BLINDED VETERANS ASSOCIATION

TESTIMONY
PRESENTED BY

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BVA NATIONAL PRESIDENT

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

BLINDED VETERANS ASSOCIATION

SERVING BLINDED VETERANS SINCE WORLD WAR II

MARCH 3, 2016

INTRODUCTION

Chairman Isakson, Chairman Miller, Ranking Members Blumenthal and Brown, and other Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) and its membership, we appreciate this invitation to present our legislative priorities for 2016. 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.

MEDICAL ACCESS TO REHAB ACT: H.R. 288 AND S. 171

Over the past decade, the VA has developed an outstanding program of rehabilitation services that provides individuals experiencing vision loss with high quality inpatient and outpatient specialized training. These programs are open to veterans whose disability is service connected as well as those who become blind due to eye conditions unrelated to military service. They teach veterans facing the loss of their eyesight basic skills of daily living such as personal grooming, cooking and performance of household chores, as well as how to travel independently without relying on vision, how to use a computer, and do many other tasks that enable a blind person to live a full, productive, and independent life. Veterans who do not have the benefit of such training face, at best, a life of dependence on other people. For those veterans who do not have a support network in place when their vision deteriorates, the only alternative is to go into an assisted living facility or nursing home, and to depend on the VA to pay for their care.

In some cases, the only thing that prevents a blinded veteran from receiving rehabilitative training is the cost of travel to a Blindness Rehabilitation Center (BRC). Current law prohibits the VA from funding travel to BRCs for veterans whose disability is not service connected. BVA believes that it would be a far more wise investment of tax dollars for the VA to pay to transport a blinded veteran who can demonstrate financial need to a BRC for training instead of spending four or five times that amount annually for the life of that same veteran in order to support his or her care in an institution. BVA urges that the costs of travel to and from BRCs be covered by the Veterans Integrated Service Network (VISN) from which the veteran is referred so that such costs do not constitute an added burden on the catastrophically disabled blinded veteran seeking to obtain crucial rehabilitation training. BVA therefore requests passage of legislation before the end of the 114th Congress, ensuring that the Veterans Health Administration (VHA) cover such travel costs by changing Title 38, Section 111 to require the VA to provide transportation costs by air, train, bus, or other methods. The legislation should specify that this transportation is solely for the purpose of providing access to training at a special rehabilitation program serving blinded veterans or the spinal cord injured and that it would be for either inpatient or HOPTEL program medical care.

BVA again thanks Senator Jon Tester for introducing S. 171 and also expresses appreciation to Congresswoman Julia Brownley for introducing H.R. 288, the companion House bill. This legislation would assist low-income and catastrophically disabled veterans by removing the financial burden and hardship of travel expense needed to access vital care that improves independence and quality of life. We affirm our support of this legislation and remind the members of the Veterans Affairs Committees that at both the Senate VA Committee hearing held

on May 9, 2013 and the House VA Subcommittee on Health hearing held June 24, 2013, the VA witness, along with VSO witnesses, testified in favor of this legislation.

To provide some perspective on this issue, the average age of veterans attending BRCs is 67 because of the high prevalence of degenerative eye diseases among people in this age group. Additionally, a large number of our constituents are living below the poverty line. None, of course, can drive an automobile themselves. VA utilization data revealed that one in three veterans enrolled in VA health care was defined as a rural resident or a highly rural resident. The data also points to the fact that blinded veterans in rural regions have significant financial barriers to traveling because of the lack of public transportation.

To elaborate on the challenges of travel without financial assistance, the data found that for most health characteristics examined, enrolled rural and highly rural blinded veterans were similar to the general population of enrolled veterans. The analysis also confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between 55 and 64. Similarly, approximately 25 percent of all enrolled veterans fell into this age group. In FY 2007, rural veterans had a median household income of $19,632, four percent lower than the household income of urban veterans ($20,400). The median income of highly rural veterans showed a larger gap at $18,528, adding significant barriers to paying for air travel or other public transportation to enter a VA BRC or other rehabilitation program.

More than 70 percent of highly rural veterans have to drive more than four hours to receive tertiary care from VA. The FY 2015 VSO Independent Budget reports from current VA research that among all VA health care users, 36 percent (more than 2.2 million) reside in rural areas, including 76,955 from “highly rural areas” as defined by VA in 2012.

State and private agencies are not the answer either since they do not usually operate blind services in rural regions. In fact, almost all private blind outpatient agency services are located in large, urban cities, making them impossible to access for daily outpatient rehabilitation by rural, elderly blinded veterans needing training. The Department of Veterans Affairs Blind Rehabilitation program is also attached to a VA Medical Center, which allows the veteran to continue receiving any additional medical care while attending a VA BRC Program.

For all of these reasons, BVA urges both of these Committees, and both Houses of Congress, to reconsider the value of this proposed statutory change. If a low-income veteran needs blind rehabilitation training to learn the skills to live independently at home, BVA believes that the benefit of a $400 airline ticket to get to a BRC will far outweigh its cost to both our nation and our blinded veterans. We again urge Congress to provide this small change in eligibility for Beneficiary Travel/Access to Care and pass H.R. 288 and S. 171 before the close of this session.

VA INFORMATION TECHNOLOGY AND SECTION 508 REHAB ACT COMPLIANCE

Section 508 of the Rehabilitation Act, which was incorporated into the Workforce Innovation and Opportunity Act of 2015, requires federal agencies to ensure that all electronic and information

technologies developed, procured, maintained, or used in the federal environment provide equal access for federal employees and members of the public. A 2012 Department of Justice report indicated that although Section 508 was enacted in 1998, major challenges with regard to the implementation and management of compliance with this provision still exist throughout the government. The report makes recommendations for training, policy, and better collaboration. We are particularly concerned about the extent to which websites and information technologies utilized by the VA remain out of compliance with Section 508. BVA has repeatedly requested in its annual resolutions that web content posted by VHA and VBA and Information Technology used throughout the VA be fully compliant with Section 508, as well as Section 504 of the Rehabilitation Act. We appreciate the fact that both the House and Senate Committees on Veterans Affairs have requested VA briefings on these issues and required updates on the status of the Department's efforts to comply with 508 and 504 accessibility requirements. The following 508 and 504 compliance issues are areas of specific and ongoing concern:

- Inaccessible kiosks at VA Medical Centers, the use of which is required to check in for scheduled appointments.
- Inaccessible Telehealth tools, namely the Health Buddy home monitoring station.
- VBA webpages containing eBenefits information that are inaccessible to blind people 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 the VA to insure its capacity to address internal and external accessibility issues.
- VA's failure to provide information in alternate formats that can be read by veterans with visual disabilities, in spite of their acknowledgement that such information can and should be provided.

Blind VA employees and BVA National Service Officers are frequently shut out of significant portions of the VHA and VBA information management systems because of their incompatibility with screen readers and other adaptive equipment used by these individuals in order to do their work. We request that Congress continue its strong oversight to ensure that the VA will devote more of its information technology program funding and human capital resources to improving accessibility for both employees of the VA and members of the public. Additionally, we request continued Congressional oversight that will hold the VA accountable for meeting stated timelines for fixing its inaccessible websites and replacing inaccessible obsolete hardware and software with equipment and applications that are accessible to and usable by people with disabilities.

There are more than a million veterans in the U.S. who have diagnosed visual disabilities. Regardless of the specific nature of such a disability, a key requirement of any determination that an individual has a visual disability is a demonstrated lack of ability to read printed material without the aid of magnification. In spite of this fact, the Department of Veterans Affairs has made virtually no effort to communicate with visually impaired veterans in alternate formats that such veterans can read. We find this state of affairs very disturbing. A case in point: This organization requested more than 18 months ago that the VA's publication on veterans' benefits be made available on a compact disk in mp3 format so that veterans could listen to the information. We were repeatedly assured that this was readily achievable and that CDs would be

sent to us for distribution to our members. Yet, we are still waiting for those CDs. Further, while this publication would be valuable, even its availability may not help those individuals who receive correspondence from the VA regarding their personal applications for benefits or services, which they currently cannot read without assistance.

We believe that it is imperative for the VA to establish policies and procedures that will enable it to provide correspondence and other communications with veterans who have visual disabilities in electronic, audio, or large print formats, in order to ensure that the veteran have independent access to such communications. This need will only grow over the next few years, and the VA would do well to begin addressing it now rather than later. We ask the House and Senate Veterans Affairs Committees to join with us in support of this effort and exercise their oversight to hold the VA accountable for making progress on this matter.

Finally, we suggest that Congress require the VA to create an Information Accessibility Officer position, which would be required in every VA Medical Center and each Veterans Benefits Administration (VBA) Regional Office. This Information Accessibility Officer would serve as a liaison between the 508 compliance officer, the veteran, the service officer, and the blind VA employee in the office. Together, these officers would be responsible for ensuring that each and every veteran has access to and the necessary knowledge to use VHA and VBA documents and websites. They could also educate veterans on how to navigate VA websites and notify the VA of any barriers that may limit veteran access to information.

DOD VISION RESEARCH PROGRAM FOR FY 2017

BVA, along with several other Veterans Service Organizations and Military Service Organizations, again supports the Department of Defense (DoD) Vision Research Program's (VRP) programmatic request of $15 million for Fiscal Year (FY) 2017. The specific request is directed to the Peer Reviewed Medical Research Program (PRMR) for extramural translational battlefield vision research. BVA requests the increase to $15 million for FY 2017 to meet identified DoD gaps in this area of battlefield research.

The Peer Reviewed VRP, within the Congressionally Directed Medical Research Program (CDMRP) appropriations, funds critical extramural vision research into deployment-related vision trauma that is not currently conducted by the Department of Veterans Affairs (VA), nor elsewhere within DoD (including the joint DoD/VA Vision Center of Excellence), nor by the National Eye Institute (NEI) within the National Institutes of Health. Less than one percent of the NEI budget and VA research are allocated to vision research and none to penetrating eye blast injury research. The largest vision research organizations consisting of the National Association for Eye and Vision Research (NAEVR), the American Academy of Ophthalmology (AAO), the American Optometric Association (AOA), and the Association for Research in Vision and Ophthalmology (ARVO) all stand together with BVA to urge Congress to fund the VRP at $15 million for FY 2017.

Today, battlefield conditions have been such that among all service members who have been medically evacuated from Iraq and Afghanistan due to Improvised Explosive Device (IED) blast forces, 14.9 percent of them have been victims of penetrating eye injuries and Traumatic Brain

Injury (TBI) related visual system dysfunction. With the continued presence of the United States in Afghanistan, coupled with other global threats, eye injuries will continue to be a challenge. The VHA Office of Public Health has reported that from October 2001 until the end of the second quarter of FY 2015 (March 30, 2015), the total number of vision-injured Operation Iraqi Freedom (OIF) and Operation Enduring Freedom, Afghanistan (OEF) veterans enrolled in VA was 201,960. These included 20,356 with retinal and choroid hemorrhage injuries (including retinal detachment), 4,985 with optic nerve injuries, 12,153 with corneal injuries, 26,290 with traumatic cataracts, and 27,541 with acute angle glaucoma, 49 percent of them below age 36.[i]

Additionally, a Johns Hopkins Public Health 2012 study using published data during 2000-2010 estimated that deployment-related eye injuries and blindness have cost the U.S. $2.3 billion a year, yielding a total of $25.1 billion, driven primarily by the present value of long-term benefits, lost wages, and family care related to these vision conditions.[ii] Upwards of 75 percent of all TBI patients experience short- or long-term visual disorders (double vision, light sensitivity, inability to read print, and other cognitive impairments). Direct blast injuries research reveals potential long-term ocular injuries from the blast wave. Research to effectively treat vision trauma and TBI-related visual disorders can have long-term implications for an individual's vision health, productivity, and quality of life for the remainder of military service and into civilian life.

Continued demand for research during the FY 2009-2010 VRP funding cycle, the program's first year, brought 120 pre-applications. There were 50 who were invited to submit full proposals and 12 projects were funded. In the combined FY 2011-2012 VRP funding cycle, 151 pre-applications were received, 50 were invited to submit full proposals, and only 21 projects were funded. In the combined FY 2013-2014 VRP funding cycle, 275 pre-applications were received and 151 were invited to submit full proposals. The number of applications awarded with existing funds is flat (approximately 20 or fewer per year) despite the increase in high quality proposals. We therefore recommend $15 million for VRP.

VRP Funding Yields Deliverables

VRP funds 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 research, which facilitates development of diagnostics, treatments, and therapies− those that can be employed on the battlefield critical to save vision. Research projects funded by the first two VRP funding cycles (2009-2010 and 2011-2013) have resulted in 80 published peer reviewed papers that are advancing knowledge about the diagnosis and treatment of eye trauma injuries.

VRP funding has also supported the development of a portable, hand-held device to analyze the pupil's reaction to light, enabling rapid diagnosis of TBI-related vision dysfunction. Other research resulted in the development of a new "ocular patch," which is a nanotechnology-derived reversible glue that seals lacerations and perforations of the eye globe on the battlefield, thus saving vision. Additional research has validated a computational model developed of the human eye globe to investigate injury mechanisms of a primary blast wave from an IED, which accounted for 82 percent of the blast injuries in Iraq and Afghanistan. The model determines the stresses on and deformations to the eye globe and surrounding supporting tissue structures to enable DoD to develop more effective eye protection strategies reducing future injuries, as well as their associated costs. Another recent development involves a new vision enhancement system

that uses modern mobile computing and wireless technology, coupled with novel computer vision (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. As you can see, the Vision Research Program funding from Congress is already having an impact. BVA requests the $15 million within CDMRP for FY 2017 to further this research.

DoD-VA VISION CENTER OF EXCELLENCE (VCE) AND HEARING CENTER OF EXCELLENCE (HCE) OVERSIGHT ISSUES

Health care is currently provided to more than 922,000 veterans who served in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn/Operation Inherent Resolve (OIR) and Operation Freedom's Sentinel (OFS).[iii] We also expect that additional service members will be deployed into dangerous war zones, exposing them to new injuries, given current conditions in Iraq, Syria, and Afghanistan. The VA health care system, after more than 14 years of conflict in the Middle East, has acquired on its rolls an increasing number of visually impaired and hearing impaired veterans who were wounded in the wars.

In FY 2008, bipartisan members of these Committees and the Armed Services Committees supported the establishment of both the Vision Center of Excellence through the FY 2008 National Defense Authorization Act (NDAA, P.L. 110-181), as well as the Hearing Center of Excellence and Limb Extremity Center of Excellence through the FY 2009 NDAA (P.L. 110-147). Congressional intent was that the goal of these Centers of Excellence would be to enhance the care of American military personnel and veterans wounded or otherwise affected by combat eye, hearing, and limb extremity trauma. Care enhancement would come through improvements in prevention, diagnosis, treatment, research, and rehabilitation. These centers are charged with strengthening clinical coordination between DoD and VHA, having been mandated with developing bidirectional joint clinical injury registries with up-to-date information on the diagnosis, surgery, treatment, and follow-up evaluations for the returning injured.

VHA records reveal that 201,980 OIF/OEF/OND veterans with eye conditions entered the VA system for care from October 2001 through March 30, 2015.[iv] The Hearing Center of Excellence website has 325,000 service members with hearing loss or Tinnitus. Unfortunately, these registries after five years are still not fully bi-directionally functional. While VCE DoD contractors have entered more than 33,000 of the eye-injured into the DoD Veterans Eye Injury Vision Registry (DVEIVR), VA has entered a total of 1,900 veterans' records into their Military Veterans Eye Injury Registry (MVEIVR). VHA in FY 2013 contracted and developed its own MVEIR with contractors entering the records. The latter system complicates the direct sharing of data with the DVEIR. The first Government Accountability Office Report (GAO), 11-114 of January 31, 2011, found that while hearing loss is a major physical injury from the wars, progress on starting a joint hearing registry to track and develop coordinated care between the two systems lags far behind VCE.[v]

Dec 2015 Report: DOD and VA Need Better Documentation of Oversight Procedures

GAO found that DoD has developed criteria to designate an entity as a Defense Center of Excellence (COE), but that VA VHA has not. Health-focused COEs are intended to bring together treatment, research, and education to support health provider competencies; identify gaps in medical research and coordinate research efforts; and integrate new knowledge into patient care delivery. GAO found that DoD leadership and its Defense COE Oversight Board established and refined the definition and criteria for designating entities as Defense COEs. DoD's criteria require its Defense COEs, for example, to achieve improvements in clinical care outcomes and produce optimal value for service members. The Oversight Board developed these criteria in order to have a consistent basis for designating entities as Defense COEs and to limit the ability of entities to self-identify as Defense COEs without meeting the criteria. DoD also developed a uniform process for designating COEs. VHA service offices use a peer review process to designate their COEs.

However, unlike DoD, VHA has not developed criteria for designating its COEs. Federal internal control standards provide that management should have a control environment that provides management's framework for planning, directing, and controlling operations to achieve agency objectives, such as VHA's objectives for how COEs are to operate and what COEs are supposed to achieve. Without defined criteria, VHA lacks reasonable assurance that its COEs are meeting the agency's intended objectives for COEs.[vi] The Defense COE Oversight Board and most service offices responsible for overseeing VHA COEs lack written procedures for documenting oversight activities related to their COEs, including requirements for documenting identified problems and their resolution.

BVA calls attention to these findings in the GAO report, which was sent to the chairmen of both the House and Senate Veterans Affairs Committees as evidence that more Congressional oversight is needed. We also question why the Surgeon General of the Navy manages the Vision Center of Excellence while the Hearing Center of Excellence is under the Surgeon General of the Air Force. VA’s limited flat line budgets and low staffing have combined to hinder significant progress toward the full establishment of the VCE and HCE. Deputy Assistant Secretary of Defense for Health Affairs Dr. Jonathon Woodson had planned in 2014 to merge these COEs under Defense Health Affairs but this has not yet occurred. BVA requests that the House and Senate Committees hold hearings with senior witnesses from both the Defense Health Affairs and senior VHA representatives to answer questions and to explain the lack of progress toward fully implementing these two COEs during the past six years.

FUNDING VHA BLIND REHABILITATION SERVICE (BRS)

Integrated among OIF and OEF veterans with eye injuries is an aging veteran population that can be characterized by a growing prevalence of age-related degenerative visual impairments. During FY 2015, there were 48,792 blinded veterans on permanent VIST Coordinator case management lists. VA research studies estimate that there are 131,580 legally blinded veterans in the U.S. population.[vii] 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. About 285,000 have glaucoma. VA currently operates 13 comprehensive residential BRCs across the country. BRCs

still provide the ideal environment in which to maximize the rehabilitation of our Nation's blinded veterans. Unfortunately, however, the Veterans Integrated Service Networks (VISNs) directors and medical center directors at some sites are claiming that there is no funding for replacing staff members who retire or transfer to another facility. A growing number of BRCs therefore now lack the staffing to help blinded veterans acquire the essential adaptive skills to overcome the many social and physical challenges of blindness.

BVA recommends that the VHA BRS Director be given VHA central control over the blind centers, personnel resources, and funding levels. BVA would like the Congressional Oversight Subcommittee to ask where the BRS funding is being used. VHA and VISNs should be required to explain how funds are allocated within and among BRCs. 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 rehabilitation admissions from the blind centers to other general medical operations. There should be no bed closings or hiring freezes on critical blind center staff positions. VHA must maintain the current bed capacity and full staffing levels in the BRCs that existed at the time of passage of Public Law 104-262.

The Visual Impairment Service Team (VIST) structure now employs 123 full-time Coordinators and 38 who work part-time. VIST Coordinators nationwide serve as the critical key case managers. There are also 81 full-time Blind Rehabilitation Outpatient Specialists (BROS). BVA believes and has long maintained that any VA facility with 150 or more blinded veterans on its rolls should have a full-time VIST Coordinator. BVA and other endorsers of the VSO Independent Budget for FY 2016 assert that in order to strengthen the ability of VHA to recruit and retain VHA health care professionals, they must have access to Continuing Medical Education conferences and updates on emerging research and professional development education to meet licensure and certification standards.

Private agencies for the blind lack the necessary full specialized nursing, physical therapy, pain management, audiology and speech pathology, pharmacy, and radiology support services. Also, most private agencies are all outpatient centers in major cities that cannot be accessed by our rural blinded veterans. In many rural states there are no private inpatient blind training centers, leaving the VA BRCs as the only option.

BVA requests that the VA ensure that all contracted care from any private agencies be required to demonstrate the peer reviewed quality outcome measurements that are a standard part of VHA BRS. They must also be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Blind Instructors should be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). No private agency should be used for newly war blinded veterans unless it can provide clinical outcome studies, evidence-based practice guidelines, mental health care counseling, and joint peer-reviewed vision research.

SUPPORT FOR S. 901, TOXIC EXPOSURES RESEARCH ACT OF 2015

BVA supports the "Toxic Exposures Research Act" (H.R. 1769 and S. 901 sponsored by Representative Dan Benishek and Senator Jerry Moran, respectively). However, BVA is specifically concerned about growing evidence that appears to demonstrate a link between exposure to toxic substances such as Agent Orange and the development of eye cancers. Vietnam era veterans exposed to toxic substances during their service in the Armed Forces have been diagnosed at the rate of 2,000 cases per year from 2007 through 2011. While Choroidal Melanoma (CM) is the most common primary malignant intraocular tumor and the second most common type of primary malignant melanoma in the body, it is still very rare, with occurrences of only 5-6 per one million in the general civilian population.

Demographic reports in the U.S. indicated there was a total of 1,000 new cases diagnosed in 2010. According to these calculations, there should have been about 115 veterans diagnosed with this form of cancer. However, among veterans within the VA system in 2007, there were just under 2,000. In 2008, there were just over 2,000 cases diagnosed, about 2,200 in 2009, and about 1550 cases in 2010. BVA requests that Members of these Committees direct that the VA appoint an ophthalmology peer review committee to assess the incidence of CM among veterans exposed to Agent Orange. We would also like to see further cooperative research by VA, DoD, and the National Eye Institute into this potential correlation. We believe S. 901 would spur such efforts. For the past four years, this alarming finding among Vietnam veterans has been ignored, and this must change.

CONCLUSION

Once again, Chairman Isakson, Chairman Miller, Ranking Member Brown, Ranking Member Blumenthal, and all Members, thank you most especially for the opportunity to present BVA's legislative priorities before you today.

RECOMMENDATIONS

- BVA requests that the 114th Congress pass H.R. 288 and S. 171, Medical Access to VA Blind Rehabilitation Centers (BRCs), which would amend Title 38 U.S.C., Section 111 to include catastrophically disabled veterans.
- BVA requests that the 114th Congress conduct an Oversight Hearing on VA lack of compliance with Section 508 throughout the VHA and VBA Information Technology programs, and require that VA set timelines, funding levels, and staffing.
- Requests oversight of full establishment of the VCE and the Defense Veterans Eye Injury Registry (DVEIR) on resources, program management, and funding. Request similar oversight for the Hearing Center of Excellence.
- DoD Vision Research Program (VRP) line item within the Congressionally Directed Medical Research Program should be $15 million for FY 2017 appropriations.

- Requests revisiting the issue of ensuring that VHA provide vital medical educational conferences to meet the recruitment, retention, licensure, certification, and professional development standards necessary for a well-qualified VHA workforce.
- Urges that Congress pass S. 901, the Toxic Exposures Research Act of 2015, to provide for research and treatment of vision-related conditions that continue to plague Vietnam era veterans and request a VA study of the link between Agent Orange and Choroidal Melanoma Eye Cancer.
- 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.

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[i] VHA Office Public Health OIF/OEF/OND **Veterans Medical Encounters for Disorders Eye and Vision**, FY 2002 to March 31, 2015 Enrollment Code data report.

[ii] Frick, Kevin Ph.D., **Cost of Military Eye Injury and Blindness**, Johns Hopkins Bloomberg School of Public Health, Published May 2012.

[iii] VA FY 2017 Budget Press Release February 10, 2016 War Related Health Care Services.

[iv] VA Office Public Health, Post Deployment War Injury Related Vision Injury & Illness, ICD-10 OIF/OEF/OND Eye Injury Enrollment Codes FY 2002 – Second Quarter March 31, 2015.

[v] "Hearing Loss Prevention: Improvements to DoD Hearing Conservation Programs Could Lead to Better Outcomes" GAO-11-114 January 31, 2011.

[vi] GAO-16-54: Centers of Excellence, Published: Dec 2, 2015. Publicly Released: Dec 2, 2015.

[vii] VHA Blind Rehabilitation Service responses to BVA Board report August 24, 2015 VA Enrollment.

ROBERT "DALE" STAMPER

The Reverend Robert "Dale" Stamper, BVA National President and a member of the organization's Spokane Inland Empire Regional Group, was part of a unit assigned in early 1968 to replace a bridge that had been destroyed by the North Vietnamese. As he scouted the area, he tripped a landmine. The explosion knocked out Dale's right eye immediately. A small piece of shrapnel severely infected his left eye, which later had to be removed. Although the MASH unit to which he was transported saved his life, he also suffered multiple broken bones and required several surgeries.

A native of Atwater, California, Dale enlisted in the Army immediately after high school at age 18 and underwent basic training at Fort Ord in Monterey. He also completed three months of advanced training in engineering at Fort Leonard Wood, Missouri. After AIT Dale received orders for Vietnam; he was assigned to C Company 15th Engineers Battalion.

Dale's military honors include the Purple Heart, the National Defense Service Medal, the Vietnam Service Medal, the Republic of Vietnam Campaign Medal with Device 1960, and Marksman (Rifle M-14). Following his recovery, he completed VA Vocational Rehabilitation and one year at San Jose State University. He transferred to Fresno State University, where he began a degree in psychology, and then to the Evangelical Christian College in Fresno, where he earned a B.A. in theology with an emphasis on counseling.

Dale is presently on staff at a large church in Post Falls, Idaho. His duties include preaching, teaching, counseling, and making hospital visits with the assistance of a secretary. He also volunteers as a mentor to many clergy who seek him out regularly for his wisdom and ability to guide others. Although he writes his notes in Braille for his own use, Dale also spends several hours a day on a computer so that he can forward Bible study sessions, notes taken at special meetings, and lesson plans to the sighted members of his Bible study group. He is now using his third computer system, having become proficient with JAWS.

Prior to his current staff position, Dale served as a minister for more than 30 years in small and large churches in less populated areas. He was a missionary in the Philippines during 1994-96. Regarding his blindness, Dale expresses the following: "I forget that I am blind and then also make others forget. Then they are surprised if I have to ask for help."