BLINDED VETERANS ASSOCIATION

TESTIMONY
PRESENTED BY

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BEFORE
HOUSE VETERANS AFFAIRS COMMITTEE

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INTRODUCTION

Mr. Chairman and members of the House Veterans Affairs Committee, on behalf of the Blinded Veterans Association (BVA), the only Congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families, thank you for this opportunity to present BVA's legislative priorities for 2007 and to take a look back at 2006.

This past year BVA has become increasingly frustrated by the lack of significant change in VHA's ability to provide the full continuum of blind outpatient rehabilitation programs. Our organization has also been discouraged by the limited attention paid to a major crisis facing the Department of Defense (DoD) and the VA health care system, that of Traumatic Brain Injury (TBI). We do, however, appreciate Congressman Michaud's recent letter to GAO requesting an investigation into TBI as an initial first step to future hearings.

SEAMLESS TRANSITION

Let me begin in greater detail by describing just two major examples of the complete disconnect between DoD and VHA with respect to the ideal of seamless transition. Within the past month alone, BVA discovered a 22-year-old Navy Reservist Corpsman at Camp Lajeune, North Carolina, in a Medical Hold Company. The corpsman had been hit by mortar attack in Iraq several months before, leaving him totally blind in his left eye and with vision of 20/200 in his right eye. He had spent more than four months in medical hold pending his disposition and, while his level of severe eye injury should have resulted in immediate consultation with VA Blind Services for admission to a Blind Rehabilitation Center (BRC), no one contacted VA. There was no seamless transition. This brave American instead was out-processed on September 8 and his instructions were as follows: "Whenever you get a chance back home in Ohio, contact the local VA and try and get an eye clinic appointment."

In a second case, an Army Sergeant First Class on active duty at Fort Bragg, North Carolina, with Traumatic Brain Injury from being shot in the head in Iraq, was returned to Fort Bragg. His diagnosis was TBI with legal blindness (vision 20/200 in both eyes). He is still on active duty with no consultation with VHA for the past four months. BVA found out about his case when he was highlighted in an ABC news story that explored the complications of TBI and the proposed cuts in funding.

BVA recently found out from DoD that more than 2,200 service members are in Medical Hold Companies. How many more, beyond the aforementioned, are blind and in need of VHA services? These cases should begin to demonstrate our complete lack of confidence in this system as one examines the current disconnect between DoD and VHA. It is apparent that computer information systems are not being able to exchange any surgical records or other critical parts of the inpatient treatment records of these service members. Mr. Chairman, these service members deserve better than this in view of their service to our country.

As of January 14, 2006, the DoD reported that 11,852 returning wounded had TBI, which is an astounding number when one considers that the total number of traumatic injuries is 19,859. TBI has become the "signature injury" of Operation Iraq Freedom (OIF) and Operation Enduring Freedom (OEF) operations. Blast-related injury is now the most common cause of trauma in Iraq. A recent study, for example, found that 88 percent of the military troops treated at an Echelon II

medical unit in Iraq were from Improvised Explosive Devices (IEDs) and that 47 percent of that group suffered TBI injuries.

More than 1,750 of the total TBI-injured have sustained moderate enough TBI to have neurosensory complications. Epidemiological TBI studies found that about 24 percent have associated visual disorders of diploma, convergence disorder, photophobia, ocular-motor dysfunction, and inability to interpret print, and other manifestations known as **Post-Trauma Vision Syndrome** (PTVS). BVA believes that Congress should ensure high-quality, ongoing screening of those at risk of TBI by examining their exposure history and through educating DOD and VA medical staff on the identification, diagnosis, and appropriate management of the condition. Congress should also support vital research and enforce mandatory tracking for service members who have sustained a TBI diagnosis. BVA fully endorsed the recent Senate Defense Senate amendment that funded $19 million to continue this effort through the Defense and Veterans Brain Injury Center (DVBIC) for FY 2007. According to a recent study by researchers at Harvard and Columbia, the estimated cost of medical treatment for those service members with TBI will be at least $14 billion over the next 20 years.

BVA emphasizes to this Committee that in addition to the above, data compiled between March 2003 and April 2005 found that **16 percent** of those evacuated from Iraq had experienced eye injuries. Walter Reed Army Medical Center has surgically treated approximately 670 soldiers with either blindness or moderate to severely significant visual injuries. The National Naval Medical Center has a list of more than 350 eye injuries requiring surgery. Several of these service members have attended the ten VA Blind Rehabilitation Centers (BRCs) while others are in the process of being referred for admission. Nevertheless, we fear that many are unaccounted for and lost in the DoD system. Some 22 percent of the wounded are National Guard or Reserves. There is no documentation as to how many have been lost to VA follow-up and to the appropriate VA blind Service consultations since so many of them are sent for Tricare services. In the month of July, The Severely Injured Service Center admitted to VHA representatives that there is no central tracking system for all of these eye injuries. We had requested that the Government Accountability Office (GAO) investigate and report to this Committee what is being done to insure a seamless transition for those who have suffered eye injuries.

The brave service members who have suffered catastrophic, life-altering injuries deserve the full continuum of care within VA blind services. They deserve the available benefits to assist them with their recovery. These numbers should highlight and make it very obvious to members of this Committee that a new generation of visually impaired, low vision, or totally blinded OIF and OEF veterans are returning home with unique TBI-related visual PTVS, neurological injuries, and direct eye trauma. This Committee should find this data extraordinarily important, sufficient to hold future hearings on TBI-associated PTVS. We must ensure that VHA has the full continuum of blind rehabilitation resources necessary for these active-duty service members in their seamless transition. The lack of proper diagnosis and treatment of these TBIs and associated visual conditions will prohibit these veterans from performing basic activities of daily living, resulting in increased unemployment, failure in future educational programs, dependence on government assistance programs, and depression and other psycho-social complications.

FULL CONTINUUM OF CARE

Due to both OIF and OEF injuries, and the increasing age of our veteran population with the known prevalence of age-related visual impairment, the VA Visual Impairment Advisory

Board (VIAB) has identified and stressed, for well over two years, the need for a uniform national standard for the full continuum of blind services. VIAB is an interdisciplinary board that includes health care providers, the Blinded Veterans Association, research, and VA network representatives.

VIAB has continued to evaluate VA's progress in implementing the recommendations of GAO. VHA completed a "*Gap Analysis of Continuum of Care for Visually Impaired Veterans,"* which was released in April 2005. The analysis found that only 14 medical centers were able to provide advanced low vision care. Only 26 could provide intermediate low vision care. Some 78 reported that they could provide only basic or no outpatient services for blindness or low vision care!

For more than 30 percent of the veterans who attend a comprehensive BRC, there is usually no full continuum of blind service care when they return home and need further assistance. BVA recommends that by encompassing the full spectrum of visual impairment services--Blind Rehabilitation Outpatient Specialists (BROS), a specialized low-vision optometry program called Visual Impairment Centers to Optimize Remaining Sight (VICTORS) and the Visual Impairment Services Outpatient Rehabilitation Program (VISOR)--service members with high risk or history of TBI and resulting neurological visual complications would be appropriately diagnosed.

VIAB presented a proposal to the Health System Committee of the National Leadership Board (NLB) late last year that recommended that all Veteran Integrated Service Networks (VISNs) implement the full continuum of care for visually impaired and blind veterans. The Committee received the proposal very positively and issued a report in November 2005 on the *Financial Projections for the Expansion of Low Vision Services in the VA's Continuum of Care*. The Committee strongly recommended that the Deputy Under Secretary for Health fully endorse all Blind Rehabilitation Service outpatient programs. Despite this recommendation, only one new VICTORS program has been established since that time.

This Committee heard the GAO testimony provided on July 22, 2004 in which strong recommendations about the status of VA Blind Services were made. The testimony advised that more outpatient programs were required to meet the needs of an aging population of veterans with blindness. When doing this review, early in the war in Iraq, GAO could not have known the extent to which future OIF and OEF eye trauma cases, or TBI visual injuries, would now confronting VHA.

BVA has closely monitored VA's capacity to deliver high-quality rehabilitation services in a timely manner to our most recently injured, but we are also concerned about the approximately 44,700 blinded veterans already enrolled in VHA blind services. By the year 2010, there will be almost 53,000 enrolled in VA who are blind or who have significant low vision impairments. These number, however, do not represent the total number of blinded veterans of whom we are not aware and who may not know what services are available to them. Census and VA research nevertheless reveals that there are now some 167,000 blinded veterans veterans in the United States. An aging population will cause this number to rise further over the next decade.

BLIND REHABILTATION OUTPATIENT SPECIALISTS (BROS)

BVA has pointed out in previous testimony that GAO and VA have reviewed the waiting list of 1,500 veterans pending admission to BRCs. We stress once again that the findings revealed at that time that 21 percent of those on the list could be served by Blind Rehabilitation Outpatient Specialists (BROS). The shift of some 240 blinded veterans to care by a BROS would create an

internal inpatient cost savings of approximately $7.9 million per year. The delivery of outpatient rehabilitation service is the most cost efficient method for veterans who have rehabilitation needs but who are either unable to attend the residential program and/or would achieve improved functional independence with VA outpatient blind services. Surveys in the gap analysis found that some medical centers were paying $90 per hour ($450 daily) for private blind rehabilitation training when such services were available. Centers were spending an average of more than $70,000 annually for contracted private blind rehabilitation services for only a few veterans.

BVA highlighted recommendations from GAO, along with our proposals, as we testified before this Committee on February 15. We attempted to reinforce the need for timely implementation of the full continuum of outpatient services for all visually impaired veterans. However, with 38 bipartisan members of this Congress as co-sponsors supporting "The Blinded Veterans Continuum of Care Act of 2005" (H.R. 3579), introduced by Congressman Michaud, the bill has not yet been marked up despite all of the previously cited evidence in favor of its passage. This cost effective legislation, if voted on as it reads in S. 1182 passed last September in the Senate, would provide for BROS in 35 VA Medical Center facilities in which none currently exist.

BVA also reported in February that three of the four VA Poly Trauma Centers did not have a BROS on staff the entire previous year. This failure made it impossible for OIF and OEF soldiers to receive the vital initial training needed when they are transferred to such centers. Only recently, after persistent questioning of VHA late this spring, were two of these centers able to acquire a BROS. One center is just now in the recruiting phase. For some of the soldiers who attend a BRC and eventually return to their homes, there are 17 newly designated VA Secondary Poly Trauma Centers that have, at most, a part-time BROS to provide for the full continuum of care that is vital to the blinded veteran. Such care allows him/her to continue utilizing the skills learned and to adapt to new changes in prosthetics or adaptive equipment that are constantly evolving.

Much like the situation now, VA BRS did not possess the workforce to carry out effective follow-up to assess how effectively the veteran had transferred the newly learned skills to his/her home environment back in 1994. Congress directed $5 million for BRS in the FY 1995 VA Appropriations, and BRS was able to establish 14 new BROS positions. Currently there are only 26 of these vital positions while the system struggles to meet the growing demands on it. The creation of these initial BROS positions provided VHA with an excellent opportunity to provide accessible, cost effective, quality outpatient blind rehabilitation services and passage of H.R. 3579 would substantially improve services. These BROS may also provide some initial training before admission to a residential blind center, thus potentially reducing the total length of the inpatient stay in the BRC. VA BRS has collected functional outcome data, through the outcomes project, for this new program. The data indicate 90 percent satisfaction rates by veterans. They also reveal higher levels (some 20 percent higher) of performance-measured outcomes when compared with private sector blind services.

RISK OF FALLS AND MEDICATION ERROR

Research on blind and low vision Americans show they are at a high risk both of falling down and making major medication mistakes (taking the wrong medication or an incorrect quantity), resulting in costly hospital admissions and loss of independence as many of them can no longer live at home on their own once the accident has occurred. Falls are the sixth leading cause of death in senior citizens and a contributing factor to 40 percent of all nursing home admissions.

Annual federal costs for nursing home admissions are at more than $45,000 for each bed. According to the Framingham Eye Study, 18 percent of all hip fractures among senior citizens--about 63,000--are attributable to vision impairment. The cost of medical-surgical treatment for every hip fracture is more than $39,000. If outpatient rehabilitation services prevented even 20 percent of these fractures, the annual federal savings in health care costs would be more than $441 million. Essential, cost-effective outpatient services that would allow blinded veterans to safely live independently are not being authorized. The purpose of this denial is to save a few dollars up front in the short run, resulting in much larger federal nursing home costs later. To BVA, this health care policy simply does not make any sense.

PAIRED ORGAN LEGISLATION

BVA is very disappointed that this committee would not vote on and approve "The Dr. James Allen Disabled Veterans Equity Act" (H.R. 2963). This legislation currently has 80 bi-partisan co-sponsors. Since August 1964, when Congress passed and the President signed the *Paired Organ* law, there has been a technical problem in the lack of a definition of legal blindness. Currently a veteran who is service connected for loss of vision in one eye due to injury or illness incurred on active duty is denied additional disability compensation if they become legally blind in the remaining eye. Because the Paired Organ section on vision did not address the legally accepted definition of blindness (visual acuity 20/200, or loss of field of vision to 20 degrees), each year a few veterans are denied an increase in compensation if they become legally blinded in both eyes. This change in the law would only affect a small number, estimated at less than five percent of the 13,109 veterans who are service connected for loss of vision in one eye. In addition, more than 155 OIF service personnel at Walter Reed Army Medical Center, 78 of which have already been found to be service connected, have been totally blinded in one eye.

BVA believes that the veteran blinded in one eye who subsequently experiences blindness in the remaining eye should not be denied the benefits that other paired organ veterans have acquired. It is projected that less than five percent of the current service connected veterans for loss of vision in one eye would eventually lose their vision in the remaining eye. The Congressional Budget Office estimated that for FY 2007 this legislation would have cost $500,000. Over three years it would have cost less than $2 million. It is therefore surprising that this bill was blocked because of its costs. For the 155 OIF service members blinded in one eye, this sends a very disturbing and sad message about the relative value and cost of their loss.

BLIND REHABILITATION CENTERS

Blind Residential Centers (BRC) provide the most ideal environment to maximize a blinded veteran's ability to acquire the essential adaptive skills to overcome the many social and physical challenges of blindness, especially for OIF and OEF service members. During FY 2006, however, we found that these vitally important BRCs had staffing shortages of more than 34 full time positions, leaving beds empty while waiting lists remained unacceptably high.

The BRC becomes even more important for many of the recently blinded service members when they suffer from multiple traumas including Traumatic Brain Injury, amputations, and other sensory loss. The BRC can bring the entire array of specialty care to bear on these severely wounded service members, optimizing their rehabilitation outcomes and allowing for successful

reintegration with their families and communities. Mr. Chairman, there is no better environment to facilitate the emotional adjustment to the severe trauma associated with the traumatic loss of vision and to provide comprehensive initial blind rehabilitation.

VISUAL IMPAIRMENT SERVICES OUTPATIENT REHABILITATION

In 2000, VA Stars and Stripes Healthcare Network 4 initiated a revolutionary program to deliver services: pre-admission home assessments complimented by post-completion home follow up. An outpatient nine-day rehabilitation program called Visual Impairment Services Outpatient Rehabilitation Program (VISOR) offers skills training, orientation and mobility, and low vision therapy. This new approach combines the features of a residential program with those of outpatient service delivery. A VIST Coordinator with low vision credentials manages the program. Staff consists of certified BROS Orientation and Mobility Specialists, Rehabilitation Teachers and Low Vision Therapists.

VISOR is currently located at the VA Medical Center in Lebanon, Pennsylvania, and treats patients within Network 4. Patient satisfaction with the program is nearly 100 percent as reported by VA Outcomes Project research. Two current documents: *Gap Analysis: Vision Rehabilitation Services for Veterans Final Report* (Atlanta: VA Rehabilitation R & D Center of Excellence for Veterans with Vision Loss), and the Low Vision Services in the VA's Continuum of Care for Veterans with Visual Impairment (VIAB Final Report) recommend that this delivery model should be considered for replication within each VISN Network without a BRC. The number of networks presently affected is 11.

The program uses hoptel beds to house veterans and beds do not require 24-hour nursing coverage, similar to a hotel arrangement. Medical care is utilized within the medical center if needed for these outpatients. The costs associated with instituting the 11 new programs would be $5,474,733 for the initial year, but annual recurring costs to maintain them would be $4,700,883. This recurring cost works out to $427,353 per VISOR facility for all staffing, equipment office supplies, and training. VISOR's annual projected caseload of 550 veterans (50 per VISOR facility) would make the cost $8,545 per veteran, which is one-third the $28,900 for one month's admission at one of the BRCs.

VISUAL IMPAIRMENT CENTER TO OPTIMIZE REMAINING SIGHT

Another important model of service delivery that does not fall under VA Blind Rehabilitation Service is the Visual Impairment Center to Optimize Remaining Sight, or VICTORS. This program is an innovative one operated by VA Optometry Service, designed to provide low vision services to veterans, who, though not legally blind, suffer from severe visual impairments. Generally, veterans must have a visual acuity of 20 over 70, or less, to be considered for this service. The program is, typically, a very short (five-day) inpatient program in which the veteran undergoes a comprehensive low vision evaluation. Appropriate low vision devices are then prescribed, accompanied by necessary training with the devices. It should be noted that one of the VICTORS programs has converted to a two and one-half day outpatient program and utilizes hoptel beds for veterans who live too far away to commute daily.

The Low Vision Optometrists found in the VICTORS programs are ideal for the specialized skills necessary for assessment, diagnosis, treatment, and management of service

members/veterans with TBI or other low vision injuries referenced earlier. The Palo Alto VA Poly Trauma Center and Eye Clinic already initiated the screening of TBI veterans. Additional VICTORS are urgently needed and should be implemented to meet the growing demands from the current conflicts. With aging veterans, this program has achieved the same outcomes and objectives as its inpatient counterpart in Low Vision rehabilitative services. The program is therefore vital to both populations of veterans. Those in most need of the programs are those who may be employed but, because of failing vision, feel they cannot continue working. VICTORS enables such individuals to maintain their employment and retain full independence over their lives.

Unfortunately, Mr. Chairman, only four such programs currently exist within VA although VIAB recommended a total of eight new VICTORS outpatient programs for FY 2007. The cost analysis was $211,050 per program annually with a projected workload of approximately 1,600 veterans, a cost per veteran of $1,206 for this outpatient service. We submit that there is a critical need for these cost effective outpatient programs to assist visually impaired veterans remaining in the workforce. In fact, expansion of VICTORS could further assist severely visually impaired (legally blind) veterans who have already attended a residential BRC and received low vision aids, and who later require minor modifications to the aids. The effectiveness of new technology aids could be reviewed, researched, and new prescriptions written when appropriate.

Programs such as VISOR and VICTORS are cost effective for veterans with high residual vision (usually macular degeneration) and few, if any, co-morbidities. BVA recommends these services should be fully funded by VHA initially. Our concerns are especially relevant now that younger OIF and OEF veterans are going to be needing referral for low vision services. These individuals will clearly need these additional outpatient diagnostic and treatment programs. As of right now, however, there are no local VISOR or VICTORS services at 78 VA medical centers located in several VISNs.

OVERSIGHT

Mr. Chairman, as stated above, the last oversight hearing by the House Committee was held on July 22, 2004. The purpose of the hearing was to receive GAO's report on VA blind Rehabilitation Services. The priority now should be to ensure that VHA has the ability to provide the full scope of preventative and acute care services. The expansion of blind and low vision specialized services provided by VHA are now critical to meet the demands of OIF and OEF injuries. We also need the full array of health care services for the aging veteran population so that independence can be maximized and costly nursing home admissions minimized. Congress has failed to provide appropriations to sufficiently fund the VHA health care system, which means that the system today is unable to fund these critical low vision and blind outpatient programs. We hear VA representatives tell Congress that there is plenty of funding for FY 2007, but internally they won't fund the $9.4 million for these new vital and critical programs. The Senate MILCOM/VA appropriations included an amendment from Senator DeWine on July 22, 2006. The amendment, which had bipartisan sponsors, directed the Secretary to review the VIAB recommendations and begin full implementation of these new cost effective outpatient blind rehabilitation programs. It also mandated reporting back within 120 days after enactment of the MILCOM/VA appropriations. We ask this Committee to take responsibility for oversight and ensure the funding of the $9.4 million necessary to solve this problem within the VA health care system.

What is most alarming, Mr. Chairman, is the TBI injury situation and the associated impact of visual complications and blinded veterans being lost in the seamless transition process. Again, the BRC, BROS, VISOR, and VICTORS programs are now even more essential in the screening, diagnosis, treatment, and follow-up for OIF and OEF service members. They are returning with a wide variety of visual injuries and neurological complications associated from TBI in the war in Iraq and greatly need these services.

CONCLUSION

Thank you again, Mr. Chairman, for this opportunity to present BVA's legislative priorities for 2007. BVA is extremely concerned that blinded veterans and service members from OIF and OEF are not able to have the full continuum of services discussed here today. The future strength of our Nation depends on the willingness of young men and women to serve in our military, and that willingness depends in large part on the willingness of our government to meet its obligation to them as veterans. Waiting will only increase the problems and expenses associated with this crisis. I will gladly answer any questions you or other members of this Committee may have concerning this testimony.

RECOMMENDATIONS

1. Authorize the $9.4 million in additional funding for the expansion of the VISOR and VICTORS programs as outlined in this testimony and, based on VHA documents, support the MILCOM/VA Senate appropriations amendment with appropriations for FY 2008.
2. Support the $19 million for the Defense and Veterans Brain Injury Center (DVBIC) for FY 2007 as adopted in the Senate Defense Authorization Amendment.
3. Direct VHA to identify strategies to develop screening, diagnosis, education, and research of TBI service members and veterans from OIF and OEF. Authorize $4 million for **Post-Trauma Vision Syndrome** (PTVS) VHA research with the VA/DOD Traumatic Brain Injury Optometric Rehabilitation Program for Walter Reed Amy Medical Center and selected VA facilities.
4. Direct DoD Military Treatment Facilities to begin to collect and exchange immediately all information on every eye injury case evacuated from OIF and OEF operations that reveal any significant loss of visual acuity, blindness, or loss of visual fields.
5. Hold hearings on the issue of TBI research and PTVS early in the next session of Congress.
6. Pass H.R. 3579 and H.R. 2963, which are essential to providing the health care and promised benefits for blinded veterans.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

Blinded Veterans Association

The Blinded Veterans Association (BVA) does not currently receive any money from a federal contract or grant. During the past two years, BVA has not entered into any federal contracts or grants for any federal services or governmental programs.

BVA is a 501c(3) congressionally chartered, nonprofit membership organization.

THOMAS ZAMPIERI BIOGRAPHY

Thomas Zampieri is a graduate of the Hahnemann University Physician Assistant Program (June 1978). He obtained a Bachelor of Science degree from State University of New York and graduated with a Masters Degree in Political Science from the University of St. Thomas in Houston, Texas, in May 2003. Mr. Zampieri recently completed his Political Science Ph.D. dissertation and was awarded his degree by Lacrosse University. He is employed as the National Director of Government Relations for the Blinded Veterans Association, a Congressionally chartered Veterans Service Organization founded in 1945.

Mr. Zampieri served on active duty as a Medic in the U.S. Army from 1972 to 1975. Upon competing Physician Assistant training, he served from September 1978 to August 2000 as an Army National Guard Physician Assistant, retiring as a Major. During this time, he was involved in several military medical training programs and schools, successfully completing the Army Flight Surgeon Aeromedical Course at Fort Rucker in 1989 and the U.S. Army Medical Department’s Advanced Officer Course at Fort Sam Houston, Texas, in 1992.