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 Moran, Chairman Bost, Ranking Member Blumenthal, 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 2025. 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 milestone 80th 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 first session of the 119th 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 aged 65 or older. These 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, introduced by Senator Chris Van Hollen (D-MD) and Senator Tim Scott (R-SC), 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 VA's progress of updating websites, files, and applications that are still inaccessible to such individuals. BVA remains 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 that 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 individuals.

The Rehabilitation Act of 1973 is a cornerstone of U.S. disability rights law, mandating that the federal government prioritize the accessibility and inclusion of people with disabilities. Section 508 of this Act specifically requires that all federal technology be accessible and usable by individuals with disabilities. However, a recent Congressional report revealed a significant gap in VA's compliance with this critical legislation. The report found that only 7.8 percent of VA's 812 websites are fully compliant with Section 508, a stark contrast to the rest of the federal government, which boasts a 20 percent compliance rate. This alarming statistic underscores VA's significant shortcomings in ensuring digital accessibility for veterans and employees with disabilities. Furthermore, VA demonstrates a persistent lack of compliance with the 2017 Information and Communications Technologies Refresh of Section 508. A prime example is the abysmal performance of VA's 58 Veterans Benefits Administration Regional Offices (VAROs), with 52 percent or less Section 508 conformance. This is further exemplified by the internal employee phone book site, which exhibited zero percent compliance. VA's career website and the Office of Employment Discrimination and Complaint Adjudication website also demonstrate a concerning lack of accessibility, with respective conformance ratings of 16 percent and 22 percent. These glaring deficiencies in digital accessibility have serious consequences. Non-compliant digital technologies can create significant barriers for veterans and VA employees with disabilities, hindering their access to critical information and services, impacting their overall well-being, and potentially violating their rights.

The Department of Veterans Affairs Office of Inspector General (VA OIG) report "VBA's 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 VBA's 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 BVA truly appreciates 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 VA's 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 VA's compliance with federal disability laws, including the Americans with Disabilities Act and the Rehabilitation Act. The reports would include recommendations for improving VA's 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 travel 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. This 30-day advance scheduling requirement can be particularly challenging for veterans who may experience unexpected medical needs or require unscheduled appointments, potentially impacting their ability to receive timely care.

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 visual 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. These last-minute cancellations cause significant disruption and anxiety for veterans, particularly those living in rural areas with limited transportation options. This unreliability of the VTS system can negatively impact veterans' access to timely medical care and create significant stress and inconvenience.

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 0.67 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. This discrepancy can create significant financial hardship for veterans, especially those living on fixed incomes.

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." This creates a significant barrier for B/LV veterans who may rely on assistive technology or require assistance with navigating online platforms. This policy change effectively discriminates against B/LV veterans and hinders their ability to receive the benefits they have earned.

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. This will ensure that B/LV veterans are not unfairly penalized for the inaccessibility of the online system.

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 consider the unique challenges and limitations of blind or severely visually impaired veterans. For example, a blinded veteran may be able to independently cook if they have adapted their kitchen and learned to use assistive devices but may require significant assistance with tasks like meal preparation and grocery shopping due to their visual impairment. BVA calls on the ADL standard to be

revised to consider the unique challenges and limitations of blinded veterans, such as difficulties with navigation, object identification, and independent living skills.

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. For a blinded veteran, tasks like reading medication labels, distinguishing between pills of different colors and sizes, and understanding medication schedules can be extremely challenging and may require significant assistance. Although 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 VA's definition of "need for supervision, protection, or instruction" in 38 C.F.R. § 71.15 because it determined that VA's definition was inconsistent with the statutory language. Veterans and caregivers await VA rulemaking to update 38 C.F.R. § 71.15. This delay in rulemaking has created uncertainty and frustration for veterans and their families who are seeking support through the PCAFC program.

VA's own numbers have shown the denial rate for PCAFC applications to be as high as 90 percent, which most stakeholders agree is too high. This high denial rate suggests that the current eligibility criteria and application process may be overly restrictive and may not adequately meet the needs of veterans with complex care requirements. To improve and simplify the PCAFC adjudications process, BVA calls on the creation of an objective clinical standard for PCAFC eligibility for blinded veterans.

BVA 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." This proposed standard would ensure that only the most severely visually impaired veterans who require significant assistance with daily living activities would be eligible for PCAFC benefits.

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. This proposed standard would ensure that PCAFC benefits are targeted towards blinded veterans with the most severe visual impairments and the greatest need for caregiving support.

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. This significant population of B/LV veterans underscores the critical need for robust and accessible Blind Rehabilitation Services.

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. This understaffing can lead to longer wait times for veterans seeking rehabilitation services, reduced access to specialized training programs, and a decline in the overall quality of care. 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. While telehealth can be a valuable tool, it cannot fully replicate the in-person, hands-on training and support provided by BRCs. 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 Injury (SCI) Rehabilitation Centers have 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. This would ensure that funding for BRS remains dedicated to its intended purpose and that B/LV veterans have access to the specialized care they need.

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. This increased caseload can lead to burnout, decreased quality of care, and limited access to services for B/LV veterans. 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 Eligibility Reform Act of 1996" (Public Law 104-262). This will ensure

that B/LV veterans continue to have access to the vital services provided by these specialized centers.

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 VA's 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 whom they refer under the Community Care program in the few states where this is 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, potentially increasing the 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 specialized training and experience needed to perform invasive surgical procedures. Ophthalmologists undergo extensive medical and surgical training to diagnose and treat eye diseases and perform complex surgical procedures.

While some procedures may be considered lower risk than others, no invasive procedure is without risk, particularly when attempted by providers who lack the specialized training and expertise of ophthalmologists. 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." This will ensure that veterans continue to receive the highest quality and safest surgical eye care. 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. It is crucial to maintain a clear distinction between the roles of these two important eye care professions and ensure that veterans have access to the most appropriate level of care.

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. These statistics underscore the urgent need for continued efforts to improve mental health care access and outcomes for veterans.

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 de-stigmatize mental health assistance while increasing access to evidence-based care and support services for all veterans, including those with visual impairments. BVA encourages Congress to robustly fund VA's suicide prevention outreach budget and peer support programs while simultaneously addressing the longstanding mental health staffing shortages across the enterprise. Furthermore, we urge VA to reinstate data analysis of special populations of veterans, including blinded veterans, to better understand the unique mental health needs and challenges faced by this population.

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 VA's 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 more than 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 VA's 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 VA's 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 VA's 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 VA's 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 significantly impacted health care delivery, including the training and hiring of health care providers. This was particularly challenging for women's health mini-residencies, which often involve hands-on training. While training and hiring initiatives continue, the growth in women veterans who use VA is outstripping VA's ability to hire and train providers to meet women's specialized gender-specific clinical needs.

Women are the fastest-growing subpopulation within 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 comprehensive plans for women veterans' health programming that respond to the evolving health care landscape, including the impact of 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. This includes addressing the specific health needs of women veterans, such as reproductive health, mental health, and chronic pain management, as well as ensuring culturally competent and trauma-informed care.

Peer support specialists have been very useful in helping veterans with mental health challenges, including those dealing with the aftermath of Military Sexual Trauma (MST), Post-Traumatic Stress Disorder (PTSD), 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. These specialized roles can provide crucial support and guidance to women veterans navigating the health care system and addressing their unique needs. VA must consider increasing funding for these critically relevant specialists to ensure that women veterans have access to the support they need.

Additionally, creating and maintaining a dedicated consultative team to assist with managing the care of veterans throughout the maternity cycle would support VA's 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. A dedicated team can help to coordinate care across different services and ensure that women veterans receive the holistic support they need during this critical period.

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 the independence and well-being of blind, visually impaired, and other disabled veterans. These highly trained animals provide invaluable assistance with mobility, retrieving objects, balance, and other essential tasks. Training a guide or service dog is a significant investment, both in time and resources, often costing upwards of $50,000 and requiring up to two years of intensive training. Many prospective guide and service dogs do not complete the training, making successful guide and service dogs (approximately one in ten) incredibly valuable assets for their veteran partners.

BVA is deeply concerned about the safety and well-being of these guide and service dogs while on federal properties. The increasing presence of uncertified and often untrained support animals poses a direct threat to guide and service dogs, as well as to the disabled veterans who rely on them for assistance. Since 2016, there has been an 84 percent spike in reported support animal incidents, including urination, defecation, and even biting incidents. These incidents can create stressful and potentially dangerous situations for veterans and their service dogs, undermining their ability to navigate public spaces safely and confidently.

This increase in untrained support animals also devalues the significant investment made in training guide and service dogs. The rigorous training these animals undergo is crucial for their ability to perform their duties effectively and safely. Unfortunately, the public often perceives rigorously trained service animals and poorly trained support animals as the same, diminishing the value and importance of the specialized training that guide and service dogs undergo.

The Department of Transportation (DOT) has issued rules regarding service animals on airplanes. According to these rules, emotional support animals are no longer considered to be service animals. Airlines may require travelers with service animals to provide forms developed by DOT attesting to the dog's training, health, and behavior. Implementing similar policies 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. These guidelines should clearly differentiate between legitimate service animals and other animals, such as emotional support

animals. BVA also suggests implementing mandatory training policies for all VA employees on guide and service dog etiquette. This training should cover topics such as recognizing legitimate service animals, understanding the rights of handlers and their service dogs, and learning how to interact appropriately with service dog teams.

Furthermore, BVA requests the establishment of a dedicated guide and service dog champion at the Veterans Affairs Central Office and at each VAMC. These champions would be responsible for developing and implementing clear and consistent policies regarding service animals within VA facilities, providing training and education to VA staff on service animal etiquette and the rights of handlers, addressing concerns and resolving issues related to service animals on VA property, and ensuring compliance with all relevant laws and regulations regarding service animals. 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 all VA 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 VRP's 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. This shift in funding priorities has had a detrimental impact on critical vision research efforts.

Eye injury and visual dysfunction resulting from battlefield trauma affect a significant number of 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 a 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-related visual impairments 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 the present value of a lifetime of long-term benefits, lost wages, and family care. These staggering costs underscore the significant economic and societal burden of these injuries.

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 are 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. This limited funding significantly hampers the progress of critical vision research. Additionally, DoD continues to identify gaps in its ability to treat various ocular blast injuries, highlighting the urgent need for continued research and development in this area.

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. This shift in funding priorities is a serious concern and could have significant negative consequences for the health and well-being of our nation's veterans.

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 the development of diagnostics, treatments, and therapies especially designed for rapid battlefield application. This two-pronged approach has been crucial in advancing the field of military vision research.

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 the funding of

the DoD/VRP Peer Reviewed Medical Research Program for extramural translational battlefield vision research in the amount of $30 million. This increased funding will be crucial to support continued advancements in the prevention, diagnosis, and treatment of vision loss and dysfunction among our service members and veterans.

HONORING COMBAT DISABLED VETERANS

When service members retire from the military, they are entitled to both retired pay from the Department of Defense (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 that they have to forfeit a portion of the benefits they earned in service. This policy is deeply unfair to those who have sacrificed their health and well-being in service to our nation.

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. DoD retired pay recognizes a veteran's years of service to the nation, while VA disability compensation acknowledges the sacrifices made and the injuries sustained in the line of duty. 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. We believe that all veterans who have sacrificed their health in service to our nation deserve to receive the full benefits they have earned.

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 fully addressed nor prioritized across the VA system.

Inaccessible communications platforms, such as VA's websites and online systems, create significant barriers for B/LV veterans in accessing information, submitting claims, and navigating the VA health care system. Poorly managed transportation programs, including unreliable VTS services, inadequate reimbursement for travel expenses, and inaccessible

reimbursement systems, severely limit B/LV veterans' access to timely and necessary medical care. The current PCAFC eligibility criteria do not adequately address the unique needs of blinded veterans, and the high denial rate for these applications highlights significant gaps in the system. Changes in standard episodes of care and potential shifts in the roles of optometrists and ophthalmologists raise concerns about the future of high-quality eye care for veterans.

Understaffing at Blind Rehabilitation Centers, inadequate support for VIST Coordinators and BROS, and the potential diversion of funding to community care providers threaten to undermine access to critical rehabilitation services. The growth in the number of women veterans is outpacing VA's ability to provide gender-specific care, leaving many women veterans without access to the specialized services they need. The increasing presence of untrained support animals on VA property poses a significant threat to the safety and well-being of guide and service dogs and their veteran handlers. These challenges, among others, highlight a systemic failure to fully address the unique needs of B/LV veterans within the VA system.

Chairman Moran, Chairman Bost, Ranking Member Blumenthal, 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 relationship with this Committee and working with you productively during these challenging times. We welcome the opportunity to answer any questions you may have.

PAUL L. MIMMS BIOGRAPHY

BVA National President

Paul L. Mimms, Heartland Regional Group (Missouri), 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 (now known as Heartland) 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. He has served as BVA's National President since his election to that office on August 18, 2023.