BLINDED VETERANS ASSOCIATION

SERVING BLINDED VETERANS SINCE WORLD WAR II

TESTIMONY
PRESENTED BY

ROBERT D. (DALE) STAMPER
BVA NATIONAL PRESIDENT

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

TUESDAY MARCH 22nd, 2017

INTRODUCTION

Chairman Isakson, Chairman Roe, Ranking Members Tester and Walz, and distinguished Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) and its membership, we appreciate this invitation to present our legislative priorities for 2017. BVA is the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our Nation's blinded veterans and their families.

Before discussing our legislative concerns for the year ahead, we would like to thank Senator Jon Tester and Congresswoman Julia Brownley for introducing S. 171 and H.R. 288, respectively, and for shepherding these bills through committees during the 114th Congress. We also want to thank the members of the committees assembled here today, as well as members of the MILCON/VA Appropriations committees for including Senate Amendment 3998, which included the provisions of the above bills, in the FY 2017 VA appropriations bill. This legislation greatly improved access to care for catastrophically disabled veterans by authorizing VA to provide travel assistance to these veterans when they need essential rehabilitation training. We thank the members of the 114th Congress for making it possible for veterans with catastrophic disabilities and limited means to gain access to much-needed training at Blind Rehabilitation Centers (BRCs) and Spinal Cord Injury Rehabilitation Centers.

GIVE VA AUTHORITY TO DO ITS JOB

Before discussing some legislative priorities that are specific to veterans who have visual disabilities, we would like to touch on some issues that BVA shares with other veterans' service organizations (VSOs) and military service organizations (MSOs) around the country. There is widespread consensus around the nature of some of the actions VA must take in order to restore the trust of our nation's veterans and their families. VA must modernize the process by which it processes claims for benefits, as well as the process for handling appeals after decisions on claims are made. Additionally, VA needs greater authority to create a culture of excellence and accountability, which enables VA to recruit highly-qualified employees, retain high performing employees, and when necessary, to relieve itself of employees who fail to serve veterans appropriately and professionally. To that end, we join with other VSO's and MSO's in urging members of the 115th Congress to ensure that VA has the statutory authority needed to move forward on initiatives that will implement positive changes in each of these areas. We also urge Congress to pass legislation that will eliminate the sunset of the Veterans Choice program so that funds appropriated for use in furtherance of this program can be spent by the VA for their intended purpose.

I. REQUEST FOR CONGRESSIONAL OVERSIGHT OF VA COMPLIANCE WITH REHABILITATION ACT ACCESSIBILITY REQUIREMENTS

As the VA undertakes a much-needed effort to modernize its information technology and communications infrastructures, two major issues arise that are of particular concern to both the VA employees and veterans who have visual impairments that prevent them from reading

printed materials. These relate to the limited extent to which the VA's efforts t
and

communications processes and policies incorporate generally accepted accessibility standards. Sections 508 and 504 of the Rehabilitation Act set forth the obligations of federal agencies to ensure that their programs and services are accessible to both federal employees and members of the public who have disabilities. As we will describe in detail below, the VA continues to fall short of meeting these obligations in several areas. We believe that greater compliance with these accessibility obligations is both readily achievable by the VA and absolutely imperative. We are at an important crossroad as VA seeks to modernize both its IT systems and its communications capabilities. If accessibility is not properly addressed as part of these modernization efforts, achieving it later will rapidly become both burdensome and cost-prohibitive. In order to forestall such adverse consequences, we are requesting that the House and Senate Veterans' Affairs Committees conduct strong oversight of the VA's policies and practices regarding compliance with sections 508 and 504 of the Rehabilitation Act.

A. VA IT Modernization and Section 508 Compliance

Section 508 of the Rehabilitation Act, which was incorporated into the Workforce Innovation and Opportunity Act of 2015, requires federal agencies to ensure that all electronic and information technologies developed, procured, maintained, or used in the federal environment provide equal access for people with disabilities, whether they are federal employees or members of the public. A 2012 Department of Justice report indicated that although Section 508 was enacted in 1998, major challenges with regard to the implementation and management of compliance with this provision still exist throughout the government, including at the VA. In spite of this report and several years of ongoing dialogue between the VA's senior IT officers and BVA's national leadership, numerous websites and information technologies utilized by the VA remain out of compliance with the most basic accessibility guidelines of Section 508. BVA has repeatedly requested in its annual resolutions that web content posted by Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA), in addition to information technology used throughout the VA, be fully compliant with basic industry standards for accessibility. Although there have been some improvements, noncompliance continues to be widespread. A case in point involves the chat site associated with the VA Crisisline. This site was implemented as a means of helping individuals at high risk of suicide to connect with mental health resources more quickly than they could in the past. However, several months after this site was launched, blind people using screen readers on their computers cannot access this site without assistance. This is both unfair and unsafe. It is also something that could have been avoided if the site's developers had followed industry-standard accessibility guidelines when building the site. Now, barriers to access via screen readers that were inadvertently built in to the site's design are not so readily undone without requiring a major, expensive, overhaul of the entire design.

We appreciate the fact that both the House and Senate Veterans Affairs Committees have requested VA briefings on the accessibility of their websites in the past, including the most recent request by the House Committee's Chair this past February. However, we submit that the

VA has a long way to go to address even the most basic of barriers currently fa
employees with disabilities, and the veterans served by VA.

The following 508 compliance issues are areas of specific and ongoing concern:

- Inaccessible kiosks at VA Medical Centers, the use of which is required to check in for scheduled appointments.
- Inaccessible Telehealth tools, namely the Health Buddy home monitoring station.
- VBA web pages containing eBenefits information that are inaccessible to blind people who use screen readers.
- The continuing accessibility barriers faced by VA employees with visual disabilities who are forced to use legacy systems that are largely incompatible with adaptive software in order to do their jobs.
- Inadequate staffing by the VA to ensure its capacity to address internal and external accessibility issues.
- Lack of an enforcement mechanism or other means of addressing compliance issues, so that if equipment, hardware, software, or a website is found to be noncompliant with accessibility standards, someone follows through and addresses the issues that are identified, and thereby fixes the accessibility problem.

We urge you to help us hold VA accountable for progress on addressing these issues. Please stand with us so that blind VA employees and BVA National Service Officers will no longer be shut out of significant portions of the VHA and VBA information management systems because of their incompatibility with screen readers and other adaptive equipment these individuals need to use in order to do their work. We also request your help in holding VA accountable for ensuring that its web resources for veterans are accessible to those who have visual disabilities, as well as other veterans. The VA must be held accountable for meeting stated timelines for fixing its inaccessible websites and replacing inaccessible obsolete hardware and software with equipment and applications that are accessible to and usable by people with disabilities.

B. VA Communications and Section 504 Compliance

There are more than a million veterans in the U.S. who have diagnosed visual disabilities that impair their ability to read printed material without the aid of magnification. As the number of Americans over age 55 continues to grow over the next 20 years, so will the number of visually impaired veterans. We are concerned by the fact that the Department of Veterans Affairs has made virtually no effort to date to put in place policies and practices that will give them the capacity to communicate with visually impaired veterans in alternate formats they can read. As the VA seeks to improve its capacity to meet targeted deliverables in communication and processing of veteran requests it is imperative that these improvements meet the needs of those veterans with disabilities. Resulting policies and procedures must identify the manner in which an individual reads material and then provide all material in the format identified by the individual. Failure to address this need now will put the VA at a major disadvantage, both in terms of the extent to which human capital will have to be devoted to it later, and the increased cost that would be associated with retrofitting infrastructure. An even greater concern is the

impact that failure to address this issue could have on efforts to eliminate the
2013, the Office of the General Counsel advised the VA that by failing to se
to claimants who were known to the VA to be blind in a format they could
violation of its statutory obligation to "send proper notice."

The OGC went on to point out that in cases where such improper notice is given, the claim must remain open until the notice is corrected, and further noted that this includes claims where decisions have been rendered denying the claim. The OGC stated that in such cases, notice of denial was improperly given, and therefore invalid, thus subjecting the VA to possible litigation for retroactive benefits. As long as the VA fails to serve proper notice in such cases, the amount of those retroactive benefits due to the applicant may continue to compound. It is imperative, for the sake of both the VA and visually impaired veterans involved in the claims process, that processes be put in place whereby VA's various agencies can:

- Identify those individuals whose disabilities prevent them from reading printed and other textual materials by traditional means.
- Collect information about which alternate formats the VA could use to communicate with these veterans.
- Provide information such as correspondence, memoranda, appointment notices, notices of decisions regarding claims for benefits, and other vital communications to these veterans in accessible formats.

We urge your committees to help us encourage VA to take steps now, as they approach new implementations, to incorporate measures that will enable them to address these needs sooner, rather than later. Policies must be developed and best practices identified and implemented, in conjunction with the development and implementation of other communications and IT modernization efforts so that measures to address these issues will be incorporated seamlessly into the general communications program. We request that you utilize your oversight authority to help us hold the VA accountable for making progress toward this goal.

C. Recommendation: Designation of Accessibility Officer Within VA

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

II. REQUEST FOR IMPROVED ACCESS TO INFORMATION ABOUT PRESCRIPTION DRUGS FOR BLINDED VETERANS

There is one area of communication where VA has excelled. In fact, VA is to b ensuring in the early 2000s that its pharmacies would be among the first entit to take advantage of technology that reads information on the labels for pres loud so that blind patients have independent access to that information when needed. VA pharmacies provide the machines that read these prescription labels to blinded veterans free of charge.

However, VA purchased most of the equipment used by pharmacies to produce these talking prescription labels 16 years ago, and since that time, the technology has evolved significantly. Blind patrons of several private sector pharmacies now have access to the same label readers for their prescription medications. But the labels on their packages contain a significant amount of additional information that is not available to veterans who obtain their prescriptions from VA pharmacies. Private sector pharmacies can give their blind patients access to information from the printed sheets that come with their prescriptions, including side effects, possible interactions with other medications, and other safety warnings. Labels from VA's pharmacies only provide access to the basic information on the label itself.

We believe it is important for the VA to upgrade the capacity of its pharmacies to provide blind veterans with access to as much information about their prescription medications as possible. This is not a matter of mere convenience, but one of safety, sometimes with life or death consequences. We are aware of numerous instances where veterans have been seriously, and even fatally injured because they were not aware of a particular medication's properties. One veteran we know of from the state of Washington died because he did not know it was inappropriate to consume grapefruit juice while taking the statin prescribed by his doctor. He developed Cirrhosis of the Liver (without ever drinking alcoholic beverages), which proved fatal. It wasn't until the diagnosis was received that physicians started investigating the cause, only then leading someone to ask if the individual had consumed grapefruit juice. If the veteran had access to the updated ScriptTalk, he may have known that the combination of grapefruit juice with his medication had lethal consequences.

In order to prevent other veterans from sharing a similar fate, we are urging VA to obtain printers for its pharmacies that will enable them to give their blind patients more detailed information about their prescription drugs, such as possible side effects, safety warnings and other noteworthy facts patients might require in order to use their medications safely. We are also urging Congress to appropriate the funds VA will need to pay for this equipment. Each printer will cost approximately $2,000. There are 145 VA hospitals and several outpatient facilities whose pharmacies issue these ScripTalk labels. Approximately 41 of these facilities have upgraded their printers within the past two years, so they would not need to purchase new ones. However, VA will require some additional funds to upgrade the printers in the remaining pharmacies. To date, the VA has provided approximately 18,000 ScripTalk reading machines to blinded veterans and purchases approximately 2,200 more units each year. These machines can read the larger, more informative, labels that we are asking the VA to make available. In order for blind veterans to get as much benefit from these machines as possible, the VA must update the equipment pharmacies use to make the labels the machines read to the veterans. Now is the time to make this happen. We are urging VA to take advantage of this new technology. Failure to

do so could endanger the lives of more blind veterans unnecessarily. We requ
in urging the VA to take steps to avoid further loss of life and give our nati
access to the information that will help to keep them safe, healthy, and indepe

III. DOD VISION RESEARCH PROGRAM FOR FY 2018

BVA, along with several other Veterans Service Organizations and Military Service Organizations, again supports the Department of Defense (DoD) Vision Research Program's (VRP) programmatic request of $15 million for Fiscal Year (FY) 2018. The specific request is directed to the Peer Reviewed Medical Research Program (PRMR) for extramural translational battlefield vision research. BVA requests the increase to $15 million for FY 2018 to meet identified DoD gaps in this area of battlefield research.

The Peer Reviewed VRP, within the Congressionally Directed Medical Research Program (CDMRP) appropriations, funds critical extramural vision research into deployment-related vision trauma. This research is not currently conducted by any other public or private entity such as the VA, DoD (including the joint DoD/VA Vision Center of Excellence), or the National Eye Institute (NEI) within the National Institutes of Health. Less than one percent of the NEI and VA research budgets are allocated to vision research and none of that funding goes to research into prevention, diagnosis, or treatment of penetrating eye blast injuries. The largest vision research organizations consisting of the National Alliance for Eye and Vision Research (NAEVR), the American Academy of Ophthalmology (AAO), the American Optometric Association (AOA), and the Association for Research in Vision and Ophthalmology (ARVO) all stand together with BVA to urge Congress to fund the VRP at $15 million for FY 2018.

One consequence of today's battlefield conditions is that 14.9 percent of those who are evacuated due to wounds resulting from Improvised Explosive Device (IED) blast forces have penetrating eye injuries and TBI-related visual system dysfunction. Upwards of 75 percent of all TBI patients experience short- or long-term visual disorders (double vision, light sensitivity, inability to read print, and other cognitive impairments). With the continued presence of the U.S. in Afghanistan, coupled with other global threats, such eye injuries will continue to be a challenge. The VHA Office of Public Health has reported that for the period October 2001 through June 30, 2015, the total number of OIF/OEF veterans enrolled in VA with visual conditions was 211,350, including 21,513 retinal and choroid hemorrhage injuries (including retinal detachment), 5,293 optic nerve pathway disorders, 12,717 corneal conditions, and 27,880 with traumatic cataracts. The VA continues to see increased enrollment of this generation with various eye and vision disorders resulting from complications from frequent blast-related injuries.

VHA data also reveals rising numbers of OEF/OIF/OND-era veterans with TBI Visually Impaired ICD-10 Codes enrolled in VHA for vision care. Reports from FY 2013 showed 39,908 OEF/OIF/OND-era veterans with symptoms of visual disturbances enrolled for care, which increased to 66,968 in FY 2015. With increased deployment to Iraq, Turkey, Afghanistan, and

other war regions, we expect this trend to continue. VHA Blind Rehabilitati also provided BVA with information indicating that as of August 2, 2016, OEF/OIF/OND-era Veterans have ICD-10 diagnoses (Impairment Codes) assc impairment, low vision, or blindness.

Research to effectively treat vision trauma and TBI-related visual disorders can have long-term implications for an individual's vision health, productivity, and quality of life for the remainder of military service and into civilian life. A John Hopkins public health study in 2012 using published

data from 2000-2010 estimated that deployment-related eye injuries and blindness have cost the U.S. $2.3 billion a year, yielding a total of $25.1 billion, driven primarily by the present value of long-term benefits, lost wages, and family care related to these vision conditions.[5]

In the first year of the VRP program, FY 2009-2010, 120 pre-applications were received, 50 applicants were invited to submit full proposals, and 12 projects were funded. In the combined FY 2011-2012 VRP funding cycle, 151 pre-applications were received, 50 applicants were invited to submit full proposals, and 21 projects were funded. In the combined FY 2013-2014 VRP funding cycle (in process), 275 pre-applications were received and 151 applicants were invited to submit full proposals. The number of projects that can be awarded at the existing funding level is flat, 20 or fewer annually, despite the increased number of high quality proposals received each year. Therefore, we recommend that the VRP receive $15 million for FY 2018 so that additional research can be supported.

VRP funds two types of awards: hypothesis-generating, which investigates the mechanisms of corneal and retinal protection, corneal healing, and visual dysfunction resulting from TBI; and translational research, which facilitates development of critical diagnostics, treatments, and therapies− those that can be employed on the battlefield to save vision. The DOD Vision Program funding from congress is having an impact, and BVA requests the $15 million level for FY 2018 to further this vital research.

Research projects funded by the first two VRP funding cycles (2009-2010 and 2011-2013) resulted in:

- 80 published papers that are advancing knowledge about the diagnosis and treatment of eye trauma injuries.
- The development of a portable, hand-held devices to analyze the pupil's reaction to light, enabling rapid diagnosis of TBI-related vision dysfunction.
- A new "ocular patch," which consists of nanotechnology-derived reversible glue that seals lacerations and perforations of the eye globe sustained on the battlefield
- A computational model of the human eye globe to investigate injury mechanisms of a primary blast wave from an IED that account for 82 percent of the blast injuries in Iraq and Afghanistan. This enabled the DoD to develop more effective eye protection.
- The development of a new vision enhancement system that uses modern mobile computing and wireless technology, coupled with novel computer vision (object recognition programs)

and human-computer interfacing strategies, to assist visually impaired v
vision rehabilitation to navigate and interact with people.

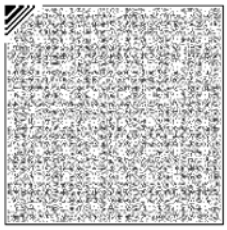
As you can see, the Vision Research Program funding from Congress is already having an impact. BVA requests the $15 million within CDMRP for FY 2018 to further this research. Further, we ask that the members of the House and Senate Committees on Veterans' Affairs express their support for this level of funding to appropriators in both chambers.

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

The VA currently provides health care to more than 922,000 veterans who served in Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND)/Operation Inherent Resolve (OIR) and Operation Freedom's Sentinel (OFS).[i] An increasing number of these veterans have vision impairments and hearing impairments, as a result of wounds they received in these wars. Due to the ongoing conflicts around the world today, and the consequent risk that service members will continue to be deployed to dangerous areas, thereby sustaining similar injuries, we can expect this number to continue climbing.

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

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



GAO found that DoD has developed criteria to designate an entity as a D Excellence (COE) but the VA VHA has not. Health-focused COEs are intended treatment, research, and education to support health provider competencies; identify gaps in medical research, coordinate research efforts; and integrate new knowledge into patient care delivery. GAO found that DoD leadership and its Defense COE Oversight Board established and refined the definition and criteria for designating entities as Defense COEs. DoD's criteria require its Defense COEs, for example, to achieve improvements in clinical care outcomes and produce optimal value for service members. The Oversight Board developed these criteria in order to have

a consistent basis for designating entities as Defense COEs and to limit the ability of entities to self-identify as Defense COEs without meeting the criteria. DoD also developed a uniform process for designating COEs while VHA service offices use a peer review process to designate their COEs. Federal internal control standards provide that management should have a control environment that provides management's framework for planning, directing, and controlling operations to achieve agency objectives, such as DoD's objectives for how COEs are to operate and what COEs are supposed to achieve. Without defined criteria, VHA lacks reasonable assurance that its COEs are meeting the agency's intended objectives for COEs.[iv] The Defense COE Oversight Board and most service offices responsible for overseeing VHA COEs lack written procedures for documenting oversight activities related to their COEs, including requirements for documenting identified problems and their resolutions.

BVA calls attention to these findings in the GAO report, which was sent to the chairmen of both the House and Senate Veterans Affairs Committees as evidence that more Congressional oversight is needed. We also question why the Surgeon General of the Navy manages the Vision Center of Excellence while the Hearing Center of Excellence is under separate supervision under the Surgeon General of the Air Force. VA’s limited flat line budgets and low staffing have combined to hinder significant progress toward the full establishment of the VCE and HCE.

The Deputy Assistant Secretary of Defense for Health Affairs, Dr. Jonathon Woodson had planned in 2014 to merge these COEs under DHA Strategic Trauma Centers but this has not yet occurred. With the VCE and HCE under programmatic control of the Navy and Airforce there is growing concern that these vital centers will not be included under the umbrella of the DHA Strategic Trauma Centers. Inclusion of the VCE and HCE under DHA would improve the management and level of care these wounded service men and women receive upon their return home. BVA requests that Congress ensure that future oversight of the VCE and HCE be moved under DHA as part of the Strategic Trauma Centers. Additionally we request the House and Senate Committees hold hearings with senior witnesses to explain the lack of progress toward full implementation of these two COE’s during the past six years.

V. FUNDING VHA BLIND REHABILITATION SERVICE (BRS)

Integrated among OIF and OEF veterans with eye injuries is an aging veteran p
be characterized by a growing prevalence of age-related degenerative visual im
FY 2015, there were 48,792 blinded veterans on permanent VIST Coordinator
lists. VA research studies estimate that there are 131,580 legally blinded veterans in the U.S. population.[v] Epidemiological projections indicate that there are another 1.5 million low-vision veterans in the United States with visual acuity of 20/70 or worse. About 285,000 have glaucoma.

VA currently operates 13 comprehensive residential (BRCs) across the country. These BRCs provide the ideal environment in which to maximize the rehabilitation of our Nation's blinded veterans. Unfortunately, the Veterans Integrated Service Networks (VISN) directors and medical center directors at some of the sites where the BRCs are located have failed to replace BRC staff members who retired or transferred to other facilities, claiming that there is no funding to support maintenance of their center's staffing at previous levels. As a result, several BRCs now lack the staffing to help blinded veterans acquire the essential adaptive skills they need to overcome the many social and physical challenges of blindness. Without intervention, we fear that the number of BRCs in this position will grow.

BVA recommends that the VHA BRS Director be given central control over the blind rehabilitation centers, their personnel resources, and funding levels. BVA also requests that the House and Senate Veterans' Affairs look into how funds allocated to the Blind Rehabilitation Service is actually being used. VHA and the VISN should be required to explain how funds are allocated within and among BRCs. These centers need directed funding to bring staffing levels up to required levels. Directors should not be allowed to divert funds designated by the Veterans Equitable Resource Allocation (VERA) System for rehabilitation admissions from the blind centers to other general medical operations. There should be no bed closings or hiring freezes on critical blind center staff positions. VHA must maintain the current bed capacity and full staffing levels in the BRCs that existed at the time of passage of Public Law 104-262.

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

Private agencies for the blind lack the necessary full specialized nursing, physical therapy, pain management, audiology and speech pathology, pharmacy, and radiology support services that are available at the BRCs because they are located adjacent to VA hospitals. Also, most private agencies are outpatient centers located in major cities, making access for veterans from rural

areas difficult, if not impossible, for blinded veterans. In many rural states th inpatient blind training centers at all. Therefore the availability of an adeq staffed VA BRC is the only option. These veterans should not be forced resourced facilities when VA has the capacity to ensure they have access to a program at a facility that is adequately staffed and funded.

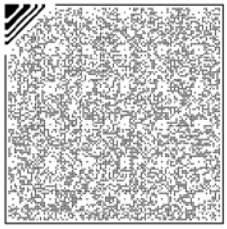
BVA requests that if the VA does contract with private agencies to provide rehabilitation training to blinded veterans, the VA should ensure that the private agencies with which it contracts have a demonstrated capacity to meet the peer reviewed quality outcome measurements that are a standard part of 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 (NAC) and Visually Impaired or the Commission on Accreditation of Rehabilitation Facilities (CARF). Additionally, the VA should require those agencies to provide veterans with instructors

who are certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). No agency should be used to train newly-blinded veterans unless it can provide clinical outcome studies, evidence-based practice guidelines, mental health care counseling, and joint peer-reviewed vision research.

VI. SUPPORT FOR LEGISLATION MANDATING RESEARCH ON TOXIC EXPOSURES

BVA supports legislation that will encourage greater research into the links between exposure to toxic substances and numerous medical conditions our veterans now face. We are particularly concerned about growing evidence that appears to demonstrate a link between exposure to toxic substances such as Agent Orange and the development of eye cancers. Vietnam era veterans exposed to toxic substances during their service in the Armed Forces have been diagnosed at the rate of 2,000 cases per year from 2007 through 2011. While Choroidal Melanoma (CM) is the most common primary malignant intraocular tumor and the second most common type of primary malignant melanoma in the body, it is still very rare in the general civilian population, with occurrences of only 5-6 per one million people.

Demographic reports in the U.S. indicated there was a total of 1,000 new cases of eye cancer diagnosed in 2010. If Vietnam Era Veterans developed eye cancer at the same rate as the general population there should have been about 115 veterans diagnosed with this form of cancer. However, among veterans within the VA system in 2007, there were just under 2,000. In 2008, there were just over 2,000 cases diagnosed, about 2,200 in 2009, and about 1,550 cases in 2010. BVA requests that members of these committees direct that the VA appoint an ophthalmology peer review committee to assess the incidence of CM among veterans exposed to Agent Orange. We would also like to see further cooperative research by VA, DoD, and the National Eye Institute into this potential correlation. For the past four years, this alarming finding among Vietnam veterans has been ignored, and this must change. BVA seeks future legislation to



support research on Agent Orange and other toxic substances that our servic have been exposed to and the medical side effects of such exposure.

VII. RECOMMENDATIONS

- BVA requests that the 115th Congress conduct an Oversight Hearing on VA lack of compliance with Section 508 throughout the VHA and VBA Information Technology programs, and require that VA set timelines, funding levels, and staffing goals for addressing areas of noncompliance.
- BVA recommends that the Veterans' Affairs Committees urge VA to develop policies and practices that enable VA's agencies to identify those veterans and VA employees who need access to materials and correspondence in formats other than print by virtue of disabilities, and to ensure that they have the capacity to communicate with such individuals in appropriate accessible formats.
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- BVA requests an increase in appropriations to support funding for purchase of new equipment needed to provide blind patients with access to updated prescription drug labels in all VA hospitals and outpatient facilities whose pharmacies provide labels for ScripTalk units to blind and visually impaired patients.
- BVA requests that members of the Veterans' Affairs Committees express support to appropriators for funding of the DoD Vision Research Program (VRP) within the Congressionally Directed Medical Research Program at $15 million in FY 2018.
- BVA requests oversight of full establishment of the VCE and the Defense Veterans Eye Injury Registry (DVEIR) on resources, program management, and funding. Request similar oversight for the Hearing Center of Excellence.
- BVA requests Congressional support for VA's adherence to high standards in the recruitment of employees and contractors who provide rehabilitation training to blinded veterans and urges Congress to insure that VA continue requiring certification by recognized accrediting bodies.
- BVA Urges Congress to pass legislation providing for research and treatment of vision-related conditions that continue to plague Vietnam era veterans who were exposed to toxic substances during their service, and further requests support for a VA study of the link between Agent Orange and Choroidal Melanoma Eye Cancer.
- Congress must repeal the inequitable requirement that the amount of an annuity under the Survivor Benefit Plan be reduced on account of, and by an amount equal to, the amount received by a veteran under Dependency and Indemnity Compensation.

CONCLUSION

Once again, Chairman Isakson, Chairman Roe, Ranking Member Tester, Ranking Member Walz, and to distinguished Committee Members, thank you most especially for the opportunity to present BVA's legislative priorities before you today.

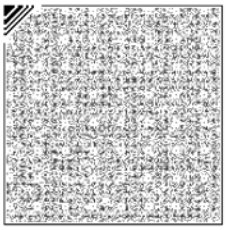
[1] VA FY 2017 Budget Press Release February 10, 2016 War Related Health Care Services.

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

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

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

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



ROBERT "DALE" STAMPER

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

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

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

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

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