BLINDED VETERANS ASSOCIATION

SERVING BLINDED VETERANS SINCE WORLD WAR II

TESTIMONY

PRESENTED BY

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BVA NATIONAL PRESIDENT

BEFORE A JOINT SESSION OF THE

SENATE AND HOUSE COMMITTEES

ON VETERANS AFFAIRS

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INTRODUCTION

Chairman Tester, Chairman Bost, Ranking Member Moran, Ranking Member Takano, and distinguished Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) and its membership, we appreciate this opportunity to present our legislative priorities for 2024. As the only Congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our nation's blind and low vision veterans, their families, and caregivers, BVA first wishes to highlight "National Blinded Veterans Day," which occurs March 28. The day coincides with the 79th anniversary of the organization's 1945 founding by World War II blinded Army service members at Avon Old Farms Army Convalescent Hospital in Connecticut.

BVA hopes that this 2nd session of the 118th Congress will proactively address the following legislative priorities:

- Establishing a Veterans Advisory Committee on equal access
- Overseeing compliance with transportation services
- Enhancing caregiver program clinical standards
- Supporting Department of Veterans Affairs Blind Rehabilitation Service funding
- Safeguarding ocular clinical standards of care
- Enhancing veterans mental health care
- Improving programs and services for women veterans
- Enacting protections for guide and service dogs
- Supporting vision research funding
- Honoring combat disabled veterans

ESTABLISHING A VETERANS ADVISORY COMMITTEE ON EQUAL ACCESS

As the only national VSO chartered by Congress exclusively dedicated to assisting veterans and their families coping with Blindness and Low Vision (B/LV), ensuring that our nation's veterans have equal access to their earned benefits remains a top priority. Veterans with disabilities have a right to equal access to programs, services, and information at the Department of Veterans Affairs (VA). Yet, recent Congressional oversight found that VA has failed to consistently make its websites, kiosks, and other technology accessible for people with disabilities, as required by law. Over 60 million adults in the United States have a disability, including over one-quarter of our Nation's veterans. Older adults are more likely to develop a disability, including more than 8 million veterans age 65 or older. Older adults in general are a rapidly growing segment of America's population, making accessibility essential for maintaining access to programs and benefits. This legislation would provide veterans with a voice to improve accessibility at VA so that no one is left behind.

BVA thanks Congress for its continued support of our nation's B/LV veterans, demonstrated by the passage of "S. 3587, the VA Website Accessibility Act of 2019." This bipartisan legislation

directed VA to report to Congress on the accessibility of VA websites (including attached files and web-based applications) to individuals with disabilities. BVA requests that there continue to be strong oversight and transparency on VAs progress of updating websites, files, and applications that are still inaccessible to such individuals. We remain discouraged by learning that platforms such as SharePoint, used throughout the VA enterprise, and other similar platforms, will not be addressed by these reviews, as VA believes they are not websites. Interestingly, Microsoft, the maker of SharePoint, defines it as "a secure 'site' to store, organize, share, and access information from any device enabling 'websites' to function via a web-browser." To the B/LV user, SharePoint looks and acts just like a website. Thus, the Department appears to depart from its alleged goal of becoming world-class promoters of diversity, equity, inclusion, and accessibility as it seems to intentionally exclude B/LV persons.

The Rehabilitation Act of 1973 is a cornerstone of U.S. disability law that made diversity, equity, inclusion, and accessibility of disabled persons a priority of the federal government. Section 508 requires that federal technology be accessible and usable by persons with disabilities. VAs most recent Congressional report stated that only 7.8 percent of its 812 websites are fully compliant with Section 508 of the Rehabilitation Act of 1973. This is woefully worse than the rest of the federal governments websites, which are at 20 percent compliance. Additionally, VA remains noncompliant with Section 508 of the Information and Communications Technologies Refresh of 2017. VAs 58 Veterans Benefits Administration Regional Offices (VAROs) received Section 508 conformance ratings of 52 percent or less, and the internal employee phone book site is rated at zero percent compliant. VAs career website was rated at 16 percent conformant while the Office of Employment Discrimination and Complaint Adjudication website was rated at 22 percent conformant. Noncompliant digital technologies result in monetary and varying other potential harm to the overall care and well-being of veterans, as well as to VA employees with disabilities.

The Department of Veterans Affairs Office of Inspector General (VA OIG) report "VBAs Compensation Service Did Not Fully Accommodate Veterans with Visual Impairments (Report No. 21-03063-04)" found that the Veterans Benefits Administration (VBA) Compensation Service did not fully comply with Section 504 of the Rehabilitation Act of 1973. The review team determined that visually impaired veterans could be excluded from accommodations by the Compensation Service's criteria, and even the legally blind veterans who meet the criteria are not accommodated through the entire claims process. Although VBAs Adjudication Procedures Manual instructs claims processors to contact visually impaired veterans by telephone to discuss the contents of decision notices, 87 of 100 claims reviewed showed no documentation of processors making such calls. Consequently, some veterans may not have been made aware of adverse claims decisions or their rights to challenge such decisions. VA OIG concluded that the Compensation Service's continued failure to coordinate with relevant agencies, along with its failure to comply with VA-wide accessibility implementation requirements, will continue to make it more difficult for veterans with visual impairments to participate fully in the disability compensation program.

VA OIG made five recommendations to the undersecretary for benefits: (1) Update the process for developing, approving, and issuing guidance for accommodating visually impaired veterans to include steps for consulting with the Office of General Counsel; Office of Resolution Management, Diversity, and Inclusion; and previously, the Department of Justice Civil Rights Division; (2) Update the adjudication procedures to comply with federal regulations and VA policies; (3) Develop and implement a quality assurance mechanism to ensure compliance with accessibility requirements; (4) Assign accessibility coordinators, publicize their names, and conduct a self-evaluation of policies outlined in VA accessibility requirements; and (5) Coordinate a process to ensure visually impaired veterans are informed of the availability of accommodations. To date, we are unaware of any remediation efforts by VBA addressing these concerns.

While we truly appreciate the efforts of VA OIG, we remain disheartened by VA senior leadership's refusal to consider Fiscal Year 23 (FY23) MilCon/VA appropriations language encouraging "the Department to explore options, such as a VA Accessibility Office led by a Chief Accessibility Officer, to ensure that the accessibility needs of disabled veterans and employees are met." B/LV and other disabled veterans will continue to face barriers until accessibility becomes a top priority for VAs entire enterprise. These intentional barriers faced by B/LV individuals are illegal and must come down.

The Veterans Accessibility Act of 2023 would establish a Veterans Advisory Committee on Equal Access at VA. The Advisory Committee would issue regular reports on VAs compliance with federal disability laws, including the Americans with Disabilities Act and the Rehabilitation Act. The reports would include recommendations for improving VAs compliance, and would be shared with Congress, the public, and agencies that oversee the Nation's disability laws. Veterans with disabilities would be among the Advisory Committee's members, ensuring that their voices are heard.

OVERSEEING COMPLIANCE WITH TRANSPORTATION SERVICES

A common complaint BVA hears from its membership relates to their transportation challenges to get to and from VA medical appointments. VA transportation is often not available, or when it is available, it is inadequate and unreliable. Many VA Medical Centers (VAMCs) require veterans to schedule their Veterans Transportation Service (VTS) accommodations at least 30 days in advance of their medical appointment, which creates a barrier to accessing timely medical care.

Additionally, Special Mode Transportation (SMT) authorizations for VTS eligibility are limited to VA clinicians, currently defined as: Physicians; Physician Assistants; Nurse Practitioners; Certified Nurse Practitioners; Clinical Nurse Specialists; Certified Nurse Midwifes; or Psychologists – rather than Blind Rehabilitation Service (BRS) Visual Impairment Services Team (VIST) Coordinators who are responsible for coordinating care and services for B/LV veterans and service members receiving VA care. BVA believes VIST Coordinators are the most uniquely

qualified professionals overseeing the needs of B/LV veterans and should, therefore, be afforded the authority to authorize SMT.

Although the VTS program is governed by VHA Instruction 1695(1), VAMC staff interpret eligibility requirements differently, leading to a wide variance in eligibility decisions. For example, although the directive authorizes travel due to vision impairment, some VAMC staff require that the B/LV veteran also be in a wheelchair or a gurney in order to qualify for VTS travel. These VAMC staff appear to be interpreting the directive too narrowly in an effort to disenfranchise B/LV veterans.

BVA hears from its members that their VTS travel, which they booked 30 days in advance, is often canceled the day before their medical appointment due to a shortage of drivers. These veterans are then forced to scramble to find a friend or family member to drive them, or pay for a taxi or Uber, or reschedule or miss their appointment.

B/LV veterans also face inadequate reimbursement for travel to their VA medical care. VA is obligated to reimburse the full cost of travel, but often B/LV veterans are only reimbursed the IRS standard of 41.5 cents per mile. Recently, BVA heard from a member who was only reimbursed $15 for his $50 Uber ride to his VAMC. VAMCs should be held accountable for providing the proper reimbursement amount for travel reimbursement claims.

Unfortunately, recent changes to the travel reimbursement process have created additional barriers to B/LV veterans. Previously, veterans could receive cash reimbursement at their VAMC cashier's window while at the VAMC. VA now requires all veterans to submit their travel reimbursement online, but the website is not accessible, meaning that B/LV veterans are often unable to file for their travel reimbursement claims within the 30-day deadline. When asking for help at their local VAMC cashier's window, B/LV veterans are told by staff. "You have to use the website; we can't help you."

To address the travel challenges facing B/LV veterans, BVA calls on Congressional oversight of the VTS program to identify and document these and other challenges B/LV veterans are dealing with when trying to get to and from their VA medical appointments. Additionally, we call for an immediate return to veterans being able to receive their travel reimbursement at their VA facility, and for the 30-day time limit to file VA travel reimbursement claims to be suspended until the travel reimbursement website is brought into full accessibility compliance.

ENHANCING CAREGIVER PROGRAM CLINICAL STANDARDS

The current method of determining eligibility for the VA Program of Comprehensive Assistance for Family Caregivers (PCAFC) is governed by 38 U.S.C. § 1720G and based on a subjective standard that requires a veteran to be unable to perform one or more Activities of Daily Living (ADLs), which are basic self-care tasks like cooking, bathing, toileting, and mobility (such as transferring from a bed to a chair). These ADLs are for sighted people and do not take into account the abilities and limitations of blind or severely visually impaired veterans. BVA calls on

the ADL standard to be revised to take into account the unique challenges and limitations of blinded veterans.

BVA has concerns about blinded veterans being able to safely take their correct medication in the correct amount at the correct time. Medication management is NOT an ADL. Rather, it is classified as an instrumental ADL (iADL), which requires more complex planning and thinking. Even though it is not an ADL, an inability to independently handle one's own medication management should be a qualifier for PCAFC benefits (at least at the lower tier level), especially for blinded veterans or veterans with cognitive impairments who are at high risk of committing medication errors.

On March 25, 2022, the U.S. Court of Appeals for the Federal Circuit set aside VAs definition of "need for supervision, protection, or instruction" in 38 C.F.R. § 71.15 because it determined that VAs definition was inconsistent with the statutory language. Veterans and caregivers await VA rulemaking to update 38 C.F.R. § 71.15.

VAs own numbers have shown the denial rate for PCAFC applications to be as high as 90 percent, which most all stakeholders agree is too high. To improve and simplify the PCAFC adjudications process, BVA calls on the creation of an objective clinical standard for PCAFC eligibility for blinded veterans and proposes a "5/200 corrected acuity (or worse) in both eyes, or a field of vision of 5 degrees or less in both eyes," to qualify blinded veterans for the PCAFC benefit. This proposed clinical standard is the same standard for compensation at the 100 percent rate with Special Monthly Compensation (SMC) L and is far more restrictive than the standard for legal blindness, which requires "20/200 or worse in the better eye, or a field of vision of 20 degrees or less."

The number of potential eligible blinded veterans with service-connected eye conditions who would qualify for PCAFC benefits under this proposed "5/200 or 5 degrees or less standard" is exceedingly small. According to FY22 statistics from VBA, out of the 25 million service conditions that exist today, only 366,268 are for eye conditions. A much smaller number, only 3,368, are for eye conditions rated at the 100 percent rate.

SUPPORTING BLIND REHABILITATION SERVICE FUNDING

In October 2020, VHA implemented a new Continuum of Care for visually impaired veterans, resulting in 81,583 low vision and legally blind veterans comprising VIST Coordinator case management rosters. VHA research studies estimate that there are 130,000 legally blind veterans living in the US. VHA projections indicate that there are another 1.1 million low vision veterans in the US with visual acuity of 20/70 or worse.

VA currently operates 13 residential Blind Rehabilitation Centers (BRCs) across the country. These BRCs provide the ideal environment in which to maximize the rehabilitation of our nation's B/LV veterans. Unfortunately, Veterans Integrated Service Network (VISN) and VAMC Directors at some sites housing BRCs are failing to replace BRC staff who retire or transfer to

other facilities, thus failing to support the Congressionally mandated maintenance of staffing at previous levels. During the COVID-19 surge, all 13 BRCs were closed as beds were reallocated for alternative needs. As a result, rehabilitation training for B/LV veterans went entirely virtual, accompanied by telehealth care. Consequently, many BRCs lack the staffing needed to help B/LV veterans obtain the essential adaptive skills they require to overcome the myriad social and physical challenges of sight loss. Without intervention, we fear that the number of BRCs in this situation will grow. Spinal Cord Rehabilitation has dedicated funding for this express purpose. Modeling BRS funding after this manner would ensure such excellence in care. VAMC Directors should not be allowed to divert BRC Full-Time Equivalents (FTEs) or funds designated by the Veterans Equitable Resource Allocation (VERA) System for these rehabilitation admissions from the blind centers to other general medical operations.

BVA is also concerned about the caseloads of VIST Coordinators and Blind Rehabilitation Outpatient Specialists (BROS). Now that the national caseload has doubled from approximately 40,000 to more than 80,000 B/LV veterans, their capacity to meet the needs of assigned caseloads is in doubt. BVA requests that the Veterans Health Administration (VHA) conduct a resource/demand gap analysis to identify VIST Coordinators and BROS whose caseloads are now overcapacity. The creation and staffing of additional VIST Coordinator and BROS positions may be necessary to adequately address the needs of these additional 40,000 B/LV veterans.

BVA is further concerned that community care funding contracted under the auspices of the VA MISSION Act will take funds away from VA BRCs. BVA holds that VHA must maintain the current bed capacity and full staffing levels in the BRCs that existed at the time of passage of the "Veterans' Health Care Reform Act of 1996" (Public Law 104-262).

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

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

An agency should not be used to train newly blinded combat veterans unless it can provide clinical outcome studies, evidence-based practice guidelines, mental health care counseling, and joint peer reviewed vision research. BVA also supports the Independent Budget Veterans Service Organizations (IBVSO) recommendation mandating that competency standards for non-VA community providers be equivalent to standards expected of VA providers, and that non-VA providers meet continuing education requirements to fill gaps in knowledge about veteran-specific conditions and military culture.

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

SAFEGUARDING OCULAR CLINICAL STANDARDS OF CARE

As the only national VSO chartered by Congress exclusively dedicated to assisting veterans and their families coping with blindness and vision loss, ensuring that our nation's veterans have access to the highest quality eye care remains a top priority. Our organization has strong concerns about the VA initiative to establish national standards of practice for health professionals within the VHA that could lower the standard of care, particularly for eye care services, available to veterans. One reason we are so concerned about the future of veterans' surgical eye care is the fact that in September 2022 VA modified its Community Care "Standardized Episode of Care (SEOC): Eye Care Comprehensive" guideline by removing language providing that "only ophthalmologists can perform invasive procedures, including injections, lasers, and eye surgery." By removing this sentence, VA is implicitly authorizing optometrists to perform ophthalmic surgery on veterans they refer under the Community Care program in the few states where permitted by state licensure laws. VA removed this language without any opportunity for the veteran community and public to comment. BVA is extremely concerned that VA has removed an important patient safeguard posing increased risk to veterans requiring surgical eye care.

Our members know all too well that eye tissue is extremely delicate and once damaged, it is often impossible to fix. While optometrists play an important role in addressing the eye care needs of veterans, they are not medical doctors who have the training and experience needed to perform invasive surgical procedures. While some procedures are higher risk than others, no invasive procedures are without risk, particularly when attempted by inexperienced providers.

Veterans have benefitted from established, consistent, high-quality surgical eye care for decades because VA has maintained a long-standing policy that restricts the performance of therapeutic laser eye surgery in VA medical facilities to ophthalmologists: medical or osteopathic doctors who specialize in eye and vision care. This policy is consistent with the standard of medical care in the overwhelming majority of states. It also ensures that there is a system-wide quality standard for surgical eye care and that all veterans have access to the eye care provider with the appropriate education, training, and professional experience needed to perform their eye surgery.

We urge Congress to mandate that VA immediately reinstate the following language into the SEOC: "Only ophthalmologists can perform invasive procedures, including injections, lasers, and eye surgery." We also urge VA to be mindful of the appropriate roles of optometry and ophthalmology as it seeks to establish national standards of practice within VA health care systems.

ENHANCING VETERANS MENTAL HEALTH CARE

Mental health conditions are common in the United States. More than 1.7 million veterans receive treatment in VA mental health specialty programs. The National Veteran Suicide Prevention Annual Reports consistently reflect the suicide rate for veterans remains 1.5 times the rate of non-veteran adults, and the most recent Report regrettably revealed yet another year of increased suicides as compared to FY20 and FY22. During the years 2001 – 2014 approximately 294 blinded veterans who were VHA enrollees were reported as having committed suicide based on data analysis provided by the Serious Mental Illness Treatment Resource and Evaluation Center, Office of Mental Health Operations, VA Central Office. This suicide rate appears consistent with suicide rates among non-blind VHA enrollees. It is imperative that we destigmatize mental health assistance, while increasing access. BVA encourages Congress to robustly fund VAs suicide prevention outreach budget and peer support programs, while simultaneously addressing the longstanding mental health staffing shortages across the enterprise and requiring data analysis of special populations of veterans to include blinded veterans be reinstated.

Providing high quality mental health services and suicide prevention remain a VHA priority. To support this mission, it is essential to recruit and hire the most qualified individuals, regardless of their mental health discipline, for positions in mental health treatment teams. This will allow VHA to provide high quality, industry-leading mental health services for veterans. This principle helps to ensure both a high-quality corps of mental health providers and an appropriate diversity of professional backgrounds. Further, this approach is most consistent with interprofessional practice, which is the cornerstone of VA mental health programs. Interprofessional practice as it relates to mental health programs is provided in an integrated environment that allows health care team members to use complementary skills to effectively manage the physical and mental health of their patients, using an array of tools that supports information sharing. High functioning teams addressing behavioral and mental health needs

require collaboration among diverse professions. It is important to create and support innovative models for all mental health professions. Promoting interprofessional recruitment for these important roles supports VHAs goal of being the employer of choice in the health care industry and assists with recruitment and retention.

Physician Assistants (PAs) are highly educated professionals licensed to diagnose, treat, and prescribe medications. The PA profession arose from the military, and PAs have been treating veterans for over 50 years. PA education includes extensive training in psychiatry with mandatory didactic and psychiatric mental health clinical rotations. Psychiatry is a required component of the National Commission on Certification of Physician Assistants (NCCPA) exam. PA mental health skillsets could complement psychiatrists as PAs can prescribe medications, whereas VHAs other identified core mental health disciplines outlined in Directive 2009-011—Nurses, Social Workers, Psychologists, Marriage and Family Therapists, and Licensed Professional Mental Health Counselors—cannot prescribe them.

PAs, with their versatile training and adaptability, are exceptionally positioned to provide comprehensive mental health services. Their inclusion as a core mental health discipline would enhance the mental health workforce within VA, ensuring that more veterans receive timely and effective care. PAs promote a team-based approach, which is essential in delivering comprehensive mental health services and which aligns with VAs mission of providing the best possible care to our Nation's veterans.

BVA calls upon Congress to expand 38 U.S. Code §7302 - Functions of Veterans Health Administration: Health-Care Personnel Education and Training Programs by increasing the number of VHA PA Health Professions Scholarship Program (HSPS) awards from the current 35 to 75 annually, which would accomplish the following: ensure a steady pipeline of uniquely trained PAs to address the specific mental health needs of veterans and expand the current four VAMC PA resident training positions to provide opportunities for PAs to gain specialized skills in areas where veterans often require the most support, such as PTSD, emergency medicine, and women's health care (all of which adversely impact VHAs rural health care service delivery). Increased PA residency positions and scholarships would offer a strategic integration of PAs within VHA, promoting improved patient outcomes, decreased wait times, and diminished chronic staffing shortages. During the last five years alone, more than 600 veterans have applied for the currently available 35 annual HSPS scholarships. Thus, we contend that this increase in scholarships and residency positions would significantly improve VHAs mental health and various other staffing shortages.

IMPROVING PROGRAMS AND SERVICES FOR WOMEN VETERANS

BVA calls on Congress to fully fund and support gender specific health care for women veterans. VA must continue creating and fully staffing high quality, clinically relevant services for women veterans. The COVID-19 pandemic made hiring and training challenging, particularly the hands-on training offered through women's health mini-residencies. While training and

hiring initiatives continue, the growth in women veterans who use VA is outstripping VAss ability to hire and train providers to meet women's specialized gender-specific clinical needs. Women are the fastest-growing subpopulation in VA (+32 percent by 2030), and there does not appear to be a strategic plan to ensure that all service lines in VHA are focused on adjusting programs to meet women veterans' unique clinical and supportive services needs. VHA must develop plans for women veterans' health programming that respond to changes in health care delivery made since the COVID-19 pandemic and evaluate other program offices to ensure that appropriate services are available to meet the unique needs of the women veterans it serves.

Peer support specialists have been very useful in helping veterans with mental health challenges, including those dealing with the aftermath of Military Sexual Trauma, Post-Traumatic Stress Disorder, and substance use disorders. Similarly, care navigators and doulas can assist women veterans with highly complex medical conditions such as cancer, amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), post-partum maternal care, and chronic pain management. VA must consider increasing funding for these critically relevant specialists.

Additionally, creating and maintaining a dedicated consultative team to assist with managing the care of veterans throughout the maternity cycle would support VAs efforts to provide women veterans with access to comprehensive wrap-around services, including help with housing, employment, food insecurity, interpersonal violence, mental health, and prosthetic support. Reproductive mental health issues are prevalent for many service-disabled women veterans and require specialized clinical support. VA is wholly dependent upon its community care network providers to render quality care and data on outcomes of maternity care. Still, specialized program managers can monitor and influence better results by enhancing services for women and improving coordination and communication between these programs.

ENACTING PROTECTIONS FOR GUIDE AND SERVICE DOGS

Guide and service dogs are critical to blind, visually impaired, and other disabled veterans working toward regaining lost independence. Guide and service dogs assist blind or disabled veterans with mobility, retrieving objects, balance, and several other vital tasks. Training guide and service dogs to perform their jobs costs upwards of $50,000 and can take up to two years to complete. Many prospective guide and service dogs do not complete the training, making successful guide and service dogs (approximately one in ten) incredibly valuable. BVA is concerned about the safety of these guide and service dogs while on federal properties. Uncertified and often untrained support animals pose a direct threat to guide and service dogs, as well as to disabled veterans who depend on their dog for assistance. Since 2016, there has been an 84 percent spike in reported support animal incidents to include urination, defecation, and biting. This additional threat to both veteran and service animal poses health and financial risks as the costly, lengthy, and rigorous training that the animals undergo becomes less apparent to the uninformed public, which perceives as the same the rigorously trained service animal and the poorly trained support animal.

The Department of Transportation (DOT) has issued rules regarding service animals on airplanes. According to the rule, emotional support animals are no longer considered to be a service animal. Airlines may require travelers with service animals to provide forms developed by DOT attesting to the dog's training, health, and behavior. Implementing policies such as DOTs at VA facilities would offer a greater level of protection for guide and service dogs, as well as for their handlers and other veterans.

BVA strongly urges VA to implement stricter guidelines for animals eligible for entrance onto VA properties and to ensure standardization across all facilities. BVA also suggests implementing training policies for VA employees on guide and service dog etiquette to increase the safety of the dogs and their handlers while also raising awareness. BVA also requests a dedicated guide and service dog champion at the Veterans Affairs Central Office and at each VAMC. The addition of these champions can ensure proper training and understanding through Standard Operating Procedures (SOPs) as to the expectations, roles, and responsibilities of a service animal as well as to ensure uniformity and equal treatment across locations.

SUPPORTING VISION RESEARCH FUNDING

The Vision Research Program (VRP) was established by Congress in FY09 to fund impactful, military-relevant vision research with the potential to significantly improve the health care and well-being of service members, veterans, caregivers, and the American public. The VRPs program area had previously aligned with the sensory systems task area of the JPC-8 Clinical and Rehabilitative Medicine Research Program (CRMRP), a core research program of the Defense Health Agency (DHA), but this program was merged into the JPC-5/MOMRP, resulting in less funding for deployment-related injuries.

Eye injury and visual dysfunction resulting from battlefield trauma affect many service members and veterans. Surveillance data from the Department of Defense (DoD) indicate that eye injuries account for approximately 14.9 percent of all injuries from battlefield trauma sustained during the wars in Afghanistan and Iraq, resulting in more than 182,000 ambulatory patients and 4,000 hospitalizations. In addition, Traumatic Brain Injuries (TBIs), which have affected more than 413,898 service members between 2000 and 2019, can have significant impact on vision, even when there is no direct injury to the eye.

Research sponsored by VA showed that as many as 75 percent of service members who sustained a TBI had visual dysfunction. The VA Office of Public Health has reported that, for the period October 2001 through June 30, 2015, the total number of Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) veterans with vision problems who were enrolled in VA totaled 211,350. This number included 21,513 retinal and choroidal hemorrhage injuries (retinal detachments are part of this category); 5,293 optic nerve pathway disorders; 12,717 corneal conditions; and 27,880 with traumatic cataracts. VA continues to see increased enrollment of this generation with various eye and vision disorders resulting from complications of frequent blast-related injuries.

VA data also revealed a rising number of total post-9/11 veterans with TBI visually impaired "ICD-10 Codes" enrolled in the VHA system. In FY13, there were 39,908 enrollees identifying with symptoms of visual disturbances, and by FY15 those numbers increased to 66,968. Based on recent data (2000-2017) compiled by the TBI Defense Veterans Brain Injury Center (DVBIC), the reported incidence of TBI without eye injury but with clinical visual impairment is estimated to be 76,900.

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

DHA leadership have consistently testified before Congress stressing the need for "specific research programs supporting efforts in combat casualty care, TBI, psychological health, extremity injuries, burns, vision, hearing, and other medical challenges that are militarily relevant and support the warfighter."

Of note, CDMRP appropriations that fund this critical extramural vision research into deployment-related vision trauma is not currently conducted by VA, or elsewhere within DoD, including within the Joint DoD/VA Vision Center of Excellence (VCE). To meet the shortage of VRP funding, the National Eye Institute (NEI) within the National Institutes of Health (NIH) funds only two VRP grants each year. Additionally, DoD continues to identify gaps in its ability to treat various ocular blast injuries.

Previously, the US Army Medical Research and Materiel Command (USAMRMC) maintained an ocular health research portfolio, the goal of which was to "improve the health and readiness of military personnel affected by ocular injuries and vision dysfunction by identifying clinical needs and addressing them through directed joint medical research." For more than two decades, the USAMRMC has held the only DoD J-09 internally funded active military Ocular Trauma Research Lab, located in San Antonio, Texas. BVA is alarmed that core internal funding is being shifted to other DoD research, leaving a larger gap in funding deployment-related vision injury research for our wounded service members.

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

BVA believes the priority in DoD research is to "save life, limb, and eyesight," which has been the motto of military medicine for decades. Therefore, along with other VSOs and Military Service Organizations (MSOs), BVA respectfully requests that Congress support funding of the

DoD/VRP Peer Reviewed Medical Research Program for extramural translational battlefield vision research in the amount of $30 million.

HONORING COMBAT DISABLED VETERANS

When service members retire from the military, they are entitled to both retired pay from DoD and disability compensation from VA if they were injured while in service. Unfortunately, only military retirees with at least 20 years of service and a disability rating of at least 50 percent are able to collect both benefits at the same time. For all other retirees, current law requires a dollar for dollar offset of these two benefits, meaning they have to forfeit a portion of the benefits they earned in service. It is time to fully honor veterans who were medically retired because of injuries incurred in combat or combat-related training. Regardless of time in service, these veterans have earned all their benefits through their extraordinary sacrifice in defending our Nation.

Under the Major Richard Star Act, former service members who were medically retired from the military with less than 20 years of service (Chapter 61 retirees) and are eligible for Combat-Related Special Compensation (CRSC) would no longer have their benefits reduced by the offset. This includes those who were retired for injuries sustained in combat and combat-related training.

DoD retired pay and VA disability compensation are two different benefits established by Congress for two different reasons. BVA strongly believes that collecting both benefits should never be considered "double dipping," and that no retiree should be subject to the offset. For this reason, BVA will continue to support legislation to eliminate the offset for all retirees and considers the Major Richard Star Act one step toward achieving that goal.

CONCLUSION

Blind and Low Vision veterans' rights to access care, quality care, dignity, and self-worth are under assault by the very agency charged with providing and protecting those rights. The needs of B/LV veterans are not being addressed nor prioritized. Inaccessible communications platforms, poorly managed transportation programs, and inadequate caregiver standards leave B/LV veterans lost in the shuffle. Changes in standard episodes of care and national standards of practice threaten to once again compromise eye health. Limitations in gender specific care and protections for guide and service dog handlers compromise diversity, equity, and inclusion initiatives—the initiatives that should be inclusive of all, not a politically motivated chosen few.

Chairman Tester, Chairman Bost, Ranking Member Moran, Ranking Member Takano, and all Committee members, thank you for the opportunity to present to you today the legislative priorities of the Blinded Veterans Association. We look forward to furthering our relationships and working with you productively during these challenging times and welcome the opportunity to answering any questions you may have.

PAUL L. MIMMS BIOGRAPHY

BVA National President

Paul L. Mimms, Missouri Regional Group, was born in Iowa City, Iowa, and moved to Kansas City, Missouri in 1960. He graduated eighth in his class from the city's Central High School in 1963.

Paul briefly attended Antioch College (Yellow Springs, Ohio) before induction into the U.S. Navy on May 16, 1966. He served shore duty in San Diego at the Naval Training Center and the Naval Electronics Laboratory Center. He was aboard the USS Luzerne County in the Mekong Delta. An accident on the ship led to the early onset of glaucoma and his medical discharge in 1969.

Paul worked in the restaurant industry and in retail management before increasing blindness led to a loss of employment in 1983. Following blind rehabilitation training in Kansas City and his enrollment at the Central Blind Rehabilitation Center (Hines, Illinois), Paul returned to college in 1986. He earned a Bachelor's Degree in Sociology at the University of Missouri Kansas City and a Master's Degree in Social Work in 1991 from the University of Kansas.

He began working for the Department of Veterans Affairs in 1992 at the Kansas City Vet Center. In 2000, he went to work at the West Palm Beach Blind Rehabilitation Center. Four years later, Paul was selected as a VIST Coordinator at the West Palm Beach VA Medical Center. At the same time, he was active in the Florida Regional Group, serving first as a District Director within the group and then as Vice President and President.

Paul retired in 2009 and returned to Kansas City, where he became involved immediately in the rejuvenation of the Missouri Regional Group and where he was originally a charter member. Paul served as both Secretary and President of the group until his election to national office on August 23, 2013.