



TESTIMONY

PRESENTED BY

Lea Rowe

BVA NATIONAL EXECUTIVE DIRECTOR

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



MARCH 3, 2026

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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, I appreciate this opportunity to present our legislative priorities for 2026. As the National Executive Director and a specialist in low-vision rehabilitation, I am seated before you representing the only Congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to the unique needs of our nation's blinded veterans and their families.[1][2] As we approach "National Blinded Veterans Day" on March 28—the 81st anniversary of our 1945 founding—we reflect on our Congressional charter's mandate to act as the official advocate for all blinded veterans.[1][2] Our mission, rooted in the legacy of those 100 war-blinded soldiers from World War II, continues today as we work to ensure that the Department of Veterans Affairs (VA) provides top-quality, comprehensive medical and rehabilitative services.

BVA LEGISLATIVE PRIORITIES FOR 2026

The Blinded Veterans Association urges the 119th Congress to proactively address a comprehensive suite of legislative priorities essential for the well-being of the blind and low-vision community. Our primary focus is the modernization of the Program of Comprehensive Assistance for Family Caregivers (PCAFC) to incorporate blindness-specific clinical standards for Activities of Daily Living that recognize functional, rather than just physical, limitations.[3][4]

We also call for vision loss claims to be centralized to a single Regional Benefits Office (RBO), rather than being routed through the National Work Queue. This approach would mirror how ionizing radiation claims are decided at the Jackson, Mississippi Regional Benefits Office. Centralizing vision loss claims would enable the development of specialized expertise among decision makers, streamline the adjudication process, and ensure more consistent, accurate decisions for blinded veterans.

We strongly advocate for the final passage and reconciliation of the Veterans Accessibility Advisory Committee Act to ensure all VA platforms and physical kiosks meet mandatory accessibility standards.[5] Furthermore, we call for a critical rule change in transportation services to allow for a "catastrophic circumstances" exemption, which would ensure veterans can receive life-sustaining treatment without the burden of upfront costs and subsequent reimbursement. Our priorities also include codifying robust protections for

guide and service dogs within VA facilities, maintaining the gold standard of Blind Rehabilitation Service (BRS) through increased funding, and supporting specialized research into traumatic brain injury-related vision loss.[6] Finally, we stand in firm opposition to the "Ameliorative Effects of Medication" rule and urge the swift passage of the Major Richard Star Act to protect the earned benefits of combat-injured veterans.[7][8]

BVA BACKGROUND AND THE EVOLUTION OF CARE

The Blinded Veterans Association is the only national Veterans Service Organization chartered by the United States Congress and exclusively dedicated to assisting America's blinded veterans and their families.[1][2] Founded on March 28, 1945, by approximately 100 war-blinded service members at Avon Old Farms Army Convalescent Hospital, BVA was established to ensure that no blinded veteran would be returned home without adequate training to meet the challenges of their disability.[1] This mission was originally inspired by President Franklin D. Roosevelt's 1944 executive order, which prioritized the rehabilitation and integration of blinded veterans.

BVA's advocacy has been the driving force behind every major milestone in VA blind rehabilitation, beginning with the opening of the first comprehensive Blind Rehabilitation Center (BRC) on July 4, 1948.[3] Today, VA estimates that there are approximately 130,000 veterans who are legally blind and more than one million who have low vision impacting their daily activities.[3][4] To serve this population, VA operates 13 residential BRCs nationwide, providing intensive inpatient training to help veterans achieve independence.[3] In 1967, BVA participated in a pilot program that evolved into the Visual Impairment Service Team (VIST) Program, and the organization later convinced Congress in 1978 to fund full-time VIST Coordinator positions to ensure every blinded veteran has a dedicated case manager.[3] Starting in 1947, BVA petitioned for outpatient services, eventually securing funding in 1995 to establish the first Blind Rehabilitation Outpatient Specialists (BROS), a cadre that has since grown to over 100 full-time positions.[3] In 2007, BVA helped secure \$40 million to implement a full continuum of care, resulting in nine Visual Impairment Services Outpatient Rehabilitation (VISOR) clinics for low-vision veterans.[3] BVA also pioneered technology and benefits, ranging from the development of the C-5 laser cane in 1975 to the establishment of Computer Access Training Sections at all BRCs and securing Specially Adapted Housing grant eligibility for the blind.

SUPPORTING BLIND REHABILITATION SERVICE FUNDING

The population of veterans facing vision loss continues to grow, necessitating a robust and dedicated funding model for BRS. In October 2020, the Veterans Health Administration (VHA) implemented a new Continuum of Care, which resulted in 81,583 low-vision and

legally blind veterans being added to VIST Coordinator case management rosters. Current VHA research estimates that there are approximately 130,000 legally blind veterans in the United States, with another 1.1 million low-vision veterans possessing a visual acuity of 20/70 or worse. This demographic surge underscores the critical need for accessible, high-quality rehabilitative care.

VA currently operates 13 residential Blind Rehabilitation Centers (BRCs), which continue to offer the ideal environment for maximizing a veteran's independence. However, these centers face severe staffing challenges as local Veterans Integrated Service Network (VISN) and VAMC Directors often fail to replace retiring or transferring staff. This chronic understaffing leads to longer wait times and a decline in care quality. BVA strongly recommends that BRS funding be modeled after Spinal Cord Injury (SCI) Rehabilitation Centers. Beyond clinical excellence, this is a matter of fiscal responsibility. Independent living training at a BRC directly reduces VA's long-term expenditure on assisted living facilities and home health Aides. Framing BRS funding as a dedicated stream is not just an ask for more resources; it is an investment in significant long-term cost-avoidance for the entire VHA enterprise.

Furthermore, BVA is deeply concerned about the unsustainable caseloads of VIST Coordinators and Blind Rehabilitation Outpatient Specialists (BROS). With national caseloads doubling from 40,000 to over 80,000, the capacity to meet individual veteran needs is in jeopardy, leading to potential staff burnout and limited access to service. We request that VHA conduct a resource/demand gap analysis to identify overcapacity positions and authorize the staffing of additional VIST and BROS roles to support these 40,000 additional veterans.

BVA holds that VHA must maintain the bed capacity and staffing levels mandated by the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262). While the VA MISSION Act facilitates community care, it must not siphon funds from the specialized BRCs that offer essential services—such as specialized nursing, audiology, and mental health care—that private outpatient agencies often lack. If private contracts are utilized, BVA insists that these agencies meet peer-reviewed quality standards and hold accreditation from the National Accreditation Council (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF) to ensure that our veterans receive care equivalent to VA's gold standard.

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 vision loss, ensuring that our nation's veterans

have access to the highest quality care and information remains a top priority. While BVA acknowledges and commends VA for its recent, consistent improvements to the VA Health and Benefits mobile app and the VA.gov website—both of which have seen significant strides in screen reader compatibility and user interface accessibility—major systemic gaps remain elsewhere in VA's digital and physical infrastructure.

Despite progress on mobile and web platforms, physical kiosks within VA Medical Centers remain fundamentally inaccessible to blinded veterans. These self-service machines, increasingly used for check-in, wayfinding, and pharmacy services, often lack the tactile indicators, voice-guided navigation, or standard headphone jacks required for independent use. This failure forces veterans to compromise their privacy by disclosing personal health information to staff or strangers to navigate a machine that was designed for "self-service."

The Veterans Accessibility Advisory Committee Act (H.R. 1147 / S. 1383)[5] would establish a permanent Veterans Advisory Committee on Equal Access at VA to address these disparities. While the House and Senate have made significant progress toward passing this bill as of February 2026, BVA urges a unified mandate to ensure that accessibility is a "baked-in" requirement for all future IT and hardware procurements. A July 2025 VA Office of Inspector General (OIG) report found that of 30 "bedrock" IT systems sampled, only four were fully compliant with Section 508 requirements.[9] This is largely because VA's procurement process often relies on vendor self-declarations rather than independent verification by the Department's Office of 508 Compliance.

BVA calls on Congress to mandate the creation of a VA Accessibility Office led by a Chief Accessibility Officer. This office must have the authority to block the procurement of any system—be it a website, a mobile app, or a physical kiosk—that does not meet the gold standard of accessibility. Accessibility is not a "feature" to be added later; it is a fundamental civil right that ensures that every blinded veteran can manage their health with the "peer-inspired self-reliance" that defines our organization.

THE 2026 BVA CARE REVIEW AND VISOR OVERSIGHT

At the beginning of 2026, BVA re-established the Care Review, an intensive oversight initiative with the goal of assessing all nine VISOR programs within the calendar year. This review will soon expand to include all 13 Blind Rehabilitation Centers. Our Care Review teams meet directly with medical center directors, chiefs of staff, and every stakeholder in the veteran's journey, including pharmacy, phlebotomy, volunteer services, greeters, and VA police. The recommendations and concerns identified at each location are shared directly with the local facility, VA's Rehabilitation and Prosthetics Services, and the "four corners" of legislative leadership. We are committed to ensuring that the gold standard of

care promised in Washington actually be delivered in the hallways of every VA Medical Center.

MODERNIZING PCAFC AND ADL ASSESSMENTS

One of our most urgent priorities remains the modernization of the Program of Comprehensive Assistance for Family Caregivers (PCAFC). While VA has recently proposed rules to expand access and extend transition periods through September 2028, the current "physical" view of Activities of Daily Living (ADLs) remains fundamentally flawed when applied to blindness. These subjective standards, governed by 38 U.S.C. § 1720G, are designed for sighted individuals and do not account for the specific functional limitations of the estimated 130,000 legally blind and over one million low-vision veterans in the United States.

The inadequacy of current assessments is clearly demonstrated by simple tasks: while a veteran may "physically" be able to walk 50 feet, a blindness-centric view must ask if they can safely navigate that path without veering into traffic or tripping over low-contrast obstacles. Similarly, although a veteran may be able to physically pick up a pill, they often cannot independently identify and differentiate between multiple, similar-looking medications or read a digital glucose monitor without assistance. Crucially, medication management is currently classified as an "instrumental" ADL (iADL), meaning that it is not a primary qualifier for PCAFC benefits despite the high risk of life-threatening errors for blinded veterans.

BVA calls on Congress to support the Veterans' Caregiver Appeals Modernization Act of 2025 and to mandate that VA assessments incorporate these functional realities of vision loss. To eliminate the current subjectivity that has led to a denial rate as high as 90 percent, BVA proposes an objective clinical standard for PCAFC eligibility: a corrected acuity of 5/200 or worse in both eyes, or a field of vision of 5 degrees or less in both eyes. This standard is intentionally more restrictive than the definition of legal blindness to ensure that benefits are targeted toward the most severely impaired veterans who require constant caregiving to maintain a realistic level of independence.

TRANSPORTATION BARRIERS AND CATASTROPHIC EXEMPTIONS

The current travel reimbursement system under 38 U.S.C. § 111 creates a significant financial and functional barrier for veterans who cannot drive themselves. While VA's Beneficiary Travel Self-Service System (BTSSS) was designed to expedite claims, it remains a "reimbursement-after-the-fact" model that forces veterans to carry the financial burden of transit. For blinded veterans, this is not merely a matter of convenience; it is a matter of clinical necessity. Many BVA members must pay high upfront costs for specialized private

transportation or rideshare services to reach one of the 13 BRCs or nine VISOR clinics, only to wait weeks for a reimbursement that frequently fails to cover the actual market cost.

Under current 2026 regulations, the VA mileage rate remains significantly lower than the actual cost of operating a vehicle or hiring a commercial carrier. Furthermore, while Special Mode Transportation (SMT)—such as wheelchair vans or ambulances—is available, it requires a VA clinician to certify "medical necessity" in advance. For many blinded veterans, "administrative" eligibility exists, but the "clinical" certification is inconsistently applied, leaving them to navigate a complex bureaucracy while their vision continues to deteriorate. BVA strongly advocates for a rule change to allow for "catastrophic circumstances" exemptions. We specifically recommend that this exemption be automatically applied to any veteran with a corrected acuity of 20/200 or worse who must travel more than 50 miles to a BRC or VISOR clinic. This would eliminate the inconsistent "clinical certification" process and ensure that those with profound vision loss have immediate, zero-out-of-pocket access to life-sustaining rehabilitation.

Additionally, BVA remains concerned about the BTSSS digital barrier. While the system is touted as "self-adjudicating," it requires a high level of digital literacy and access to 508-compliant platforms that, as previously noted, are often inaccessible to the very veterans who need them most. The current system also imposes a deductible of \$3 one-way (\$6 round-trip), which, while capped at \$18 per month, represents an unnecessary "tax" on the disabled. We urge Congress to waive these deductibles for all veterans traveling for blindness-specific rehabilitation and to ensure that no veteran is forced to choose between the specialized care that could save their independence and their immediate financial stability.

SAFEGUARDING OCULAR CLINICAL STANDARDS AND PATIENT SAFETY

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. BVA has strong concerns regarding current VA initiatives that threaten to lower the standard of care through both regulatory shifts and the erosion of surgical safeguards.

Maintaining Surgical Excellence: Ophthalmology vs. Optometry

BVA is deeply concerned about VA's move to establish national standards of practice that could dilute the quality of surgical eye care. In September 2022, VA modified its Community Care "Standardized Episode of Care (SEOC): Eye Care Comprehensive" guideline by removing the explicit requirement that "only ophthalmologists can perform invasive procedures, including injections, lasers, and eye surgery."^[12] By removing this

language without public comment, VA is implicitly authorizing optometrists to perform ophthalmic surgery in the Community Care program where state laws permit.[13]

Our members know, all too well, that eye tissue is extremely delicate; once damaged, it is often impossible to repair. While optometrists play an important role in eye care, they are not medical doctors and do not possess the specialized surgical residency training required for invasive procedures. Veterans have benefited for decades from a consistent policy that restricts therapeutic laser surgery to medical or osteopathic doctors (ophthalmologists). We urge Congress to mandate that VA immediately reinstate the original SEOC language to ensure that a system-wide quality standard remains in place for all veterans, regardless of where they receive their care.

Protecting Benefits from the "Ameliorative Effects" Rule

Parallel to these clinical concerns is a critical threat to the stability of veteran benefits. On February 17, 2026, the VA issued an Interim Final Rule (91 FR 7118 / 2026-03068) that amends 38 C.F.R. § 4.10 to mandate that disability ratings be based on a veteran's "actual" functioning while using medication or treatment.[14] This rule effectively attempts to abrogate more than a decade of judicial precedent from *Jones v. Shinseki* and *McCarroll v. McDonald*, which required VA to discount the ameliorative effects of medication unless a diagnostic code specifically stated otherwise.[15][16]

For blinded veterans, this is a dangerous shift. Conditions like glaucoma require lifelong, rigorous medication regimens to manage intraocular pressure. Under this new rule, a veteran whose vision is temporarily stabilized by medication could see their disability rating reduced, even though the underlying disease remains severe and would cause immediate vision loss if treatment were interrupted. Furthermore, VA implemented this change as a "clarification" to bypass the required notice-and-comment period, a move BVA views as a dubious justification to prioritize inventory control over the "pro-veteran" canon of law.

Veterans should not be penalized for complying with life-sustaining treatments. We urge Congress to conduct immediate oversight to ensure that VA does not use administrative shortcuts to strip away earned benefits or lower the clinical bar for surgical safety. We must maintain a clear distinction between professional roles and ensure that compensation reflects the true severity of a veteran's service-connected condition, not a medicated snapshot of their performance.

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.[17] 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.[18] 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 support 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 coverage 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.[19] 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 douglas 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 among these programs.

GUIDE DOG PROTECTIONS AND THE SAVES ACT

Guide dogs are essential "prosthetic" aids that provide critical mobility and safety for blinded veterans. However, BVA members continue to report significant access issues and dangerous encounters with untrained animals within VA facilities. Since 2016, there has been an 84 percent spike in reported incidents involving support animals, including biting incidents that pose a direct threat to the safety of legitimate guide dogs and their handlers. BVA appreciates the Senate's recent resolution honoring the Association's 81-year history and urging safe, unobstructed access for guide dogs, but policy enforcement must be standardized across all facilities to differentiate between trained service animals and emotional support animals.

To address these systemic barriers, BVA strongly supports the Service Dogs Assisting Veterans (SAVES) Act (H.R. 2605 / S. 1441),^[6] which was reported with amendments by the House Committee on Veterans' Affairs in late 2025 and passed the House of Representatives on February 11, 2026. This legislation is vital because training a single guide dog can cost upwards of \$50,000 and take two years of intensive work. The Act would require the Secretary of Veterans Affairs to award grants to nonprofit organizations to provide service dogs to eligible veterans and would guarantee coverage for commercially available veterinary insurance, alleviating the financial burden on disabled veterans who rely on these animals for their daily well-being.

Additionally, BVA suggests mandatory training for all VA employees on guide dog etiquette and the establishment of dedicated "guide and service dog champions" at each VAMC to resolve access issues and ensure compliance with federal law. We are particularly concerned by reports indicating that when incidents occur, VA police may only file a formal report if physical injury or blood is involved. Under VHA Directive 1178,^[20] VA Police are responsible for completing a Uniform Offenses Report for any reported incident that places a person or animal at "significant risk of harm," regardless of whether an injury resulted in blood. BVA is further investigating this area and urges Congress to mandate an update to VHA Directive 1178. VA Police protocols must explicitly require a "Service Animal Incident Report" for any reported interference or aggression, regardless of whether blood is drawn. A non-bloody attack can end a guide dog's working career through trauma just as effectively as a physical bite, and law enforcement must document these incidents to ensure professional accountability across the enterprise. BVA calls on VA to ensure that law enforcement protocols reflect the reality that an attack on a guide dog is an attack on a veteran's primary means of safe mobility.

CONCLUSION

The Blinded Veterans Association remains the leading voice for those who have sacrificed their sight for this nation. Whether it is ensuring that the Major Richard Star Act finally passes to end the unfair retirement offset for combat-injured veterans or ensuring that a pharmacy kiosk can be used independently by a veteran through the reconciliation of the Veterans Accessibility Advisory Committee Act (S. 1383 / H.R. 1147), our focus remains on "peer-inspired self-reliance". We are encouraged by the House's passage of S. 1383 on February 11, 2026, and urge final action to establish the Veterans Advisory Committee on Equal Access.

Our ongoing focus remains dedicated to ensuring that the Department of Veterans Affairs remains a leader in accessibility, transparency, and clinical excellence for the blind community. We thank the Committees for their ongoing support and look forward to a productive 2026.

BIOGRAPHY: LEA ROWE National Executive Director, Blinded Veterans Association

Lea Rowe serves as the National Executive Director of the Blinded Veterans Association (BVA). With a Master of Science in Low Vision Rehabilitation and a certification as a Low Vision Therapist, Ms. Rowe brings a unique clinical and administrative perspective to BVA's advocacy mission. Throughout her career, she has been dedicated to improving the functional independence of individuals with vision loss through adaptive technology and specialized training. Since joining BVA leadership, she has spearheaded the restoration of the BVA Care Review, focusing on the clinical standards of VA's VISOR and BRC programs to ensure that they meet the modern needs of blinded veterans.

Endnotes

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