYNDROME

Although TBIs rarely result in legal blindness, we have found "functional blindness" and other manifestations diagnosed as Post-Traumatic Vision Syndrome (PTVS). The VA Polytrauma Center in Palo Alto, for example, has reported that 80 percent of all TBI patients in its facility have complained of visual symptoms as a result of their exposure to TBI. VA research has further revealed that approximately 63 percent of those with visual dysfunction have experienced associated disorders including diplopia, convergence disorder, photophobia, ocular-motor dysfunction, color blindness, and an inability to interpret print. 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 policy guidelines on visual screening. Vision-related TBI research is vital, as is the enforcement of mandatory tracking of all service members who have sustained a mild-to-moderate TBI diagnosis.

Many wounded service members are from rural communities of less than 20,000 inhabitants. BVA believes that some of the eye-injured from this group may have been lost and not received a VA eye care follow-up, especially if they have been sent for Tricare services. National Guard or Reserves leadership health care programs must facilitate the reporting of any eye wounded to the Eye Trauma Registry. The Seamless Transition of traumatic visual injuries and TBI-related vision dysfunction among Reserve or National Guard members is a vital oversight that will prevent them from being lost. The failure to administer a proper and timely diagnosis of TBI and to appropriately treat its accompanying vision dysfunction 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.

FUNDING VHA BLIND REHABILITATION SERVICE

Combat-related eye injuries in Iraq and Afghanistan, coupled with an aging veteran population with the known prevalence of age-related visual impairment, are the reality in 2009.

Consequently, the VA Visual Impairment Advisory Board (VIAB) has adopted a uniform national standard for providing a full continuum of outpatient vision rehabilitation services. BVA was pleased with Secretary Nicholson's January 25, 2007 announcement that VHA would dedicate $40 million over three years toward implementation of this continuum of care. Consequently, new outpatient blind and low-vision VA personnel are now in place at 52 locations, improving local access and decreasing waiting times for both legally blind and low-vision veterans.

BVA also appreciates the fact that the MILCON/VA Appropriations included $7 million for FY 2009 for the continued implementation of these new outpatient blind and low-vision programs and $6.9 million toward VA implementation of its part in the aforementioned Vision Center of Excellence initiative. Nevertheless, the FY 2010 proposed VHA budget will need a final directed amount of $9 million. This amount is necessary so that progress can be made on final implementation at the VA sites. BVA requests that Congress include this amount in the FY 2010 MILCON/VA appropriations.

VA FUNDING FOR FY 2009

The past few years have shown that a new method of funding VA health care is needed. BVA respectfully disagrees with the premise that the presently constituted discretionary budget process works. The current process has been filled with political road blocks, mismanagement, bad models, and delays for almost two decades now. While we appreciate the extra effort that went into passing the current year's appropriations on a timely basis, which made FY 2009 a notable exception, it was one of the rare years in which VA was allowed to fund its critical needs before the situation became dire. Former VA directors and chiefs of staff have stepped forward to support the Partnership for Veterans Health Care Budget Reform in requesting that Congress support the concept of Advance Funding. Appropriations should be matched with the number enrolled in providing for the timely and sufficient care of veterans. BVA supports the recommendations of the VSO Independent Budget and the group's analysis and budget projections for the time period leading up to FY 2010.

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 February 12. The most viable long-term solution is to replace the current discretionary system with a new methodology providing for "sufficient, timely, and predictable" funding models. The confusion created by Continuing Resolutions, supplemental appropriations, inaccurate enrollment costs for aging veterans, and constant tinkering to adjust for increasing numbers of injured war veterans entering the system must stop. We request a different health care funding methodology that will eliminate these shortfalls.

VISION IMPAIRMENT SPECIALIST TRAINING ACT (VISTA), H.R. 228

Although Public Law 104-262, The Eligibility Reform Act of 1996, requires VA to maintain its capacity to provide specialized rehabilitation services to disabled veterans, the Department cannot do so when there are not enough specialists to address these needs. With passage of legislation in December 2006 that increased the number of Blind Rehabilitation Outpatient

Specialists (BROS) by 35 nationwide, there are an insufficient number of those certified in blind rehabilitation to provide for the growing number of blind or low-vision veterans.

BVA appreciated the passage of a bill introduced in the House by Representative Sheila Jackson Lee in June of 2007 in the 110th Congress. We were disappointed that the equivalent legislation never passed on the Senate side. Its reintroduction in the House as the 111th Session convened is encouraging. The Vision Impairment Specialists Training Act (VISTA), or H.R. 228, directs the VA Secretary to establish a scholarship program for students seeking a degree or certificate in blind rehabilitation (Vision Impairment and/or Orientation and Mobility). VA testified in favor of this legislation at a previous House hearing. The discretionary scholarship program would provide an incentive to students who are preparing for work in this vital occupation and who would consider entry into VA employment. Because such training is necessary to help veterans function independently, we request that the House and VA Senate Committees include this legislation in the recruitment and retention bills this spring. With 30 currently vacant positions in this field affecting the Continuum of Care of all blinded veterans, we urge immediate passage of this bill.

ELIMINATING DISABLED VETERAN CATASTROPHIC CO-PAYMENTS

H.R. 6445 was introduced and passed with full bipartisan support of the House VA Committee during the 110th Congress. 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 total bill of some $1,500 for a blinded veteran staying at BRC for six weeks. BVA thanks Representative Debbie Halvorson of Illinois for introducing this legislation in the 111th Congress just this week. We appreciate her commitment to help our Nation's veterans in this manner.

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 financial burdens. Veterans who must currently shoulder this hardship, which often involves air transportation, can be discouraged by the co-payments. These payments and the added burden of transportation prevent them from obtaining the crucial rehabilitation training needed to gain independence through the world-class rehabilitation services offered by VA. We request of both Committees that this legislation be introduced again and passed during the first session of the 111th Congress.

BLIND VETERANS FAIRNESS ACT

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 nonservice-connected, currently

receive an annual payment of $1,101. The figure is $750 in New Jersey, $1,800 in Pennsylvania, and $2,000 in Massachusetts. Under current law, however, such blinded veterans actually lose their VA pension benefits for receiving this modest annuity from the aforementioned states. 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.

H.R. 3997, enacted in the 110th Congress, 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. Veterans currently receiving these small state annuities are often disabled and 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.

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.

The need for financial support to disabled veterans is urgent. Waiting for action by VA on their pending claims, veterans and their families often suffer hardships, resulting in protracted delays that can lead to financial strains. Some of our "Greatest Generation" veterans have died after waiting for years for their disability claims to be resolved. "The New Greatest Generation" of OIF and OEF veterans faces the same situation in years to come if action is not taken immediately to address this broken system. Meeting the claims needs of disabled veterans, especially the recently injured who served in Iraq and Afghanistan, should be a top priority of Congress and VA. New and improved information technology should be utilized to fix this problem. We request 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.

BLIND REHABILITATION CENTERS

After 60 years of existence and progress, 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 2008 resulted in 1,884

blinded veterans receiving full rehabilitative services and adaptive prosthetics prescribed by VA eye care specialists. The services also provided information on disability benefits.

BRCs are especially important for returning OIF and OEF service personnel. Combat-blinded veterans 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. BRCs can deliver the entire array of highly medical surgical and psychiatric specialized care needed for veterans to fully optimize their rehabilitation outcomes and successfully reintegrate into their families and communities. Mr. Chairman, we wish to strongly emphasize that private agencies lack all of the highly specialized consultant services and the VA prosthetics expertise that our residential blind centers have each developed over many years of experience. Only the inpatient VA BRCs have all of the diverse, specialized, and necessary orthopedics, neurology, rehabilitative medicine, occupational and physical therapy, pharmacy services, radiology, and lab services to treat the complex sounds of these service members. Further questions must be asked about the ability of some private agencies to demonstrate quality outcome measurements that are already part of VHA. We recommend further that services be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). We urge that such services also submit peer reviewed scientific studies demonstrating measures of functional improvements, not routine surveys of patient satisfaction attitudes toward treatments that often do not meet the scientific standards to be included in publication reviews.

There is no environment of which we are aware that better facilitates the initial emotional adjustment to the severe trauma associated with the traumatic loss of vision than full VA comprehensive blind rehabilitation. VHA Blind Rehabilitation Service (BRS) should have more 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 outpatient programs while ensuring continued full staffing at the BRCs. Development of outpatient services is a positive step forward that improves access for blinded veterans. With the current structure and system of VISNs, however, some medical center directors may attempt to mandate that BRC directors cut staff, reduce the number of inpatient beds, or limit the time of the individualized training inherent in these highly specialized programs. Oversight of the high quality and excellent reputation of BRCs must continue.

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. Seamless Transition from DoD to VHA is best achieved through the dedication of VIST and BROS personnel. VIST Coordinators are now following the progress of 130 visually impaired or blind OIF/OEF veterans who are receiving services as outpatients.

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 46,269 blinded veterans, a number that is projected to increase to 52,000 within five years.

It is our belief that as the current system successfully encourages additional outpatient programs, VA should increase the number of full-time VIST Coordinators. We urge Congress and VA to create funding for more full-time Coordinator positions. The part-time Coordinators handle ever-increasing workloads, which results in greater difficulty to help the hundreds of blinded veterans utilize the variety of services available to them. .

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 100 or more blinded veterans on its rolls should have a full-time VIST Coordinator. Veterans attending BRCs often require additional training later due to changes in adaptive equipment or technology advances. VISTs and BROS ensure that such training occurs. Thanks to passage of BROS legislation during the 109th Congress, VA BRS established 30 new BROS positions during FY 2008 in facilities throughout the system. 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 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 Skills Training, Orientation and Mobility, and Low-Vision Adaptive Devices Therapy with appropriate prosthetics. The programs combine many of the features of a residential BRC with those of outpatient service delivery. 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 a part-time Low-Vision Ophthalmologist.

VIAB's report recommended and endorsed a plan for this delivery model to be replicated within each VISN Network that does not currently have a BRC. BVA is pleased that 11 VISN networks now have them. The program uses "hoptel" beds to house veterans so that 24-hour nursing coverage is not required. The experience is similar to staying in a hotel. BVA expects these new programs to considerably improve existing services, 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 four days. Veterans undergo a comprehensive, low-vision optometric evaluation. Appropriate low-vision prosthetics devices are then prescribed. This process is subsequently accompanied by necessary training with the devices so that independence in daily life can be maximized.

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 require low-vision services. The Palo Alto VA Polytrauma Center and Eye Clinic, for example, have already initiated the screening of OIF/OEF veterans for PTVS. The Intermediate Low-Vision Programs being planned and implemented will assist in the growing rehabilitation needs of aging veterans with degenerative eye disease. They will enable working individuals to maintain their employment and retain full independence over their lives. Legally blinded veterans who have already attended a residential BRC and who have received specialized low vision aids that require minor modifications will benefit greatly from these expanded intermediate outpatient programs. They will provide a means for testing the effectiveness of new technology aids through review, research, and the writing of new prescriptions when appropriate. Programs such as the new Advanced and Intermediate Low-Vision programs are cost effective in improving access and quality care for high-need, low-vision veterans with residual vision from conditions such as macular degeneration, diabetic retinopathy, and other co-morbidities.

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 2009, Congress increased the amount to $510 million. Severely disabled service members returning from war zones need the very finest in research, training, and rehabilitation care. Ensuring adequate funding for such care is crucial.

Future research could potentially preserve sight, restore lost functions, and/or prevent further deterioration. BVA endorses the recommendation of Friends of VA Research (FOVA) that the

VA Medical and Prosthetics Research Program receive a total of $575 million in FY 2010 in order to keep pace with biomedical research cost increases. We also support the FOVA request for construction funding directed at the many medical centers that have old research clinics. The age of such facilities reduces the speed with which new research progresses. It also cuts down on efficient utilization of physical resources if facilities do not allow technology to be implemented to its fullest capacities. Old facilities also cause recruitment and retention problems.

BVA also strongly supports the National Association of Eye Vision Research (NAEVR) position that eye and vision research funding be expanded in the DoD Peer Reviewed Medical Research Program (PRMRP) within the Congressionally Directed Medical Research Program (CDMRP). While there were 56 grant applications received for FY 2009, the program received barely enough funding for six research projects. We request, for FY 2010, an increase in PRMRP of $10 million as a dedicated line item for Vision Research. The request is based on the large number of serious combat eye-injured returning from Iraq and Afghanistan, a number believed to be approximately 13 percent of all wounded who have been evacuated by air.

OVERSIGHT

Mr. Chairman, we emphasize again that the establishment and progress of the DoD/VA Vision Center of Excellence and Eye Trauma Registry should be carefully overseen. With approximately 4,970 moderate to severe combat eye-injured from OIF and OEF operations, and ever-increasing reports of the TBI visually impaired returning from duty, follow-up from both Armed Services and these Committees is necessary to ensure that real Seamless Transition is occurring. BVA also recommends that every TBI center within VHA have a low-vision optometrist and ophthalmologist assigned at least part-time to the specialized staff in order to conduct TBI visual screening. We recommend further that cases of vision dysfunction be promptly reported to VHA.

CONCLUSION

Once again, Mr. Chairman, thank you very much for the opportunity to present the Blinded Veterans Association's legislative priorities for FY 2010. BVA is still extremely concerned that all blinded veterans have future access to the full continuum of services discussed here today. We are especially mindful of our returning service members from Iraq and Afghanistan who have experienced visual injuries requiring long-term, specialized rehabilitative services. During its implementation VCE must necessarily have directed funding, staffing resources, information technology support funding for the Registry, and strong oversight by Congress during its implementation. Thank you again, and I will gladly answer any questions you or other Members of these Committees may have concerning our testimony.

RECOMMENDATIONS

1. Make veterans health care "Advance Funding" sufficient, timely, and predictable. BVA strongly endorses the VSO Independent Budget recommendation that funding for veterans health care be removed from the discretionary budget process.

2. Congress must ensure the establishment and funding of the Vision Center of Excellence and Eye Trauma Registry, and that joint DoD/VA resources be available for its success thereafter. We request that Views and Estimates include $6.8 million for Defense appropriations in FY 2010.

3. 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.

4. BVA endorses the recommendation of Friends of VA Research (FOVA) that the VA Medical and Prosthetics Research Program receive $575 million in 2010 to keep pace with biomedical research cost increases.

5. BVA firmly supports the National Association of Eye Vision Research (NAEVR) position that vision research funding in the DoD Congressionally Directed Peer Reviewed Medical Research Program (PRMRP) is essential. BVA urges that $10 million be authorized this year as a line item for Congressionally Directed Medical Research Program (CDMRP) "Vision Research".

6. BVA is grateful that the 52 new outpatient blind and low-vision optometric programs within the "Full Continuum of Care" for veterans were implemented in FY 2008 and 2009. The FY 2010 VHA budget requires $9 million for the planned Continuum of Care.

7. Legislation similar to the previously passed H.R. 6445, which would eliminate the "Catastrophic Disabled Veterans Co-Payment," should be reintroduced. BVA believes that VA should remove the co-payments for catastrophically disabled veterans who are accepted to one of the VA special disabilities programs. For veterans who are currently not eligible for travel benefits, the new law must provide for the cost of their travel to attend one of the inpatient BRCs. Blinded veterans are required to pay the Social Security Administration co-payment and a daily per diem rate during the rehabilitation period, which can exceed a total of $1,500 for a six-week stay. This serves as a strong disincentive to those who would otherwise take advantage of the world-class rehabilitation services offered by VA. BVA is appreciative of Congresswoman Debbie Halvorson's efforts to introduce a new bill just this week.

8. Transitional vocational training and employment assistance are critical if disabled veterans and their families are to be returned to full employment and financial security. We urge family counseling services for all catastrophically wounded with caregiver assistance.

9. 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.

10. 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.

11. The Committees on Veterans Affairs should pass the Vision Impairment Specialist Training Act, H.R. 228. The legislation would make VA BRS employment attractive to university students majoring in a field related to blind rehabilitation. The demand for high-quality Orientation and Mobility Specialists and Blind Instructors is currently high.

12. H.R. 1338, "The Blind Veterans Fairness Act," was passed in the first session of the 110th Congress. The act was designed to prevent a state annuity from counting as Supplemental Security Income. The legislatures of New York, New Jersey, Pennsylvania, and Massachusetts provide a small yearly annuity for blinded veterans who have sustained a total loss of sight as a result of their service. This annuity is provided in New York to all blinded veterans regardless of the cause of blindness. Under current law, lower-income blinded veterans actually lose their VA pension benefits for receiving this modest annuity.