THE VISION CENTER OF EXCELLENCE: WHAT HAS BEEN ACCOMPLISHED IN THIRTEEN MONTHS?

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

MARCH 17, 2009

Serial No. 111–7

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE
48–421 WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

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TUESDAY, MARCH 17, 2009

U. S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:06 a.m., in Room 334, Cannon House Office Building, Hon. Harry E. Mitchell (Chairman of the Subcommittee) presiding.

Present: Representatives Mitchell, Space, Walz, and Roe.

Also present: Representatives Buyer, Boozman, and Rodgers of Kentucky.

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. Welcome to the Subcommittee on Oversight Investigations Hearing on the Vision Center of Excellence.

We will begin, and I would like to ask unanimous consent that Mr. Boozman be invited to sit at the dais for the Subcommittee hearing today. Hearing no objection, so ordered.

This hearing is now in order, and we will begin with opening statements.

In April of 2008, this Subcommittee held a hearing on Traumatic Brain Injury (TBI)-related vision issues. In that hearing, there was an extensive discussion with the U.S. Department of Veterans Affairs (VA) and U.S. Department of Defense (DoD) about the Vision Center of Excellence mandated by the National Defense Authorization Act of 2008 (NDAA). We heard from both agencies that they were working hard on this initiative. Today, we will receive an update on the product of that hard work and how it has affected veterans in need of vision care.

We will also discuss the future needs of both of these agencies that we can assure that the center will be worthy of our veterans.

Last August, we were assured by the DoD that funding for a Vision Center of Excellence (VCE) would be distributed in fiscal year 2009. I applaud Congressman Space and Congressman Walz for urging Chairman of the Defense Appropriations Subcommittee, John Murtha, to set aside $5 million for the Vision Center. This demonstrates how important this issue is for the Members of this Subcommittee.

We now know that the fiscal year 2009 Defense Health Program Operation and Maintenance Budget allocated $3 million to the Vi-

sion Center of Excellence. However, it troubles me that even with this funding and appointment of a director and deputy director, whose testimonies we will receive shortly, the center is still without offices, computers, phones, and staff.

To put these delays in perspective, we will hear from a number of veterans and their families about the difficulties they have experienced receiving vision care.

Kentucky National Guardsman, Travis Fugate, suffered grievous injuries in Iraq in 2005. He lost his right eye and much of the vision in his left, and recently he lost what little vision remained.

The Vision Center of Excellence would have included the Military Trauma Eye Injury Registry that is designated to provide a seamless transition of information which could have preserved at least some of Travis' vision. This is a reminder of the cost in delaying interoperability between the departments.

Although Travis' story is troubling, unfortunately he is not alone. Sergeant David Kinney's involvement in an improvised explosive device (IED) explosion in 2005 forced him into treatment for headaches and a vision-related injury. He is here today to tell us what has happened since his injuries and the tribulations he has faced while seeking treatment.

We will also hear from Gil Magallanes, a Green Beret in Afghanistan who was seriously injured in 2001. His wife Sherry will be sitting beside him to help tell his story.

I am confident that none of us in this room would actively choose continuous delays or failures that needlessly hurt our veterans, yet we have seen time and again our veterans being left in a void where they don't know where to turn for treatment.

It took almost 7 years for Gil Magallanes to be introduced to his vision impairment speech team coordinator. That is unacceptable, and the Vision Center of Excellence would have provided a means to provide the specific care that is needed.

Planning for the Vision Center of Excellence has been under way for years, and I have no doubt that our second panel, which includes Colonel Donald Gagliano and Dr. Claude Cowan, will testify that VA and DoD are eager to get to work.

I expect today's hearings to be followed by speedy action from DoD and the VA to open the Vision Center of Excellence.

Travis, David, and Gil, thank you for your service, and for appearing before this Subcommittee today. Your testimony will be very helpful to us as we work to ensure that your colleagues in arms receive the care they deserve.

And thank you Dr. Zampieri for appearing here today and for your endless advocacy on behalf of our Nation's veterans.

And thanks also to DoD and VA for coming to the Hill to provide us with an update.

One of our Subcommittee Members, Mr. Walz had to attend to family business back home, but will be joining us shortly. He had the distinct honor of meeting Specialist Fugate at Walter Reed last week, and would like to extend his thanks to all witnesses, for being here today.

And before I recognize the Ranking Republican Member for his remarks, I would like to swear in our witnesses. I would ask all witnesses to stand and raise their right hand.

[The prepared statement of Chairman Mitchell, and additional background documents, appear on pps. 38, 54, and 56.]

Mr. MITCHELL.

[Witnesses were sworn.]

Mr. MITCHELL. Thank you, you may be seated.

I now recognize Dr. Roe for opening remarks.

OPENING STATEMENT OF HON. DAVID P. ROE

Mr. ROE. Thank you, for yielding, Mr. Chairman, and before I begin, I would like to recognize one of my closest personal friends, Dr. David Jones, who is a veteran from my district who is attending here today.

The Vision Center of Excellence, and accompanying Military Eye Injury Registry, were included as provisions in the Military Eye Trauma Treatment Act introduced last Congress by my colleague, Dr. John Boozman, an optometrist and Member of this Committee. These provisions were also included in the fiscal year 2008 National Defense Authorization Act, which passed in late January 2008, but was not funded at that time.

Funding for this program was approved with passage of the fiscal year 2009 Military Construction Veterans Affairs Appropriations Bill in late September 2008 when $6.9 million was allocated for this purpose through the Department of Veterans Affairs. The Subcommittee staff asked the Department of Defense over a month ago about when the funding would be available for the VCE.

We were informed last Friday, March 13, 2009, that the Department of Defense authorized effective March 12, 2009, $3 million for the establishment of the Vision Center of Excellence.

I am pleased that this funding has been finally identified and provided by the Department of Defense.

Mr. Chairman, I would like to ask that the letter from the Department of Defense dated to you March 12, 2009, be submitted into the official hearing record.

I agree with the Chairman, that it is important that this Committee take a look at the process being made in implementing this legislation, and closely follow the interaction between the DoD and the Department of Veterans Affairs.

It is no secret to this Committee that these two departments have not always played well together in the past; however, with the increasing numbers of servicemembers returning from Iraq and Afghanistan, with what has become one of the signature injuries of the war or terrorism, traumatic brain injury, and the related comorbid ocular injuries, it is critical that Congress conduct strict oversight into how this program is developed and implemented to assure that our Nation's servicemembers and veterans are well served.

This hearing is not the end of our oversight in this matter. In the very near future Dr. Boozman intends on scheduling a round table to further discuss the issues with Members of the Armed Services Committee and other stakeholders, including Blind Veterans Association, other veteran service organizations, and medical specialty organizations to be invited to the table for an open discussion of the progress being made and where we can address possible improvements.

I am looking forward to delving into this subject matter in greater detail, and appreciate Chairman Mitchell's interest on this issue.

I look forward to listening to the testimony today, and I am encouraged there will be future discussions and oversight on this matter as well. Again thank you, Mr. Chairman, and I yield back.

[The prepared statement of Congressman Roe, and the DoD letter of March 12, 2009, appear on pps. 39 and 56.]

Mr. MITCHELL. Thank you.

Mr. Space.

OPENING STATEMENT OF HON. ZACHARY T. SPACE

Mr. SPACE. Thank you, Mr. Chairman.

Thank you for calling this hearing and for your leadership on this issue.

I would like to thank also those veterans and family members who are here today to tell your stories so that we can better understand and help other soldiers and veterans keep and regain their sight. I appreciate how difficult it must be to speak publicly about your struggles, and I want to commend you for such a selfless action.

I also appreciate the testimony from the representatives from the Department of Defense, the VA, and from Colonel Gagliano on the progress that has been made on setting up the Vision Center for Excellence and the Eye Registry. Of course, as we all know progress has been slow.

As we will hear today it has been too slow for many veterans who are returning home to a broken system that is unable to effectively treat the injuries they have sustained defending our country. This has to change. And like others here today, I am frustrated that the solution that was debated and vetted and ultimately put forth by Congress more than a year ago has not been implemented.

The Congressional intent behind the Vision Center of Excellence is clear. With hundreds of injured soldiers experiencing eye trauma, we must have a comprehensive store of information about the particular injuries incurred, options for treatment, and rehabilitation, and the ability to simply share information between facilities.

When any servicemember goes into battle, he or she does so knowing the risk of bodily injury. That is an inherent part of the obligation incurred when you defend your country. What he or she may not expect is to return home and watch his or her condition deteriorate as a result of gaps in knowledge and incomplete paperwork.

It is simply unacceptable that these soldiers and veterans have lost their vision not on the battle field, but here at home under our watch. In some cases their vision is a casualty not of warfare, but of bureaucracy.

Some may say that we have here a tragedy of errors in which none of the various government entities are blameless and none are solely at fault. I believe that we can, and we must, do much more to serve these veterans by establishing the Vision Center of Excellence that was authorized in appropriated funds for last year.

Yet, instead of pointing fingers, I hope that this hearing will provide the impetus for immediate action to begin setting up these Vision Centers of Excellence, and ultimately I hope that hearing the

stories of veterans who have been affected by the delay in implementation will shed light on what is at stake in this situation.

I regret very deeply, Mr. Chairman, that I will have to depart after making this opening statement. I have conflicting, actually three hearings set for 10:00 this morning, but I wanted to make a point to be here to emphasize those issues that I, my colleague, Mr. Walz, and our Chairman feel so strongly about.

I am very eager to see this project move forward and anxiously await news of its progress. I yield back.

Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you.

Mr. Boozman.

OPENING STATEMENT OF HON. JOHN BOOZMAN

Mr. BOOZMAN. Thank you, Mr. Chairman, very briefly. I will just be very brief, because I want to go ahead and hear what everyone has to say. But I see Mr. Rogers here. I want to thank you for your, you know, doing a tremendous job of advocating this. You are here as a Republican, and yet I know that you represent the Appropriators, and this has been a very bipartisan thing, and we do appreciate your help and appreciate your advocacy in recognizing how valuable this was early on.

So thank you, Mr. Chairman.

Mr. MITCHELL. Thank you. I ask unanimous consent that all Members have 5 legislative days to submit a statement for the record. Hearing no objection, so ordered.

At this time I would like to welcome Panel One to the witness table. I now recognize Mr. Rogers of Kentucky to introduce our first witness, Specialist Fugate.

OPENING STATEMENT OF HON. HAROLD ROGERS

Mr. ROGERS. Mr. Chairman, Ranking Member Roe, and distinguished Members of the Subcommittee, thank you for letting me have the chance to say a few brief words this morning, and introduce to you a constituent of mine, who is your first witness on the panel this morning.

I am sorry that I can't stay as well for the entire hearing. My Subcommittee on Appropriations is meeting as we speak, and I have to run back to that session, at which I am the Ranking Member.

But I am very, very pleased to see your Subcommittee conducting this very important hearing and timely hearing and initiation of the Vision Center of Excellence.

As I am sure you will hear from today's testimonies, it is imperative that the Department of Defense and VA work together quickly to firmly establish this center and valuable Eye Trauma Registry to assist our young men and women in uniform facing vision challenges.

So many of us take for granted driving to the grocery store, watching a ball game, reading a good book. Sight affords us such simple things.

Our brave soldiers, sailors, airmen who have lost their vision will survive and can thrive, but if we can prevent vision loss, we ought to do everything possible to make that happen.

The Vision Center of Excellence is a part of ensuring that we are doing our job as they go about doing their job on our behalf.

I met U.S. Army Specialist Travis Fugate, the extraordinary young man and soldier sitting to my left 2 weeks ago when he came in my DC office. I learned about his family back in Kentucky where I know his family. They live in a small town called Hindman in Knott County, coincidentally the home of former Congressman Carl Perkins, whom some of you may remember. Small town.

I was extremely moved by his story, his personal experience, and I think probably most importantly his positive attitude on life. Despite perhaps some failures on our part, he has not given up on himself or our country.

Travis is a native of Knott County, Kentucky, located in the heart of my district in the mountains of east Kentucky. He entered the Kentucky National Guard in December of 2003, he deployed to Iraq in February 2005 with Co. B 206th Engineers. What unfolded there was no less than a series of tragic events, and yet you will see his truly American spirit. A spirit that overcomes obstacles and conquers life's setbacks.

And I will let Travis tell his story, as I could not do it justice. But I do want to commend him for his courage and thank him for his service and sacrifice for our country, and in this selfless campaign he is assisting all of us in, in trying to help people like himself throughout the service of our country.

And with that, Mr. Chairman, I am honored and pleased to introduce to you Travis Fugate.

Mr. MITCHELL. Thank you, Mr. Rogers for your introduction. Also joining us on our first panel is Sergeant Kinney, U.S. Army retired, an Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veteran from Deland, Florida, Master Sergeant Magallanes, U.S. Army retired, and his wife Mrs. Magallanes from Clarksville, Tennessee, and Dr. Tom Zampieri, the Director of Government Relations from the Blinded Veterans Association.

I ask all witnesses to stay within 5 minutes of their opening remarks. Your complete statements will be made part of the record.

First let me just say that at the end of 5 minutes you will all hear a beep, so hopefully we can keep within that so all people can be heard.

At this time I would like to recognize Specialist Fugate to begin.

STATEMENTS OF SPECIALIST TRAVIS FUGATE, USA (RET.), HINDMAN, KY (OIF VETERAN); SERGEANT DAVID WILLIAM KINNEY III, USA (RET.), DULAND, FL (OEF/OIF VETERAN); MASTER SERGEANT GILBERT MAGALLANES, JR., USA (RET.), AND SHERRY MAGALLANES, CLARKSVILLE, TN (OEF VETERAN AND SPOUSE); AND THOMAS ZAMPIERI, PH.D., DIRECTOR OF GOVERNMENT RELATIONS, BLINDED VETERANS ASSOCIATION

STATEMENT OF SPECIALIST TRAVIS FUGATE, USA (RET.)

Specialist FUGATE. Thank you Chairman and Congressman Roe and other distinguished Members for letting us come up here and talk to you guys.

It is really exciting here in how all that is being said. Everyone seems to be moving in the right direction with our Vision Center of Excellence. But I remember feeling the same excitement last January when I got the e-mails describing what was being given to us veterans, and I hope this time that excitement and energy doesn't dwindle to the halt that is has been at for the past year.

I submitted a written testimony which has the dates and times and everything, and I couldn't sit up here and tell you how everything happened, but I will tell you that I was injured in 2005 on May the 18th. I was hit by an IED just south of Baghdad, and there I lost my vision. And vision is the second leading injury only behind hearing loss. A lot of people don't know that.

I came home and I received great treatment here at Walter Reed, and even as a transition into the VA it was a lot of work. I had to do a lot of work myself to get through it all, but I made it. I made it through. And the doctors up here sent me with a job. I had to tell the Ears, Nose and Throat doctors back in Lexington, Kentucky, that I needed an issue addressed on my frontal sinus.

When I got enrolled in the VA and requested to have it addressed, due to my records being scattered and inaccessible to the doctors, they couldn't go in and do what they needed to do. Without the records they couldn't really determine the anatomy of my face, as the inside was so severely injured by the blast.

So the doctor, making a wise decision not just to cut in there not knowing what is what, told me to just wait and see what happens. And I trusted that decision, because I had gained a great trust in all the medical professionals on DoD and the VA side.

Well anyway, with the VA's rehabilitation I got a lot of devices, a lot of good technology. I really gained a hope that I could be successful, but then I got this infection and then it pretty much led to the loss of the rest of my vision.

And that is it, thanks.

[The prepared statement of Specialist Fugate appears on p. 40.]

Mr. MITCHELL. Thank you. Next Sergeant Kinney.

STATEMENT OF SERGEANT DAVIS WILLIAM KINNEY III, USA (RET.)

Sergeant KINNEY. Thank you, Mr. Chairman, everybody on the panel up there.

Like Travis said, our statements are in the record. And a short version, in Afghanistan, Mazar-e Sharif, Afghanistan in the north an IED went off, I banged the back of my head on the back of the seat real hard, caused bruising, and cracked the two top vertebrae in my neck right at the base of the brain stem. All right?

Trying to get doctors to understand that I was having severe headaches—my vision started to blur almost immediately afterward, within a month it started to blur. Trying to get doctors to understand that, you know, there was something going on, all I heard was that you are 40 years old, you shouldn't be running around with 20 year olds. Okay? That is unacceptable. We are out there training people, we are training the guys, we can't be that way.

To start getting glasses issued. I have had six pairs of glasses issued. My last eye exam says that I don't need any more prescriptions, they won't do me any good. Okay?

This happened in November of 2005 where I have had different eye exams. And the records, if I didn't carry them with me and get a copy from each place I went from Landstuhl to Eisenhower Medical Center, to the Tampa VA, Daytona VA, carry these records with me there would be no track record of showing what is going on. And every time I go to a new facility, you get new treatment. Everybody wants to change the direction of which way the wheel is turning.

We need to get one roof where everybody can get together and our records are tracked, a database of some sort where our records can be tracked and our care can be under one roof, one facility somewhere that when you have this type of vision and you are having these problems, they can be addressed in a way that would be done right.

I had a civilian doctor say I had a closed head trauma. Anybody who has been in a car wreck, you know, what that is, where you bang your head real hard. Okay? And that is what happened to me. I didn't have a blast that would cause any scarring or anything like that, so it was real hard to see my injury. Is that me? I was going to say, I didn't talk that much, did I?

Mr. MITCHELL. No, that's something else. I'm sorry. No, that's not you.

Sergeant KINNEY. But we have got to have somewhere to track this stuff. We have got to get the Vision Center of Excellence, TBI studies, and get everybody on the same ball program.

I mean, I know there are new programs starting. The VA has been a great help, the Wounded Warrior Program has. I have gotten good care, but it is just not—nobody is talking to each other, and you can't get the care if nobody is talking to each other.

You know, if it was you or your son out here that was sitting on this side of the desk, how would you feel and what would you do for him?

Thank you.

[The prepared statement of Sergeant Kinney appears on p. 41.]

Mr. MITCHELL. Thank you very much.

Master Sergeant Magallanes.

STATEMENT OF SHERRY MAGALLANES ON BEHALF OF MASTER SERGEANT GILBERT MAGALLANES, JR., USA (RET.)

Mrs. MAGALLANES. I am Sherry Magallanes, and I am honored to be speaking on behalf of my husband——

Mr. MITCHELL. Very good.

Mrs. MAGALLANES [continuing]. Who is retired Master Sergeant Gilbert Magallanes. He is a veteran of the United States Army who served in both the Gulf War and Operation Enduring Freedom. He is a Green Beret that served with Fifth Special Forces Group at Fort Campbell, Kentucky, and now medically retired after 21 years of active-duty service due to combat wounds that he sustained in Afghanistan during Operation Enduring Freedom.

He sustained his injuries actually from a friendly fire accident on December 5th, 2001, while his Special Forces team was guarding

Hamid Karzai, the President of Afghanistan, and he incurred an open traumatic brain injury with loss of skull and brain matter around the occipital lobe, that is actually larger than a 50 cent piece. The skull has actually been repaired by craniotomy, but the brain damage is obviously permanent.

He also has numerous other injuries, including homonymous hemianopsia, which is complete loss of his left field of vision bilaterally. He has slight left-sided hemiparesis, a cognitive thinking dysfunction and disorder, migraine disorder, and seizure disorder. He has lost two digits and part of his palm of his left hand, he has nerve damage to the left wrist, severe hearing loss, and he is now in stage three kidney failure and will require a transplant.

He spent over 1½ years in the hospital having multiple surgeries, recovering, numerous hospitalizations since. He has had to relearn how to walk and learn his left from his right, and so forth.

After his wounds were stabilized in Landstuhl, Germany, he was sent to Walter Reed where he resided in intensive care in a coma for several weeks.

At the end of January, he was sent for traumatic brain injury rehabilitation at the Palo Alto VA in California. After that, he was sent to a community reentry program that was a civilian-based unit in Sharps Medical Rehab in San Diego. It was our understanding he would obtain vision training for him to adapt for the vision loss and improve his independent living skills. However, once he completed the course in San Diego, they did the craniotomy to repair the skull deficit and he was sent back to Fort Campbell, Kentucky.

I assumed his care would be transferred to the Blanchfield Army Community Hospital at Fort Campbell at that time; however, his records were not completely transferred each time he was transferred between a military medical facility and a veterans medical facility, therefore, causing a break in his continuity of care.

The case manager he was assigned to when he reached Blanchfield Army Community Hospital in Fort Campbell was not aware of the extent of his injuries, and the hospital could not provide the adequate care that he needed. At the time, they did not have a neurologist on staff to treat the effects of the traumatic brain injury, the seizure disorder, the migraine disorder, or anything else.

He was assigned a staff physician who in turn told us traumatic brain injury and neurological disorders were not her specialty, but she would do the best that she could, and she did.

When the seizure disorder actually worsened, we had to go to his commander at Fifth Special Forces Group to arrange for him to be sent to Walter Reed so he could be treated by an actual neurologist.

We were not married at the time. I had no knowledge of the military, how to handle a medical board proceeding, or the procedure for retirement. I do not have a background in the medical field to understand the extent of Gilbert's injuries, diagnosis, or required treatment, and the proper protocol for therapy. Therefore, a lot of phone calls were made to his commander at the time and he was added to the temporary retirement disability list upon the findings of the Army Medical Evaluation Board.

At this time, all of his care was to be transitioned to the Department of Veterans Affairs. Since my husband's medical records were not transferred with him each time he transferred, we had to request copies and begin the process of compensation and pension exams as ordered by the Department of Veterans Affairs to identify all of his injuries and ongoing medical problems as defined by the findings of the Army Medical Evaluation Board.

At the time, he had a vision exam to confirm field vision loss and told him to be happy that at least the vision he does have is good.

After he was assessed and given 100-percent disability rating through the Department of Veteran Affairs, we were told that any care he needed would be provided. However, when I called to get him an appointment with the vision clinic, because his vision seemed to be changing, they told us he couldn't be seen. There was a certain protocol that had to be followed. I went to the hospital administrator. They told me that he needed to be seen by his primary care, referral had to be made, even though he was already rated for vision loss.

In 2008, we attended a paralympic sporting event, which we were fortunate to meet Travis Fugate, and at that time he forwarded our information to the Blind Veterans Association. And in turn, Ms. Christina Hitchcock with the BVA contacted us and invited us to their convention in Phoenix this past year. And it is 7 years post injury. We finally were introduced to our Visual Impairment Services Team (VIST) coordinator at the Nashville VA.

We now get to go to blind vision rehab to make him more independent and so forth on March 25 of this year in Palo Alto.

Although his vision impairment stems from the loss of brain matter and brain damage, not an actual disease or damage to his eyes, I still feel things may have been easier for him and our family if he was taught how to compensate for the visual loss in the beginning. I feel, and actually thought, there to be some process to prevent events like that. I know from our experience I was wrong. If we had not met Travis and the BVA, he would still not be receiving the vision testing and so forth that we have waited almost 7 years for.

It is our hope there will be a plan implemented not only to traumatic brain injury, but also for vision impairments and care coordination. We would like to see a system that tracks and follows patients through their course of care and during active duty and as they transition to retired members of the Department of Veterans Affairs to ensure that they are receiving the proper care and training as their injuries indicate. Therefore, no one would have to wait for 7 years to receive care and training as we did.

This, in turn, would mean additional educational training and research in visual impairments caused by traumatic brain injury for the staffs of both military facilities and the Department of Veterans Affairs.

In closing, I would just like to say that my husband, being the loyal and dedicated ranger that he is, has absolutely no regrets about his service to our great country. He would be back in uniform and on the front lines if he was medically able to do so, but he is not.

It is our hope that he be offered the necessary training and medical care to help him live his life as independently as he can with the injuries that he did sustain.

Thank you for your time.

[The prepared statement of Mrs. Magallanes appears on p. 42.]

Mr. MITCHELL. Thank you very much.

Mr. Zampieri.

STATEMENT OF THOMAS ZAMPIERI, PH.D.

Dr. ZAMPIERI. Ranking Member and Chairman Mitchell and Congressman Boozman and other Members of the Committee, on behalf of Blinded Veterans Association we appreciate that you scheduled this hearing today.

For our part we want to thank each of the Members of the Committee and the Committee staff who have followed this issue since the NDAA was passed a year ago, and I think you obviously all know my frustration with this slow process, and I am being kind in describing it that way, I think.

You know we started off with a lot of excitement because the physicians, the ophthalmologists in the military and the ophthalmologists in the VA and the optometrists in both the military and the VA actually started planning and talking about the great things that could be accomplished with this Vision Center of Excellence right around the same time that the original legislation was introduced in the Congress to create this in the Wounded Warrior section of the NDAA, which included the TBI and the Post-Traumatic Stress Disorder (PTSD) Centers of Excellence. And we thought that the train would all pull out together. That these three centers would all be established at the same time. They would be equally funded, equally staffed, they would all deserve the same amount of resources and support. Well, could fool me.

What happened was somewhere along the lines after the—soon after the NDAA passed, I started being told by different sources that, the famous story of "there is no money." This was not included in the specific line item in the Appropriations for fiscal year 2008. And when I went to the Armed Services Committee and Defense Appropriations Committee and the VA Committee and various people, they said there was plenty of money that was not only included in the War Supplemental for wounded warrior care, but there was money that was also included in regular Defense Appropriations for the Centers of Excellence. Meaning all three centers, not two. However, we now know that that wasn't, or at least according to different sources, the case.

What happened was, as time went on in April, in fact a year ago, April 2nd, we had a hearing in this very room. DoD witnesses came and they talked about all the excitement of what they were going to do and how they were going to do it, and yet nobody in writing ever promised how much they were going to put into this.

There were public statements made by senior leadership at the end of April about how they were having funding challenges in trying to establish the Vision Center of Excellence. And at the same time, I would point out that Congress was in the middle of examining the War Supplemental request to cover the remaining part of 2008 and the beginning of 2009, and there was a vehicle there

where someone could have simply asked for the $5 million if that was indeed the issue.

Then again in May, I was told again that there was no money. June there was a hearing in this room by the full Committee, and Mr. Dominguez came over to testify about seamless transitions and meeting the requirements of the NDAA. And if you go back and review his testimony, he talked extensively about the TBI Center of Excellence, the PTSD Center of Excellence, and he has one paragraph about the Vision Center of Excellence and no mention of funding, and that should have set off all sorts of red flags.

Basically, where we are at today is I was astounded and not amused that suddenly last Friday, the Chairman gets a letter from the Pentagon saying we have mysteriously found $3 million for the Vision Center of Excellence. And you have to excuse my sarcasm here, but I don't believe that that suddenly was just found. There is no reason at all, with all of the other Appropriations that have come through, that someone could not have simply asked if that truly was the issue.

The Vision Center of Excellence is going to play a very critical part of ensuring that research is coordinated, that these individuals that have had eye trauma or traumatic brain injury and vision disorders are tracked, that their diagnoses, their tests, their surgical reports are collected, examined, outcome studies will be developed.

And just briefly, the Vision Center of Excellence is not one big hospital. The idea is that it is a virtual center that will work across both the VA and DoD systems in finding literally thousands of these individuals who have come back with different types of either TBI vision dysfunction or with penetrating eye trauma.

I will end it here.

Again, thank you very much, I look forward to your questions.

[The prepared statement of Dr. Zampieri appears on p. 44.]

Mr. MITCHELL. Thank you very much.

And first I just want to thank all of you for the service that you have given to our country and the service that you have rendered in the past and your attitude today. It is just terrific.

The first questions I have are for Travis Fugate.

First of all Travis, have you been happy with the overall care that you have received from the VA and the DoD?

Specialist FUGATE. What was that again, sorry?

Mr. MITCHELL. Have you been happy with your overall care from the VA and DoD?

Specialist FUGATE. In combination, no. Individually, each entity individually, yes. I have encountered wonderful doctors, wonderful staff, and wonderful rehabilitation, numerous devices, the newest technologies to assist me in my daily living, and going to school. I have used the vocational rehabilitation program that the VA offers to go back to school, and begin a new life as a blinded individual.

So for both of them as a whole no, but each individual entity I have been happy. Yeah, I have been happy.

Mr. MITCHELL. Thank you.

Travis, can you describe what the transition was like between the VA and the DoD facilities?

Specialist FUGATE. It was a lot of paperwork, a lot of time. This was in 2005, or excuse me 2005/2006, that I transitioned, and since there have been a couple programs that has been implemented to help. I am not sure how they are doing now.

But during the transition, once I got to the VA, they seemed that they were completely unfamiliar with the way things were working with DoD. It was obviously just two completely different entities. And had there been some sort of central access point or hub to medical records and documentation and things like that, educational information for the staff regarding blindness and other things, I think it could have been a lot better, a lot easier.

Mr. MITCHELL. Okay.

Travis, how far is your home to the nearest VA facility?

And also I want to ask a couple other questions. Who is your primary caretaker in Kentucky? And along with that, how have your injuries affected your family, especially your dad?

Specialist FUGATE. Currently, I use a VA home loan to buy a home, and I have lived just by myself. Luckily my mother, my sister, and my father all live in a close proximity, so I have daily assistance. So their lives have been affected greatly in that a lot of their time and care goes into making sure that I am getting by and I am living comfortably.

My dad has made great sacrifices in that he has risked losing multiple jobs working in the coal mines of the Appalachian mountains in order to drive me 2½ hours to the closest VA that is in Lexington, Kentucky. Several times a month occasionally.

So if that answers your question.

Mr. MITCHELL. Let me just ask a question of Dr. Zampieri.

If the Vision Center of Excellence was fully operational, how could this Center have potentially changed the stories of Travis, David, and Gil?

Dr. ZAMPIERI. I think the big thing would have been having the ability of any ophthalmologist, either in the VA or DoD system, be able to go in and see the surgical reports.

And I think one of the most complex problems that providers have, and I am sure that the Ranking Member appreciates this as a physician, and I know Congressman Boozman does also, is all of these individuals suffer multiple traumas, multiple different types of injuries where they have had multiple surgeries. In Travis' case he was in a coma for a month, so he doesn't even remember any of the surgeries that he had.

So having the Vision Center of Excellence Eye Trauma Registry set up and operational, a physician could see Travis, go to the VCE's site, look at the different types of surgeries that were done on his retina, and he has had multiple surgeries, and be able to quickly figure out this is, you know, what I need to do next, you know, in my clinical decision making. And I think that is the big thing with all of them, not just with Travis.

You know, because David described to me yesterday about how he went through multiple different tests at multiple different hospitals and they are repeating the same tests over and over, which is not only inefficient and expensive, but having those diagnostic tests in one registry, eye registry, would efficiently, you know, improve that.

Mr. MITCHELL. Thank you.

Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman.

First of all, I just want to tell you, Travis and all of you, we appreciate your service to your country. And secondly, you made a statement earlier that you appreciated what had been given to you. Nothing has been given to you. You earned every bit of it and we need to make sure that we understand that in this room and in this country, I think.

And I also want to thank the family members. You mentioned your family, Travis, and certainly other family members that have stood by their family members and have assisted them in what they needed to do. And I found it astonishing last night when I read this entire testimony that we had let this go on for as long as it had, and the nonsense that this government funds every day and then not to fund this very needed program was appalling to me.

I believe this hearing, Mr. Chairman, is very much needed, and I appreciate your doing this, to bring this to light.

This incident, and I am going to call you Sergeant Gil so I won't step all over your name. I am from Clarksville, Tennessee, and we had a Sergeant Davis I believe from Elizabethton, Tennessee, who was Special Forces that was killed in that very incident I recalled when I was reading the testimony last night, it just tripped my memory, and so I am very familiar with where you were injured.

I think in all the testimony I have heard screams for a seamless electronic transferable, easy readable, electronic medical records where when you go from one point to another point for care, that it is seamless. And it looks to me like that would have prevented many of the problems that each of you have experienced in the 7 years that you all went through not to get to the point where you could get care was amazing to me when I read that.

And I think the injuries that each of you all have sustained, loss of vision—I am a surgeon, and it would have prevented me from doing any of that, and I admire and appreciate what you all have done.

One of the things that we noticed in testimony from a year ago, and I will just read it briefly and then ask each of you to answer this question.

This was testimony from 1 year ago.

"It is important to emphasize, however, that neither the transfer between health care systems, that is DoD or VA, is a linear path to ensure every veteran or servicemember receives the care or benefits they deserve.

The VA has created a case management program for Operation Enduring Freedom/Operation Iraqi Freedom veterans. The VA, DoD, Federal Recovery Coordination Program further provides needed assistance in support for veterans and servicemembers."

The question that each of you can answer. Have any of you worked with a Federal Care Coordinator to assist you in your treatment plan, and when did that care begin or has it?

Sergeant KINNEY. I can say no for me, I haven't met anybody in that way.

Mr. ROE. Okay, Sergeant Kinney.

And Sergeant Fugate?

Specialist FUGATE. For me there has been—I have heard some rumors of case managers, but I don't know any names or I haven't personally—there is a couple social workers, but I think that is a whole different thing. So no.

Mrs. MAGALLANES. In regards to us, we had a case manager when he first arrived in Blanchfield Army Community Hospital, but again she wasn't aware of the extent of his injuries or were able to provide any services that he really needed. In regards to Federal case management, no.

Our local VA, which is an hour from us, which is Nashville, actually started their own little polytrauma unit, a little over a year ago, and called us in, and again we reiterated that it was 6 years. We understand he was injured early in the war and they were not prepared for the extent of the injuries, but they had him again go through a series of different clinics, vision, speech, and identified all of his injuries, but in regards to getting therapy he still wasn't offered it.

So they still don't contact him or follow up in regards to making sure that he gets the necessary treatment he needs. It basically falls upon the patient. And a lot of them, I know in my husband's case, I don't have a medical background, so to have to understand what he needs and to understand a traumatic brain injury and that a cognitive disorder requires ongoing treatment. It is not just something you can have once and then be done with, because the brain needs repetitiveness. And to understand, I didn't know that, I was not aware of it. And I honestly thought that someone would be there to help us guide through this, but now hopefully, you know, we are going to get the care that we need and this will just prevent someone going through the same situation, you know, that they won't have to do the same things we did.

Mr. ROE. The bottom line answer is no.

Mrs. MAGALLANES. Yeah, pretty much, yeah. Which we did have a case manager, like I said, but it is just not the same thing. They didn't actually do anything for us.

Mr. ROE. Okay, thank you.

Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you.

Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman, and again thank you and the Ranking Member for being such a leader in this effort to try and resolve the problem that we have got.

I want to thank all three of you guys. My dad retired as a master sergeant in the Air Force, so he was an enlisted guy, so I feel very comfortable around you all. But I do appreciate your sacrifice, not only of you, but of your families. And I know that you have gone through a very difficult situation, and you really do exemplify the cost, the true cost of the endeavors that we are involved in now, and we really do appreciate your service.

Tell me, I guess you know, you eluded to—my concern is you all have had a tough time in the area of vision, and what we are trying to do is establish this Center of Excellence to prevent, as just was said, you know, so that people wouldn't go through this in the future by trying to, you know, this center, giving best management

practices being an advocate in that way. And as you have learned it has really been a very frustrating experience.

Mr. Zampieri, I don't want to put you on the spot, but where is the bottle neck? Where do you see things? You are a guy that has been around here for a long time advocating for, you know, vision problems and things, where do you see the bottle neck in this thing?

Dr. ZAMPIERI. I seriously question, some folks will get angry about this, but the Senior Oversight Committee (SOC) was supposed to be responsible for the implementation of the NDAA, and you know, I think, you know, their function was to be able to cut through, identify problems, make solutions to those, advise both Secretary Gates and now Secretary Shinseki, and this never seemed to get to their level of well okay, if somebody says, if it is Dr. Casells or I don't care who it is, says we can't find the money, you know, I assume that was the SOC's responsibility.

And I think there was, you know, mentioned in the earlier start of the testimony, there was $6.9 million that Senator Johnson and Congressman—Chairman Chet Edwards put into the MilCon/VA budget specifically for helping to get this started. And you know, I question why is it no one went and identified that and said okay, this is some resources that we could put into this.

I hope that helps, you know, help point one finger in one direction.

Mr. BOOZMAN. No, very good, thank you.

Let me ask you all. You had your injuries, and at what time did you start receiving any sort of mobility training?

Sergeant KINNEY. I didn't get mine until last year, because everybody wouldn't combine the TBI with eye injury. I think I said it in my statement, it is like saying a bad word in church. You just couldn't say TBI and vision, nobody would believe that there was a conflict between the two.

Mr. BOOZMAN. Right.

Sergeant KINNEY. And it took till last year and they got me to the Birmingham BRC down there.

Mr. BOOZMAN. Uh-huh.

Sergeant KINNEY. The Blind Rehabilitation Center in Birmingham. And I learned a lot there, but just getting the people to understand that there is a problem——

Mr. BOOZMAN. So once you got down there that was very beneficial in helping you to navigate.

Sergeant KINNEY. Oh, yes, sir.

Mr. BOOZMAN. How about you, Mr. Fugate?

Specialist FUGATE. I was injured in May of 2005. I started planned rehabilitation in August of 2005, so that was pretty quick.

But I will say that in the time, that I sat up here at Walter Reed waiting to recover from other injuries, I had no information on blindness or no one to come and tell me that it is going to be okay, that there is accessible computers and that there are other blind people in the world.

Mr. BOOZMAN. Right.

Specialist FUGATE. I was really alone. I had my mother trying to Google blindness basically.

So I understand now the VA has the BROS (Blind Rehabilitation Outpatient Specialist), the blind—I always—I will just say BROS, because I always mess it up—that comes out and works with the soldiers.

So hopefully that is addressing that particular issue on a small scale.

Mr. BOOZMAN. Thank you.

So your mom is trying to figure it out, which is a sad situation.

Specialist FUGATE. Yeah, yeah.

Mr. BOOZMAN. I am Boozman or Boozman you all are——

Mrs. MAGALLANES. Magallanes.

Mr. BOOZMAN. Magallanes.

Mrs. MAGALLANES. Uh-huh.

Mr. BOOZMAN. Okay.

How about very quickly can you tell us as far as when you started getting your mobility.

Master Sergeant MAGALLANES. For actual vision training I have had no training at all. I have just used my Special Forces training for teaching my myself. I had a great occupational therapist down in San Diego who helped me work with my scanning capabilities, and quit making me use my head back and forth for turning, because I am half blind, I don't see any to my left.

Mr. BOOZMAN. Yeah.

Master Sergeant MAGALLANES. So I always walk like this. I mean just completely.

Mr. BOOZMAN. Right.

Master Sergeant MAGALLANES. And so now as soon as I walk in the room, I scan and I just scan with my eyes and try to walk normal, and that is the way it was. But now I am going March 25th to the trauma center in California.

Mr. BOOZMAN. Very good.

Yeah, I think as the other two indicated, that is something that really will be very helpful. Even though you are a tough guy and were able to, you know, figure out a lot of this yourself, I think that training will be very useful.

Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you.

I would like to ask two questions very quickly of Dr. Zampieri.

And you were talking with Mr. Boozman, and in your testimony you also indicated in several places the lack of funding available for the Vision Center of Excellence. Do you feel that that is still a concern today?

Dr. ZAMPIERI. Thank you for asking that.

Yeah, the $3 million I have some serious questions. I don't know what is in the testimony of the DoD representative here today, but I would ask—I don't get to ask—but I will ask you to ask, you know, how much money is it going to cost for information technology support for the Vision Center of Excellence? Because I have been told, off the record, that it is at least $2 million.

I would also want to know how are you going to cover the construction costs, because there has been concerns about space—office space for the Vision Center of Excellence out at Bethesda at the National Naval Medical Center, that is where the Vision Center of Excellence is supposed to be headquartered, and they have identi-

fied space, but they need some construction money, and I don't ever in the past year, I have never seen a figure for that. Is it $5 million that they need for space renovation?

And the third thing is, you know, the original estimates last May were $5 million to get this up and running, because there are going to be four clinical sites, Bethesda, Brook Army Medical Center, Madigan Army Medical Center, and Balboa National Naval Medical Center are supposed to be designated as quote, "four Clinicalized Centers of Excellence." And how do you fund and staff with $3 million? You know, those four sites, plus the headquarters, none of that still adds up.

Hope that helps.

Mr. MITCHELL. Yes, and one last question really quickly.

To your knowledge, is DoD utilizing the Blind Rehabilitation Centers for vision-impaired active-duty members awaiting medical boards, and do you think we could be providing this training to those members sooner to assist with the transition from the DoD to the VA system?

Dr. ZAMPIERI. Briefly, you know, the VA has taken a lot of positive steps. As Travis mentioned now, they do have blind rehabilitative outpatient specialists who do early intervention now, and they have for the last few years, at both Walter Reed, Bethesda, Brook Army Medical Center, and so that has been a positive step. That helps them with the initial education about blind rehab training and orientation mobility training.

And then those BROS and the VIST coordinators, Visual Impairment Service Team coordinators from the VA, they can help expedite and make sure that the individuals get transferred into one of the ten VA blind centers for their training.

And so I think one of the things too that I identified as sort of a failure, I think is the case managers and the Federal Recovery Coordinators don't always even understand that there are these VA resources available.

I know that it is a big system, it is complex, you are dealing with a lot of different people, a lot of turnover, but I think that, you know, part of the—hopefully the Vision Center of Excellence mission will be in educating, you know, the staff, the case managers. That if you have a servicemember with TBI with vision problems or with penetrating eye injuries that the first thing they should do is initiate a consultation with VA's blind rehabilitative services, because they do an excellent job. But if they aren't told, we are going to continue to have people fall through the cracks.

Sergeant KINNEY. Sir?

Mr. MITCHELL. Yes, sergeant?

Sergeant KINNEY. Sorry, I don't mean to interrupt, but the seamless transition. We can't get into the VA system 6 months prior to us getting discharged. Some of us, our care has lasted up until—I was injured November 2005, I didn't retire until June of 2008, okay? I started trying to get into the VA system as non-service connected. You can't get care that way. They won't give you medicine, they won't start your stuff for you until you are all the way into the VA system. There is no seamless transition. You start everything over when you retire. When you get your DD–214 in hand is when you retire, that is when you get into the VA system. Before

that it is not seamless. It is non-service connected. You don't get care. You get seen and that is it. And I have got records to prove that.

Mr. MITCHELL. Thank you.

Dr. Roe, did you have any other?

Mr. Boozman, any other questions?

Mr. Walz.

Mr. WALZ. Well thank you, Mr. Chairman, I apologize for being a little late here. Thank you to each of our witnesses who are here today. Thank you for your service and thank you for your continued service by coming here and pointing out what we can do better.

Specialist Fugate, I had the opportunity to meet you. Travis, this is Congressman Walz, and again I was deeply inspired by your willingness to try and help us figure out what we need to do to make this work.

You mentioned something to me, Travis, last week I have thought about all this weekend. You mentioned something that sometimes we forget here. You said your only desire is to try and live as independently as you possibly can.

Are you going to be able to do that back in Kentucky the way it is now? You talked to me about the little place you bought on the hill and how you'd like to go back there and do some things. What do you think, is it possible?

Specialist FUGATE. No, unfortunately it is not. I bought the place, it is beautiful up there in the mountains, but for me the house that I bought I quickly realized that it was more like a cell or a prison, because I have no way of leaving there. You can't just get a sidewalk—hop on a sidewalk and go down the street. There is no public transit. So now I am forced to change my life plans and move to a more urban area so that I can adapt and try to live independently.

Mr. WALZ. Travis, if I can ask, and you are thinking one of the urban areas may be DC or something like that. You are probably finding out like the rest of us, it is a lot more expensive than Kentucky.

How about your retirement plan and your disability? How is that impacted by you being basically unable to make that choice to go to Kentucky, you just simply can't, as you have spoken about. Where is your disability pay at and retirement pay and how does that affect your decisions?

Specialist FUGATE. I have realized since being up here in the hospitals since January, I have made a lot of good contacts and good friends, and I have realized that what I am getting currently, which is less than $3,000 a month, is definitely not going to support me moving up here and living efficiently. I will have to get some sort of part-time job, which I am excited about, I want to get back out into the working environment.

But I have also realized since talking to my fellow veterans here that there are several types of pay and assisted pay through the VA that I haven't even been informed about in nearly 4 years. Apparently I am not getting what I deserve.

So maybe after the changes I can reevaluate the financial situation, but as for now, I am really nervous about the transition, but

unfortunately it is a requirement for me to be independent, regardless of the cost.

Mr. WALZ. Well thanks, Travis.

Sergeant Kinney, you brought up something, if I can just raise one more thing, and I could not agree with you more. We talk about seamless transition but it doesn't seam to exist anywhere except in words, and it is something I have been deeply concerned about because of exactly the things you stated.

There was an initiative we started last year, the Eye Care Centers of Excellence, that was supposed to be a joint initiative between DoD and the VA system to try and deal with this very same thing, to make sure that you are receiving the care on the DoD side and the totally seamless transition in these shared facilities or shared initiative to switch you over, and it has not been done.

If we get that done do you think that is going to make a big difference in terms of your care, quality of life, and those types of things?

Sergeant KINNEY. Well in my care it would, because the VA doctors would be able to talk to the DoD doctors, okay? They would be able to track what the Army doctor started at Landstuhl and Fort Gordon Eisenhower Medical Center, then the VA would be able to pick up from there.

I also have a civilian neurologist that needs to see these records, because he is closer to where I live. And he is the one that found out that I had TBI and he is the one that put everything together. But the VA and the DoD don't want to have nothing to do with him because he is civilian, but I am outsourced by the VA to go see him and DoD. So it does not make sense.

If we can start something up to get to my records, okay? If I give a doctor permission to look at my records or through the DoD, just like signing into a bank account or something like that, somebody—we were talking about this last night, if they are able to get into like an access account to access my VA records like an account, he would be the only one able to do it, and he would be able to see what is being tracked and what is being done. He has asked for tests to be done and they were never done, because the VA won't approve them or the DoD wouldn't approve them. He is a civilian, he does not know what he is talking about. And you hear things like this.

And I can get into a big story about it all, but it is not worth it. But one department does not talk to the next and then they outsource you and you still can't get the care that you need.

Mr. WALZ. Well, and I appreciate it, I know, I can hear the frustration in your voice being a veteran myself——

Sergeant KINNEY. Sorry.

Mr. WALZ. No, no, don't be sorry about it. This is exactly what we are trying to alleviate, and it is absolutely diminishing the care of our warriors, and I am absolutely convinced it is costing us a lot more money, not to mention it is creating a culture of frustration with our warriors who are willing to go and serve and be injured and then our care is not what it needs to be. So I am incredibly frustrated by that.

I know talking to Travis, his doctors were a little frustrated with him and the VA because they kept asking him how many surgeries

he had, and as you have heard him he is very well spoken and kind of a mild mannered kid, and he said—he finally had to tell them "It was pretty hard to know how many surgeries I had when I was in a coma and don't remember those." So you would like to think that those records might have been passed on.

So you can rest assured that this Committee is absolutely committed to putting this in the past, and your being here is helping us do that. So thank each of you.

I yield back, Mr. Chairman.

Mr. MITCHELL. Thank you very much.

And again, I want to thank you on behalf of all of us and the American public, the service you have given. We appreciate your testimony.

And like I have said before, this isn't just for you that you are doing this today. This is for a lot of other people so that we can avoid the mistakes that have been made in the past and we can correct it so other people won't have to go through what you have done.

So thank you very much, and we appreciate your service.

I would like to welcome Panel Two to the witness table.

For our second panel we will hear from Dr. Madhulika Agarwal, Chief Officer of Patient Care Services for the Department of Veterans Affairs, Dr. James Orcutt, Chief of Ophthalmology for the Veterans Health Administration, Department of Veterans Affairs, and they are accompanied by Dr. Claude Cowan, Deputy Director for Vision Center of Excellence, U.S. Department of Veterans Affairs. Also joining this panel are Colonel Donald Gagliano, Executive Director of the Vision Center of Excellence, and Dr. Jack Smith, Deputy Assistant Secretary for the Clinical Program Policy for the Department of Defense.

I would like to begin by recognizing Dr. Agarwal, if she would begin, and then we will continue with Dr. Orcutt, Dr. Cowan, and Colonel Gagliano and Dr. Smith.

Each of you have 5 minutes, and if you could keep it between that. We have your written testimony that will be entered into the record.

STATEMENTS OF MADHULIKA AGARWAL, M.D., MPH, CHIEF OFFICER, PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; JAMES ORCUTT, M.D., PH.D., CHIEF OF OPHTHALMOLOGY, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY CLAUDE COWAN, M.D., DEPUTY DIRECTOR, VISION CENTER OF EXCELLENCE, U.S. DEPARTMENT OF VETERANS AFFAIRS; JACK W. SMITH, M.D., M.M.M., ACTING DEPUTY ASSISTANT SECRETARY FOR CLINICAL AND PROGRAM POLICY, U.S. DEPARTMENT OF DEFENSE; AND COLONEL DONALD A. GAGLIANO, M.D., USA, EXECUTIVE DIRECTOR, VISION CENTER OF EXCELLENCE, U.S. DEPARTMENT OF DEFENSE

STATEMENT OF MADHULIKA AGARWAL, M.D., MPH

Dr. AGARWAL. Good morning.

Good morning, Mr. Chairman, and respected Members of the Subcommittee. Thank you for the opportunity to discuss VA's collaboration and accomplishments with DoD concerning the Vision Center of Excellence or VCE.

Dr. Jim Orcutt, National Director of Ophthalmology and I are accompanied by Dr. Cowan, Deputy Director of the Vision Center of Excellence.

I would like to request our written statements be submitted for the record.

Mr. Chairman, before I begin my statement I would like to acknowledge the service and sacrifice of the members of the first panel. We as a Department and a Nation appreciate the courage they have displayed both on the battlefield and here today.

I would like to thank them and you Mr. Chairman, for allowing us to hear their concerns and to provide an update to you about our work in addressing visual impairment and vision loss in veterans and servicemembers.

VA has been working jointly with DoD to implement the components of the 2008 National Defense Authorization Act to establish a Vision Center of Excellence in prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries, to implement a defense and veterans Eye Injury Registry and coordinate care and benefits between DoD and VA. We appreciate Congress's support in this area.

During the summer of 2008, VA began discussing the Eye Trauma Registry with DoD. The registry will include veterans and servicemembers with direct eye injury from service in Operation Enduring Freedom and Operation Iraqi Freedom, as well as other servicemembers and veterans who have sustained TBI with resulting visual symptoms.

Of note, VA's polytrauma centers conduct comprehensive assessments of TBI related visual function, ensuring a comprehensive approach to identification, treatment, and rehabilitation of visual impairment.

VA and DoD have outlined the requirements for a concept of operations (CONOPS) for a registry. The CONOPS address the registry structure, the competence required within the registry, and the system requirements to make the registry functional. We have agreed to use a central database with input from the Joint Theater Trauma Registry, VA's electronic health record, and the DoD's electronic health record. We approved this concept in January 2009, and VA's Office of Information and Technology is providing critical support for this effort.

The VCE will maintain the registry and continue monitoring and improving it. While the registry is not designed to be a real-time care management system, the registry's strength is in its ability to follow patients long term and look at the nature of an injury and the process of care from as early in the sequence as possible.

Care management is, and always will be, the responsibility of VA and DoD staff who work with other facilities to anticipate, identify, and address the patient's needs.

DoD is the lead agency for developing the Vision Center of Excellence or VCE.

In November 2008, DoD and VA appointed Colonel Don Gagliano and Dr. Claude Cowan as Director and Deputy Director, respectively, of the VCE. They eagerly accepted their responsibilities and are currently recruiting additional staff.

The VCE will monitor patterns of care and create standard protocols to ensure consistency of care, it will help to identify gaps in care delivery, and to find areas for improved collaboration and coordination.

The VCE will also support the full continuum of care from both departments, extending rehabilitation services to those with vision loss by leveraging existing services already in place.

VA blind rehab services, include 10 intensive inpatient blind rehab centers, 157 visual impairment service team coordinators, 75 blind rehab outpatient specialists, and 55 newly established low vision and blind rehab outpatient clinics. Veterans and servicemembers will be able to receive vision rehab services at these sites.

VA has assigned a blind rehab outpatient specialist at Walter Reed Army Medical Center and Bethesda National Naval Medical Center to receive referrals and coordinate and provide direct rehab care for veterans and active duty servicemembers.

Through the Eye Registry, the VCE will identify servicemembers with visual injuries and will work with both VA and DoD researchers to support new advances in knowledge and care. This work will allow the VCE to educate providers about new findings on eye trauma and the visual symptoms of TBI.

VA and DoD are organizing a second conference in December 2009 to educate providers in VA and DoD on the visual consequences of traumatic brain injury.

Thank you again for the opportunity to speak about VA's role in supporting the VCE and the Eye Injury Registry.

We are here and happy to answer your questions.

[The prepared statement of Dr. Agarwal and Dr. Orcutt appears on p. 50.]

Mr. MITCHELL. Thank you very much.

The next person that I want to call on is Dr. Jack Smith.

Thank you.

STATEMENT OF JACK W. SMITH, M.D., M.M.M.

Dr. SMITH. Chairman Mitchell, Ranking Member Roe, Members of the Subcommittee, thank you for the opportunity to discuss the Department of Defense and Department of Veterans Affairs Vision Center of Excellence current initiatives.

I would like to thank the panelists from Panel One for your service and for sharing your stories with us today. Certainly you help us to identify areas in which we still need to improve, and we are committed to continuous improvement and to ensuring that our warriors receive excellent quality care, especially for vision, threatening injuries, and illnesses across the continuum of care from prevention, to diagnosis, mitigation, treatment, rehabilitation, and research from the Department of Defense to the Veterans Administration or the private sector.

In August of 2008, the Assistant Secretary of Defense for Health Affairs solicited nominations from the services and from the VA, and in November he appointed Colonel Don Gagliano as the Direc-

tor, and Dr. Claude Cowan as Deputy Director of the Vision Center of Excellence.

DoD has also allocated $3 million in funding from the Defense Health Program for fiscal year 2009.

And if I may make a clarification, this funding has been available since the beginning of the fiscal year in October. The memorandum that was referred to dated March 12th was provided at the request of Veterans Affairs Committee staffers and simply validates that Mr. Middleton has had that money allocated for the Vision Center of Excellence.

Together, and with ongoing DoD and VA support, Colonel Gagliano and Dr. Cowan have already begun the challenging work of strategic planning of establishing better linkages and communication between DoD and VA vision treatment and research assets, and have started identifying their near, intermediate, and long-term requirements for space and other support for the center.

DoD's primary focus is to provide expert services for our servicemembers and their families in all areas of vision care. Developing and implementing innovative ways of managing eye injuries is crucial.

The Department is committed to improving the quality of care for our wounded warriors who deserve the very best treatment for their sacrifices they have made for our Nation.

We thank the House Veterans' Affairs Committee for your continued interest and support for the Vision Center of Excellence, and we are pleased to be here to talk about this significant initiative.

I welcome your questions. Thank you.

[The prepared statement of Dr. Smith and Colonel Gagliano appears on p. 52.]

Mr. MITCHELL. Thank you.

I think you can tell by the testimony before that the results of all your planning and your talk and so on really hasn't been very fruitful for these soldiers that were before us.

Let me just ask a question for all of you.

In a meeting that this Subcommittee had regarding funding in February of this year, it was stated that DoD reallocated $3 million for the Vision Center of Excellence, and you provided this Subcommittee with a memo dated March 12th with the official documentation of this reallocation.

Now some questions about this. When exactly was the money allocated for the Center of Excellence? And when we hear testimony from veterans like we just had from the first panel, who could have been helped by the Center of Excellence, I wonder how DoD came up with $3 million, and why wasn't this $3 million allocated 14 months ago when the authorizing language was enacted? And how much of this money has actually been spent to date and on what?

Dr. SMITH. Sir, let me try that.

I am not sure that I can answer all of the questions. The allocation of the money was part of the allocation process for this fiscal year and was set aside for the Vision Center of Excellence. The $3 million is still largely remaining. I think some $7,000 has been spent at this point.

And I can't answer the exact date question, I will have to take that for the record, sir.

[The following information from DoD was subsequently received:]

The Department of Defense (DoD) is committed to improving the quality of vision care for our wounded warriors and veterans, who deserve the very best for the sacrifices they have made for our Nation. During the past year, Optometry and Ophthalmology Consultants from the Armed Services and the Department of Veterans Affairs created the plan that lays the foundation for the Vision Center of Excellence (VCE). The DoD analyzed and reviewed the necessary requirements and identified $3 million in funding that was available at the beginning of FY 2009 to commence initial operating activities.

To achieve the objectives of the VCE, Colonel Donald Gagliano, Executive Director, and Dr. Claude Cowan, Deputy Director, have made significant progress in the Center's strategic and operational planning efforts and have identified primary resource requirements (personnel, registry and operational costs) to appropriately obligate the funding available.

The Defense and Veterans Eye Injury Registry (DVEIR) is key to achieving the Center's goals because it will provide data necessary to measure rates of injuries and longitudinal outcomes; this data will also support improvement in clinical care and care processes, and ensure consistency across the entire continuum of care. The remainder of the funds will be used for necessary operational tasks such as space, travel and equipment. The VCE will expedite the strategic and operational planning efforts identified by the VCE leadership.

We have embarked on a mission to address the issues of the visually disabled and to enable our wounded warriors and veterans to return to a fully functional status; anything less is unacceptable.

Mr. MITCHELL. Let me ask this. How much money has the VA and DoD spent so far on information technology (IT) support?

Dr. AGARWAL. The VA has allocated $2 million for the Office of Information Technology (OIT) support.

Mr. MITCHELL. And what has the money been spent on?

Dr. ORCUTT. Maybe I can respond to that a bit.

The process of developing the concept of operations began well over a year ago, and during the process developing that we have used IT dollars to support the contractors who worked with us to develop the concept of operations. That was even paid for that operation before the $2 million was allocated, so it is not out of IT dollars.

I can't tell you the exact amount of contracts, since I am not on that side of the fence, but that whole operation was funded internally by Office of Information Technology within the VA.

The $2 million is now allocated to the implementation. A project manager has been assigned to this. They have the money ready to go, and we are actually having a meeting next April—the 1st of April this coming month in Seattle to actually develop coding and operational planning for the implementation, and the $2 million is being used to set up that particular meeting.

I hope that answers your question.

Mr. MITCHELL. And my understanding has been there is no staff so far, there is no computers, there is no secretary. There is no staff at all for the Centers of Excellence for vision; is that correct?

With all this money that is been spent or allocated we are not serving the veterans yet are we?

Dr. SMITH. Sir, the staff that we have are the Director and Deputy Director, and Dr. Gagliano does have some statement that he would I think like to share with the Committee concerning what has been done already.

If I may return to your question about the $3 million. There had been working groups between DoD and VA, and the $3 million requirement was a recommendation of some of those working groups that were originally headed by General Gale Pollock, who testified before this Subcommittee back last April. So there has been work ongoing to identify the requirements.

As to space, there has been space allocated for the immediate needs of the center. There are some intermediate and longer term plans that are being looked at programmatically, but we do have computers for Dr. Gagliano and communication devices and space available to get started. There are some hiring actions also.

Mr. MITCHELL. And I am just curious, why there has only been $7,000 spent in 6 months when these veterans need this help. You said only $7,000 has been spent out of the $3 million.

Dr. SMITH. Yes, sir. The director and deputy director have been spending time largely in strategic planning, in connecting the Clinical Centers of Excellence, working with the programs for research—clinical research in eye injuries, and that hasn't been very expensive so far. Certainly we expect those requirements to ramp up substantially as we get additional staff members on board.

Mr. MITCHELL. And as we have more hearings I assume too about these issues.

Let me ask, you know a comment that Sergeant Kinney made at the last panel. He talked about his VA and DoD doctors and the consultants that he had back and forth and he finally went to a private neurologist, and as a result of dealing with a private neurologist there is no consultation at all, sharing of records or anything with the VA and DoD doctors and a doctor that was actually recommended or approved by the VA and DoD. How could that happen?

Dr. SMITH. Sir, I am not familiar with the details of his case. We could certainly look into that.

[The following information from DoD was subsequently received:]

Sergeant Kinney's experience is unfortunate and regrettable. To ensure our servicemembers and veterans never have to go through what he did, the Department of Defense (DoD) and the Department of Veterans Affairs (VA) have continued to develop and improve continuity of care programs. In May 2007, the VA expanded the Case Management Program for Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans to enhance and improve case management procedures, coordination of services, and overall case management. Now, the VA screens all OEF/OIF veterans and automatically assigns case managers to veterans with severe injuries.

In late 2007, the VA and DoD established the joint Federal Recovery Coordination Program. The Federal Recovery Coordinator (FRC) serves all seriously injured servicemembers and veterans to ensure a continuum of world-class lifelong care. FRCs coordinate care with VA, DoD, and private health practitioners and facilities to ensure veterans have access to the right services at the right time.

The Vision Center of Excellence is taking steps to ensure members of the armed services and veterans who are visually impaired receive appropriate blind/vision rehabilitation quickly and effectively, including assuring that appropriate clinical information about patients follows them from one system to another for uninterrupted care.

As we identify opportunities to better address the health care needs of our armed services and veterans, we will continue to enhance access to care.

Mr. MITCHELL. It is not just him, I have heard that from others as well, so it is not a stand alone case.

Dr. AGARWAL. Sir, if I may just address the issue of the records for a moment.

We certainly have access using the bidirectional health information exchange to information when it is available from the DoD. And it is available in the form of remote data view or VistA web.

One of the issues has been on making all the clinicians aware of it and also in training them. We are taking that with the Joint Information Interagency Board, so there is a group that is going to help us move that information further.

Mr. MITCHELL. Thank you.

Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman.

I spent 31 years practicing medicine and looking and taking care of patients, and quite frankly—and you all are bright people in here and not totally responsible, but I find this embarrassing to have treated our veterans this way. I really truly do.

And doing a registry, I have been familiar with tumor boards and for years, and this is not rocket science, it is just somebody needs to get the bull by the horns and get the job done, and I think that these folks need to know where to go.

I know when you are a primary care physician you direct the care of the patient. And I forget which person it was that said their doctor tried to do the best they could, and I am sure they did with the limited knowledge they had, and I have done the same thing. I was in the military and did the best I could, but I wasn't the right person many times to have seen.

I can't imagine walking around for 5 minutes without my sight, I have used it so much. And the limitation it puts on lives, we should be jumping through every hoop we could, and I think someone needs to be in charge of this problem, and we don't ever need to hear of this again. It needs to work for these folks. And they certainly have earned our help, I think.

And you have listened to the testimony, Dr. Agarwal or Dr. Smith or whomever, to this. It is compelling to me, very compelling testimony, these three brave soldiers who made almost the supreme sacrifice, and it's obviously changed their lives forever, how they live forever, and what they went through.

And what do we have in place right now? What can you tell me to satisfy me right now that this is not going to continue to happen? We are not going to be sitting here a year from now listening to the same thing again.

Colonel GAGLIANO. Ranking Member Roe, thank you. I am Colonel Gagliano and the Director of the Vision Center of Excellence, and it is really a great honor, and I really am thankful to have heard the testimony of my fellow warriors. I have been there, done what they have done, and I know what they have experienced and what they have been through.

I have been an ophthalmologist in the Army for close to 30 years. As a matter of fact, I am facing retirement here in a couple of weeks, and I hope to come back in order to do this job as a retiree recall because I am so passionate about what we need to do to address this issue. I have been working in vision care my entire career essentially.

So what I can tell you is that I totally concur with everything you are saying about what needs to happen. I will say that everybody who works in the system recognizes that there is a problem, and the problem is not just in vision care, it is a deep problem. And vision care will actually be the leader, I believe, of resolving this problem. We will take this to the ability to exchange records in a way that probably hasn't happened in any other specialty before because it is such a serious consequence of injury.

We have been able to break many barriers, as a matter of fact just in the short time that I have been working on this in the last few months. I think we are making progress, and I think we will continue to make process. And the best thing I can do today is assure you that we do have a strategy in place that will track these cases. We have a strategy in place to implement the bidirectional health information exchange, and we also have a strategy in place to drive innovation and research so that we cannot only take care of them the way we are taking care of them today, but do it better tomorrow.

Mr. ROE. Colonel, thank you.

I guess what I am thinking as I am putting my doctor hat on, is that when Travis Fugate comes to my office or comes somewhere and gets evaluated, are his needs going to be met? In other words, he is now here on his own, and will there be through this registry and so forth to identify these folks, then a treatment plan that they can leave there with, or is this left with the VA or who is it left with? So when they leave knowing what is going to happen, one, two, three, four, not bounce them pillar to post.

Colonel GAGLIANO. The registry will actually be rather unique. We intend to design this so we will be able to look at longitudinal outcomes and track patients and get statistics and data on the kinds of injury mechanisms as I talked about before. That will help us understand where the gaps in care are.

Right now we are facing a new type of injury mechanism. Blast injuries are relatively unknown to the field, and we are already starting to make great progress in addressing these by—in fact having meetings a couple a weeks ago in laying out these priorities for the announcements for this year's research funding. So that is one part of what the registry do.

Will the registry be able to communicate with every provider in the system? We hope so, that is the intent, that is what we are looking for.

The idea of allowing that information to be exchanged with the private sector is another one, but that is going to be pretty hard. At the moment we don't really know how to do it.

I will tell you that we have designed this along the lines of the private-sector registry so we not only can have the data from our registry, but the data from the U.S. Eye Injury Registry. As a matter of fact we call ours the Defense and Veterans Eye Injury Registry in order to align it with the bright people who have put in place a registry for eye trauma in the past, both internationally and nationally.

We are looking at the moment for the data fields required in order to provide the kinds of information that I just mentioned. And this meeting we are having in April will help us identify what

data elements actually don't exist in the current health records so that we can get to the longitudinal outcomes and we can make some decisions for the process of care and what the new requirements are in terms of research.

Making it visible to the care providers in the DoD and VA system I think is achievable, and achievable in the near term.

Mr. ROE. Thank you, Mr. Chairman.

May I have just one quick question?

Colonel, I can't understand how it is so hard to get information from a private doctor to the VA and vice versa. For good patient care it requires information, and all we did was sign a records release and we had that information, and why is that so hard?

Colonel GAGLIANO. Locally it is not, and it is based on relationships and it is happening, but it is not happening nationally. And I think a little bit of that has to do with some of the perceptions of Health Insurance Portability and Accountability Act (HIPAA) rules and registrations, and some people even interpret HIPAA as an obstacle. I think we just have to work through some systems realignment in order to get that not to be an obstacle, but actually to be an opportunity to share that data.

Mr. ROE. Thank you, Colonel.

Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you.

Mr. Walz.

Mr. WALZ. Well thank you, Mr. Chairman, and thank you to our panelists for your service to our veterans. I can assure you there is no pleasure in us asking all the questions. We are here as partners, and each of us up here represents 700,000 Americans that want nothing more than the best possible care for our veterans.

So when we see three of them come up here it is just the nature of our business, I say it time and time again, if there were three that were not cared for properly that is three too many. This is a zero sum proposition that has no room for error, and all of us understand that.

So I guess what you are hearing out of this, and you will continue to hear it, is frustration, because we all know we are in this together. And we will accept responsibility for our side of things. We want to see that that responsibility is being shared all the way around. But the end result is, and I understand and I have seen this and I keep saying it, DoD produces and is the best war fighters the world has ever seen. The VA provides the best care in the world. The problem is sometimes figuring out how to talk to each other.

I have to tell you, it is a milestone achievement to have both DoD and VA at the same table today, that I am happy about. I am not happy about how slow it's been in getting there.

So just a couple things I would ask is, how often is the Committee that is sitting in the strategic planning, including the BVA, the Blind Veterans Association, a group that knows more about this than almost anyone out there, are they being included in any of this? If I can ask anyone who has an answer on that.

Colonel GAGLIANO. I would be happy to answer that.

We are committed to engaging with the veteran support organizations.

I think the first effort I did the first day I was appointed was to set up a meeting to hear what they had to say about what their perceptions are of what was needed, and I have met on several occasions with Mr. Zampieri and Mr. Miller from the Blind Veterans Association and other veteran associations to hear what they are hearing from their members, because that is where we will be able to gather information about what is really happening. Sometimes you have to look externally to find what is happening internally, and that is one of the ways we plan to do that, is to continue that relationship.

Mr. WALZ. Just one more question, if I could, Mr. Chairman. And I would associate myself with Dr. Roe, who by the way is a great addition to this Committee, a great area of expertise and very insightful and helps us understand and coming from a physician, Dr. Roe's personal practice transferred over to electronic medical records, has been helping all of us talk through that.

My question is, the Centers of Excellence on TBI and PTSD were up and running at a much shorter rate. Is it the nature of the vision issue, the eye care issue, or why did it take so long for us to get yourself in, Colonel and others to get going? I am just asking why does it seem like this was an incredible lag as opposed to the other two joint Centers of Excellence?

Dr. SMITH. Sir, the Congress did appropriate over $900 million in funding for traumatic brain injury and for post-traumatic stress disorder, which was very helpful in accelerating the process of standing those up.

Mr. WALZ. So this is a funding issue? If we had given more money these guys would have received better care?

Dr. SMITH. Not primarily, sir, no, sir.

I would say that the challenge has been somewhat different. We had already Centers of Excellence in clinical care around the country, and the challenge here with the Vision Center of Excellence is to link those together and to establish better communication and collaboration between those than has previously existed, along with the VA centers. So the nature of the challenge is different.

The Center of Excellence for traumatic brain injury and psychological health had rockets put on it basically to launch and to fill a void that I think was larger than has existed for vision.

Still, many challenges to be met, and certainly we acknowledge that and are committed to improving on this.

Mr. WALZ. Well, I appreciate that, but now I feel even worse for our three veterans sitting here, knowing that we didn't strap the rockets on this one then and get it going, and if there are experts out there who could have helped us know that that was going to be the problem we failed them, if that is the case. So that is frustrating.

And I will come back as a final comment on HIPAA. I agree with you and I see this happen in VA cases with my county veteran service officers. The HIPAA issue, I do believe at times it poses an obstacle, but I do believe at times it is been there as a crutch for a failure to deliver at times. It cannot be allowed to be that. We need to figure out how to protect privacy, but at the same time not hinder you from doing your job.

So I yield back.

Mr. MITCHELL. Thank you.

And I would like to say something very quickly to add on to what Congressman Walz said.

Looking at your organizational chart for the Vision Center of Excellence. Based on this since it was authorized there are only two people that have been hired. No wonder it is so slow. The only ones that are on here are Colonel Gagliano and Dr. Claude Cowan. Nothing else has been done.

Mr. Buyer.

Mr. BUYER. Thank you very much, Mr. Chairman, and I thank the Members for your leadership, in particular Dr. Boozman.

Following up the question by the Chairman, I would like to ask Secretary Smith. What resources were used to reallocate the $3 million from DoD to the VCE? In other words, how much has been obligated so far? One person, no space, no furniture, no IT.

Dr. SMITH. Sir, the allocation of the $3 million has been from the Operations and Maintenance (O and M) funds for the Defense Health Program, and the space allocation has been solved as a temporary measure. There is strategic planning ongoing for an intermediate and long-term plan.

Does that answer your question?

Mr. BUYER. Then according to this plan, what additional funding has been requested in the President's fiscal year 2010 budget request for both VA and DoD?

Dr. SMITH. I will have to take that for the record, sir. We support the President's budget, though.

Mr. BUYER. Well, we are going to get it here in a few days. You know the answer, right?

Dr. SMITH. I don't have an answer today, sir. I will have to take that for the record.

[The DoD response is included in the answer to Question #4 in the Post-Hearing Questions and Responses for the Record, which appears on p. 64.]

Mr. BUYER. All right.

Well then let us do this, maybe this will be the best thing to be productive. Let me ask Dr. Agarwal?

Dr. AGARWAL. Agarwal.

Mr. BUYER. All right, thank you.

How many active duty soldiers have been through the VA's blind rehabilitation centers to date?

Dr. AGARWAL. Sir, I will have to get back to you on that information.

Mr. BUYER. We are on a roll.

Well, let me finish with this.

I would like for you, since you are going to be providing information to the Committee, please provide a timeline for the full implementation of the Vision Center of Excellence Program, including the following items.

Number one, completion of the concept of operations.

Number two, sharing VA and DoD electronic records in an interoperable manner.

Number three, coordination of care between VA and DoD for blind veterans and servicemembers.

With that I would like to yield the balance of my time to Dr. Boozman.

[The DoD response is included in the answer to Question #5 in the Post-Hearing Questions and Responses for the Record, and the VA response is included in the answer to Question #11 in the Post-Hearing Questions and Responses for the Record, which appears on pps. 64 and 61.]

Mr. BOOZMAN. Thank you, very much.

You know when this all started this really was a thing that started from the ground up, and you all are part of them, Dr. Cowan, Dr. Orcutt, Dr. Gagliano, you are an ophthalmologists. But what people were seeing were people like the three individuals that we had testifying earlier that go through the system, because they have other injuries many times. The eye part is just forgotten to a large degree, and then somebody eventually, an optometrist or ophthalmologist or whatever, an eye care practitioner would acquire these individuals and then have to figure out who was going on and move them in the right direction.

So there is a lot of excitement, you know, about getting it done, this and that, and so we get it enacted and then nothing happens. The only time that anything seems to happen at all is when we have a hearing.

A year ago we had a hearing, everybody was excited, the colonel that was here then said you know it is time for action, you know we have been sitting around we need to get on the stick. But as we can see, the reality is very little has been done.

Now I say that, VA has done a good job, and we appreciate you. DoD, the best I can tell has done very, very little.

And again, nobody is more supportive of you guys than I am, but in this particular case you either don't want to do it or you are incompetent. I think that is the only two conclusions that we can draw.

You mentioned the money. Were you aware Dr. Gagliano that you had $3 million? When did you find out that there was $3 million in the budget?

Colonel GAGLIANO. Yes, sir. Shortly after I was appointed I was informed that $3 million had been set aside for the Vision Center of Excellence.

Mr. BOOZMAN. It has got to be a record just spending $7,000 in any agency of government as far as moving forward. I mean, if we are actually doing anything.

The other thing I would say, Mr. Smith, is there is really a lot of contention as to you are saying that there is money funded for the other vision—not other visions, but other Centers of Excellence.

Mr. Murtha and Mr. Young don't agree with your interpretation. They feel like that money was supposed to be spent for all three. They talk about money above the neck. And again, like I say, that just hasn't been done. So our Appropriators, they are not saying the same thing that you are saying, okay?

Dr. SMITH. Thank you, sir.

Mr. BOOZMAN. I would like know really just some basic things, you know, if we had money problems, as you attested, why didn't you ask for more?

Dr. SMITH. Sir, I didn't mean to suggest that we have money problems. What I have suggested is that the requirements for establishing the Vision Center of Excellence are different from the requirements for establishing the TBI and Psychological Health Vision Center of Excellence.

And in fact, the $3 million that has been allocated for this fiscal year was based upon recommendation jointly from a work group that was from the services and the VA.

Mr. BOOZMAN. Now in the USA Today article, in that article it said that there was no money.

Dr. SMITH. I am sorry, who said that, sir?

Mr. BOOZMAN. In the USA Today. They reported that somebody from DoD said there was no money appropriated.

Dr. SMITH. That is not correct, sir. There has been $3 million allocated from the Defense Health Program.

Mr. BOOZMAN. So if we have had money and things, why like the concept of operations and things like that, why haven't we been able to do those things?

Dr. SMITH. We haven't had the benefit of a full-time director and deputy director.

Mr. BOOZMAN. Well if we had money, why haven't we got a full-time director and why don't we do the other?

Dr. SMITH. I am sorry, I don't understand the question.

Mr. BOOZMAN. You said if we have the money, if we have the resources, why don't we have the manpower to do the job?

Dr. SMITH. I understand that there are hiring actions underway to get additional staff for the center.

Mr. BOOZMAN. So why didn't we do that a year ago?

Dr. SMITH. I think that a year ago there were actions underway to identify where was the best location, what were the strategic objectives for the center. So work has been ongoing, but that is the point to which we have come today.

Mr. BOOZMAN. Since the NDAA was enacted in January of 2008 there were specific funding requirements due within—I am sorry—specific reporting requirements due within 180 days on staffing, funding, activities of the three Defense Centers of Excellence. The first report came was delayed. Came to the report in mid-November, did not meet the Committee's expectations on the Vision Center of Excellence.

The fiscal year 2009, NDAA also required a specific report within 30 days, not only on the staffing, funding, and plans for the VCE for fiscal year 2009, but also 2010, 2011, 2012 within 30 days. But it has been 100 days later and we still haven't seen any report.

Dr. SMITH. Sir, I will have to check on the status of that report. I know there has been some work done to produce that.

[The final report regarding the establishment of the Joint Department of Defense/Department of Veterans Affairs (DoD/VA) Vision Center of Excellence was sent to the House and Senate Armed Services Committees on April 30, 2009. The report entitled, "Report on: The Joint Department of Defense/Veterans Affairs Vision Center of Excellence," dated March 2009, is being retained in the Committee files.]

Mr. BOOZMAN. I guess the problem is this. You know, again we enact the law—I mean, do you all agree that we have a problem

based on the testimony of the three and from the field? I mean, do you not want to do the center, is that the problem?

Dr. SMITH. No, sir, that is not the problem. Certainly we acknowledge that there is a need for this center. We think that we need to push ahead and get this business done and see how we can best improve the care that we provide. So we certainly acknowledge that and thank the Committee for your interest and support.

Mr. BUYER. Will the gentleman yield?

Mr. BOOZMAN. Yes.

Mr. BUYER. I have this great sense that there was just a different priority, Dr. Boozman. I think there was a great sense here, but for DoD to focus more on the TBI and the PTSD and this is an issue that they didn't embrace as strongly as you embrace. And when you look at the pure "numbers," and where their focus should be, I think their energies and priorities were somewhere else. I mean that is quite obvious here in my assessment today. That is unfortunate.

You know, Colonel, I just read your bio, you have an extraordinary career, and I want you to be able to walk out that door with your head held high. And you are having to salute your civilian led leadership, and I feel really uncomfortable here that you have had such a remarkable career, and please don't get smacked on the backside as you end that career. You have had a wonderful career, and hopefully you can step back through the door and provide the leadership that we are looking for someone to do.

And it is unfortunate that the Committee here is using some pretty tough language and they are pretty firm, because I think the Members here are very upset. And the reason they are very upset, is because they wanted specific things to happen and that did not happen. And I think this panel has gotten the message. We don't need to keep bringing veterans in here to tell their stories of how that care had not been fulfilled, and I think that is what you are hearing here today.

I yield back to the gentleman.

Mr. BOOZMAN. The only thing I would say is this. I agree totally with the comments of Mr. Buyer. And again, you know, nobody is more supportive of you than I. But in this particular case, and I really do understand this in the sense my brother was an ophthalmologist, I started a low vision program at the Arkansas School for the Blind, worked with Eleanor Faye in New York, so I really do understand, you know, the things that you get into with this. And I do understand too how easy it is to overlook things when you are dealing with all these other multiple injuries and this and that. And then too, many times it doesn't matter in the military or whatever, the individuals just don't have the training to recognize.

So when I visit with the Appropriators, when I visit with whoever, again, this is something that everybody agrees, I think, you know, would be an outstanding thing to do, the problem is it is not getting done.

And you know, we talk about funding, you know, the funding appears. But if there is a funding problem, I guess my frustration is that nobody is really asking for that. Nobody is coming forward and saying we need this or that.

Again, there is a real differences in opinion with the Appropriators as to whether or not funding has been appropriated or not, but it all comes down to priorities, and there is a lot of money, you know, circulating through the defense. It is not like Congress, it is not like I haven't been very supportive in giving a tremendous amount of funding to the effort, and yet, you know, this not doing the concept of OPS, that doesn't cost any money, it doesn't cost any resources. It does cost resources, but that is something that VA has gotten on the stick and done and DoD hasn't done.

So again, I yield back, and I hope that we can move forward and show some progress.

Mr. MITCHELL. You know, just before we ask some other questions here, because there is some other questions that want to be asked.

This is for Dr. Orcutt. We had a hearing April 2nd on last year traumatic brain injury related vision issues. That was the whole purpose of the hearing. And I want to quote part of your statement.

You said, "For the seriously injured, ill, or wounded, VA and DoD have created a new Federal Recovery Coordinating Program that will assign coordinators capable of working within and between VA and DoD and the private sector to monitor and support our severely wounded veterans and servicemembers. VA's OEF and OIF Case Management Program provides a fully integrated team approach at every VA Medical Center."

And listening to what these gentlemen had said at the first panel, they didn't get that service. What has happened?

Dr. ORCUTT. Yes, that was part of our joint statement, and that is what the polytrauma directors have set up in the system to have this case coordination.

In terms of what happened to these patients on an individual basis I have no idea, since I can't track their individual processes. But it is certainly my understanding from the polytrauma folks that we in fact have those case coordinators set up at all these sites.

I don't know if Dr. Agarwal would have more comment on that or not.

Mr. MITCHELL. Well, I would just assume first of all if these three fell through the cracks and didn't get the services that are at every VA Medical Center, there is a lot others, and somebody is not checking on them.

Yes?

Dr. AGARWAL. Sir, we are committed to providing the full scope of services for the entire continuum of care and also for coordinating the care when the transitions happen from DoD.

It is true that it is very unfortunate, and I totally agree with you, that none of what transpired with the previous panel members should have ever happened. But as a system we have tried our best to address it, especially over the course of the last 18 to 12 months.

The Federal Recovery Coordinator Program that you have mentioned, which is intended to navigate between the VA and DoD, as well as outside of the two systems for our servicemembers, and veterans who are going to need lifelong care.

We have a case management system, a very comprehensive case management system of the OEF, OIF program managers, case

managers, transition patient advocates. This team has been set up at each of our Medical Centers.

We have 27 military treatment facility (MTF) coordinators, the MTF liaisons stationed at the 13 MTFs. So in essence, there is a system which is fairly comprehensive that has been in motion for the last 12 to 18 months where a referral is made to the MTF liaison, the VA liaison who is stationed at one of the military treatment facilities who in turn gets in touch with the OEF/OIF case manager at a facility when the veteran—or the servicemember I should say, is being transferred to the VA.

Within the VA system we also have lead case managers for four areas, which are fairly complex. The polytrauma system of care, the blind rehab system, the spinal cord injury, and for mental health.

There is a lot of interconnectivity between the case managers and the liaisons, and this is to ensure that we coordinate the care to the extent that is possible.

Mr. MITCHELL. I have heard all this, and I understand that. I am just saying that it hasn't worked in the case of the three people that came before us on the first panel, and I assume there are others in the same category.

Dr. Roe, do you have anything else to ask?

Mr. ROE. No further questions.

But first of all it is obviously extremely complex—it is, and having to get these systems for the numbers of people you all are having to treat is enormous. But as all of you physicians know, it all comes down to what happens to one patient at one time. And for them it is 100 percent if it doesn't work. So we have got to try to make that system work.

And Colonel, thank you for your service and for what you have done for almost 30 years for your Nation.

And Mr. Chairman, thank you for bringing this to the attention of myself certainly, and to the Congress.

Mr. MITCHELL. Thank you.

Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman.

Well, I am sure not going to pile on, because I have the Minneapolis Polytrauma Center, which is I think the best facility in the system, and I would argue I have also the Mayo Clinic in my district, and I would compare the two any day of the week.

And so I will say it again, I am the biggest supporter of what we do for our veterans, but I would be remiss to say how incredibly disappointed I am.

And it is seldom that I hear the Members up here, and Dr. Boozman has got a lot of experience. He is also a very mild mannered guy, but I can hear the upset in his voice, and he understands this.

These three didn't come here for pity or for handouts or for anything. They simply wanted care that this Nation has the ability to deliver, and the thing that is most frustrating to me is for a Congress that anticipated something ahead of time, or at least in the midst of it and tried to put things into place to deal with it. And so here we are, and I just shudder to think of the number of these

individuals who could have been treated differently had we got this up and running.

So I think much has been said here, and I think it has been very clear to all of you, there is going to be a very, very bright eye watching this from now on. I believe we have been there before, but it is going to be like nothing you have seen yet. And all I can say is, this thing has got to run. It is got to go. We have got to see the things that Mr. Buyer asked for in the plan, and you have been charged with the mission to do it. And so I fully expect as I have seen time and time again, you will rise to the occasion, you will get it done, and we will provide excellent care for our warriors, and that is all of us in this together.

So I do appreciate all of you being here. I appreciate the complexity of what you are going through, and I know also, don't think for a minute I don't know the disappointment you all share that we are at this. The difference is, is that you all possess some ability to change that, and I hope you take that advantage.

So I yield back.

Mr. MITCHELL. Mr. Boozman, any final words?

Mr. BOOZMAN. Just one thing.

I did pull up the USA Today article, and you might want to look at that. Mr. Kelly was quoted in that as saying, "No money was appropriated for a vision center," Kelly says.

So again, you know, you might need to visit with him and see if you guys are on the right track.

But I would just encourage you, you know, what we are here to do is really to try and help move this thing forward, and you have got tremendous support. I know Mr. Walz wrote a letter to our Appropriators requesting money in visiting with Mr. Murtha and Mr. Young. Again, if we need more resources we can work and help you get those things, but we do have to get on the stick and move forward. And it is some of the things that haven't been done on the DoD side really haven't required money, they have just required doing. And I don't think there is any excuse for not getting the concepts of OPS done so that we can move forward. And you know, you just can't do these things until you do the basic things, and we just aren't getting that.

So I appreciate your efforts. Nobody appreciates it, you know, anymore than I do, and the rest of the Committee, this is a very bipartisan group that really just has the heart of our veterans and our servicemembers at heart. And like I say, I am here to help you. But on the other hand, I think if you don't accept that help, you know, and let us help you, then we are going to hold you accountable, and I think that that is important, and I know, you know, that you want that of yourselves.

So thank you very much, Mr. Chairman, I appreciate you and the Ranking Member again for going this, taking the time, and I think we made some real head way.

Mr. MITCHELL. Thank you very much, and thank all of you for appearing today. I appreciate it, and hopefully as a result of all this we will see some real changes in the lives and the future of our veterans.

With that, this hearing is adjourned.

[Whereupon, at 12:06 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Harry E. Mitchell, Chairman, Subcommittee on Oversight and Investigations

In April of 2008, this Subcommittee held a hearing on TBIRelated Vision issues. In that hearing, there was an extensive discussion with the VA and DoD about the Vision Center of Excellence mandated by the National Defense Authorization Act of 2008. We heard from both agencies that they were working hard on this initiative. Today we will receive an update on the product of that hard work and how it has affected veterans in need of vision care. We will also discuss the future needs of both agencies so we can ensure that the Center will be worthy of our veterans.

Last August, we were assured by DoD that funding for a Vision Center of Excellence would be distributed in FY 2009. I applaud Congressman Space and Congressman Walz for urging Defense Appropriations Chairman John Murtha to set aside $5 million for the Vision Center. This demonstrates how important this issue is to the Members of this Subcommittee. We now know that the FY 2009 Defense Health Program Operation and Maintenance Budget allocated $3 million to the Vision Center of Excellence. However, it troubles me that even with this funding and the appointment of a Director and Deputy Director, whose testimony we will receive shortly, the Center is still without offices, computers, phones, or staff.

To put these delays in perspective, we will hear from a number of veterans and their families about the difficulties they have experienced receiving vision care. Kentucky National Guardsmen Travis Fugate suffered grievous injuries in Iraq in 2005. He lost his right eye and much of the vision in his left, and recently, he lost what little vision remained. The Vision Center of Excellence would include the Military Trauma Eye Injury Registry that is designed to provide a seamless transition of information which could have preserved at least some of Travis's vision. This is a reminder of the cost in delaying interoperability between the Departments.

Although Travis' story is troubling, unfortunately, he is not alone. Sergeant David Kinney's involvement in an IED explosion in 2005 forced him into treatment for headaches and vision related injuries. He is here today to tell us what has happened since his injuries and the tribulations he has faced while seeking treatment.

We will also hear from Gil Magallanes, a Green Beret in Afghanistan who was seriously injured in 2001. His wife Sherry will be sitting beside him to help tell his story.

I'm confident that none of us in this room would actively countenance delays or failures that needlessly hurt our veterans, yet we have seen time and again our veterans being left in a void where they don't know where to turn for treatment. It took almost 7 years for Gil Magallanes to be introduced to his Vision Impairment Services Team coordinator. That's unacceptable and Centers of Excellence provide a means to provide the specific care that is needed.

Planning for the Vision Center of Excellence has been underway for years, and I have no doubt that our second panel, which includes Colonel Donald Gagliano and Dr. Claude Cowan, will testify that VA and DoD are eager to get to work. I expect today's hearing to be followed by speedy action from DoD and the VA to open the Vision Center of Excellence.

Travis, David, and Gil—thank you for your service and for appearing before the Subcommittee today. Your testimony will be very helpful to us as we work to ensure that your colleagues in arms receive the care they deserve. Thank you Dr. Zampieri for appearing here today and for your endless advocacy on behalf of our Nation's veterans. Thanks also to DoD and VA for coming to the Hill to provide us with an update.

One of our Subcommittee Members, Mr. Walz had to attend to family business back home, but will be joining us shortly. He had the distinct honor of meeting Specialist Fugate at Walter Reed last week, and he would like to extend his thanks to all the witnesses for being here today.

Prepared Statement of Hon. David P. Roe, Ranking Republican Member, Subcommittee on Oversight and Investigations

Thank you for yielding, Mr. Chairman.

The Vision Center of Excellence (VCOE) and the accompanying Military Eye Injury Registry were included as provisions in the Military Eye Trauma Treatment Act (METTA), introduced last Congress by my colleague, Dr. John Boozman, an Optometrist and a Member of this Committee. These provisions were also included in the FY 2008 National Defense Authorization Act, which passed in late January 2008, but was not funded at that time. Funding for this program was approved with passage of the FY 2009 Military Construction/Veteran Affairs (MILCON/VA) appropriations bill in late September 2008 when $6.9 million was allocated for this purpose through the Department of Veterans Affairs.

The Subcommittee staff asked the Department of Defense over a month ago about when the funding would be available for the VCOE. We were informed last Friday, March 13, 2009, that the Department of Defense authorized, effective March 12, 2009, $3 million for the establishment of the Vision Center of Excellence. I am pleased that this funding has been finally identified and provided by the Department of Defense. Mr. Chairman, I would like to ask this letter from the Department of Defense to you, dated March 12, 2009 be submitted into the official hearing record.

I agree with the Chairman that it is important that this Committee takes a look at the progress being made in implementing this legislation, and closely follow the interaction between the Department of Defense and the Department of Veterans Affairs. It is no secret to this Committee that these two departments have not always "played well" together in the past. However, with the increasing numbers of servicemembers returning from Iraq and Afghanistan with what has become one of the signature injuries of our war on terrorism, traumatic brain injury (TBI) and related co-morbid ocular injuries, it is critical that Congress conducts strict oversight into how this program is developed and implemented to assure that our Nation's servicemembers and veterans are well served.

This hearing is not the end of our oversight into this matter. In the very near future, Dr. Boozman intends on scheduling a Roundtable to further discuss this issue with Members of the Armed Services Committee, and other stakeholders, including the Blinded Veterans Association, other veteran service organizations, and medical specialty organizations to be invited to the table for an open discussion of the progress being made, and where we can address possible improvements. I am looking forward to delving into this subject matter in greater detail, and appreciate Chairman Mitchell's interest on this issue.

I look forward to listening to the testimony being presented today, and am encouraged that there will be future discussions and oversight on this matter as well.

Again, thank you Mr. Chairman, and I yield back.

Prepared Statement of Hon. Timothy J. Walz

Chairman Mitchell, Ranking Member Roe, Members of the Subcommittee, and our witnesses, thank you so much.

I want to immediately recognize the brave young veterans who are here today to speak with us. I commend your service and I thank you for helping to educate us today. I had the true honor to meet Travis Fugate, an exceptional young man, the other day and it would be hard to express how impressed by him I was. I look forward to hearing his story in his own words today.

It is always useful to hear directly from our veterans on such important issues as the Center of Excellence in Prevention, Diagnosis, Mitigation, Treatment, and Rehabilitation of Military Eye Injuries, as well as related programs to address visual dysfunction among our servicemembers and veterans established by section 1623 of the Fiscal Year 2008 National Defense Authorization Act (NDAA).

Military eye injuries have not been as high-profile as some other forms of injuries prevalent in our current conflicts. But this is a very important project. There is good evidence that a substantial number of TBI patients are reporting vision problems. More generally, the Eye Center of Excellence would enable the DoD and VA to gather and disseminate important information on the diagnosis, treatment and follow-up for all significant eye injuries among members of the Armed Forces on active duty and veterans.

Unfortunately, the NDAA did not provide funding for the Eye Center of Excellence. I have been working on this issue for quite some time. It is one part of what I think is absolutely essential—ensuring a seamless transition from DoD to VA for

our servicemen and women, particularly our injured servicemen and women. Nothing is more important than to establish real and substantial cooperation across DoD and VA as our troops make the transition to civilian life and veteran status. This is complex, it involves two huge and complex organizations. And quite frankly, I think what we know about the Eye Center illustrates not just how important ensuring that seamless transition is, but how difficult it is.

I will be honest. VA has made a real commitment to this project. I have not seen the same commitment on the part of DoD. We are, of course, entering a new era with a new Administration, so I look forward to hearing from DoD about its part in this legislatively mandated project, and about its cooperation with VA. I approach this unhappy with the lack of progress thus far, and willing to listen and work with DoD. Thank you.

Prepared Statement of Specialist Travis Fugate, USA (Ret.), Hindman, KY (OIF Veteran)

My name is Travis Fugate. I am 25 years old, and I am a retired specialist in the U.S. Army.

I served as a member of the Kentucky National Guard starting December 5, 2003, until April 2, 2006, when medically retired because of my OIF injuries. While in support the 18th Military Police Brigade I was mobilized on active duty December 13, 2004, then deployed to Iraq February 2005 . . . I was severely injured on patrol on May 18, 2005, from IED blast. So on May 18, 2005, when I was hit in the face by an IED, I remember telling myself to stay calm. We had been on a routine mission just south of Baghdad, and I had been in the turret of our vehicle. My buddies told me, "The bird is on its way," and as soon as I heard the helicopter, I knew I'd be all right. I had that much trust and confidence in the medics who were about to take my life in their hands."

The initial blast caused severe facial injuries with loss of my right eye, traumatic brain injury, and penetrating injuries to left eye resulting in severe visual impairment to left eye. Initial emergency surgery done in Green Zone, then to Landstuhl Germany, then evacuated to Walter Reed Army Medical Center. I was in coma at WRAMC for over a month, and had several surgeries during this time on facial injuries, and left eye.

I was home from Walter Reed, living in Kentucky. I had lost my right eye, and I had a limited field of vision from my left eye—about 20/200 which is legally blind. But I could still see colors, shapes, large print and shadows. I could see which girls were pretty and which ones weren't.

In 2006, I went for a follow-up visit with an ENT doctor at the Lexington VA Medical Center. The nurse brought him a big stack of my files, and he told her, "There's absolutely nothing relevant that I need in there." He told me the anatomy of my sinuses was so disfigured, he didn't know what in my face tissue was, what was natural and what was artificially implanted. He said he wouldn't feel comfortable going in there and messing around, and he said let's wing it and wait for an issue to arise, then address it. I trusted that decision immediately, because my experience was that the medics and Army doctors are all professionals, and I was used to putting my faith in them.

For 2 years, things were OK. I went back to community college, and I started being active with many different disabled sporting events and programs where I had chance to meet other injured OIF veterans, and attended the Blinded Veterans Association national convention in August 2007.

Last November, 3 weeks before finals, I had to call my dad at 10 p.m. to tell him I thought I had one of those headaches that the doctors at Walter Reed warned me about. They said it would come from directly over my left eye and could lead to a severe infection and possible brain injury. He took me to the ER, and I was in the hospital for 10 days with a serious infection. The upper left hemisphere of my face was so swollen that my eyelids swelled together. And that was the last time I had any sight.

In January, I returned to Walter Reed, where the doctors would have better access to all my surgery records. I saw a retina specialist, and within 5 minutes, he'd scheduled a 5-hour surgery the following day for detached retina and bleeding in left eye. My situation was that severe. Since then, I have had several more surgeries, including one just over a week ago March 6th 2009 where they again tried to save my retina because of another detachment.

I am on many medications with some strong pain medication; I am still in some constant pain. While inpatient at Walter Reed Medical Center I was constantly vis-

ited by a VA Blind Rehabilitative Specialist who helped me with orientation and mobility training while an inpatient, and helped arrange my transfer to the Hines VA Blind Rehabilitation program in Chicago that I will start this week on March 18, 2009.

With the rehabilitation I have already completed, I understand that special devices and adaptive technology can make nearly anything achievable for a person who has lost his vision. But because of a lack of my electronic surgery files being accessible from the WRAMC, the VA medical doctors in Kentucky might not have had all the information needed about my very complex eye injury and surgery facial reconstruction treatment in various military medical centers.

My sister recently reminded me that I wrote her a letter from Iraq before I was injured. I told her that if I was hurt, I'd rather die than go on living without my sight. I don't feel that way anymore. Today, I am happy to be alive, and I'm excited about my future. But just like everyone else in this room, and everyone else in this country, I want to live a life that's full and bright and rich. I need your support to do so.

The reason I am here today is to tell my story and let you know that the Vision Center of Excellence that this congress established a year ago, is critical to ensuring that all the combat eye injured and TBI with visual impairments are entered into a registry where the surgery records and treatments can be tracked from both military and VA eye care providers. I am disappointed that after a year, they have not set this up and I asked Congressman Rogers to ensure this isn't delayed any longer.

I want to stress that my retinal surgeon at Walter Reed Medical Center was one of the best in the world, he is well respected by everyone, and cares deeply about me and other combat eye injured, so want to make clear that my military medical care was top notch in this story. I am sad that Dr. Weichel is going to soon leave the Army this next week, but him like others have been waiting for this Vision Center of Excellence for a long time, and he can't keep waiting forever for this support.

The Vision Center of Excellence will help thousands of those returning with eye injuries by coordination of there follow-up care, developing vision research plans for both medical and technology research to help all of us and previous generations of war injured veterans who need these things. Why they can not find $ 5 million to get this set up is beyond me, and funding should not be an excuse now, for not doing this today!

Prepared Statement of Sergeant David William Kinney III, USA (Ret.), Duland, FL (OEF/OIF Veteran)

I joined the Army in June 1979 as a Parachute Rigger and heavy weapons specialist. After years of dedicated service I enlisted in the Florida Army National Guard as an Anti-Armor Specialist and Infantryman in 1983. In 2003 my Florida national Guard Unit was deployed to Iraq. During my tour in Iraq my unit was assigned to guard the Bagdad Convention Center. In the coming months we would be barraged with countless explosions in and around the parameter that we were stationed. Not only were these explosions deadly, but were so loud that they would shatter nearby glass and throw fellow guard members to the ground. Although I was never hurt, my unit experienced heavy mortar and rocket fire throughout my stay.

I was sent to Afghanistan for my second tour of duty in April of 2005. During a local mail run in February of that year, an Improvised Explosive Device (IED) detonated between the lead HUMVEE and my vehicle. The impact of the explosion caused my HUMVEE to roll over. As the HUMVEE was rolling, I reached over to pull the gunner stationed above the HUMVEE inside the vehicle. This action caused me to slam the back of my neck into the seat back bar. Thankfully everyone in the HUMVEE survived with only minor bruises, cuts, and headaches.

A few days later I visited the Troop Medical Center (TMC) to see why I was still sore and experiencing mild head aches. I was advised by the senior medic on staff that I was a forty-3 year old man and therefore, my injuries would take longer to heal. I was prescribed Motrin and returned to duty.

In December 2005, I received my second injury when I was assigned to a security detail that detonated three 1,000 lbs bombs found in a farmers field. Before the detonation of the bombs, we moved back the safest distance possible due to the village's location and local terrain conditions. Although we moved to the safest area possible, we were still not within the maximum safe distance needed, but the Officer in Charge (OIC) stated that we were at a safe distance. This however, was not the case. The explosion reached my position and caused us to lose our balance and to

become disoriented as well as causing our ears to bleed. I was a couple weeks later I was treated at the Troop Medical Center because my vision had started to become blurry, my headaches became more frequent, and with greater intensity. These headaches began to affect my sleep, causing me to be able to accumulate a maximum of 1 to 3 hours of sleep a night.

Since 2005, my medical troubles have continued to rise. I was medically retired from the Army June 2008 and received a disability rating of 80 percent combined from MEB. I am on TDRL status and not permanent status. Since then I have received my VA pension in Feb. 2009, my eye sight has worsened, I am being treated for post traumatic stress disorder (PTSD), and my headaches continue to inhibit my ability to sleep.

Since leaving Afghanistan I have been shuffled around to various locations around the globe including hospitals and research institutions in Germany, Georgia, Florida, and Alabama. With each visit I am greeted with the same barrage of tests that still have not correctly diagnosed my condition. My eye sight continues to worsen. No doctor, technician, or researcher has been able to tell me why I am losing my vision. When I started my Eye Care in Tampa VA, where on my first visit I was told not to drive anymore due to my eye's poor condition! I was given no explanation and no written reason why. I was told to see a low vision specialist. Nothing was done after that eye exam. I received a letter for legal blindness after completion of the BRC and I was taught about my new lifestyle I was going to live. I am currently on my 6th pair of eye glasses.

I have endured MRIs, spinal taps, numerous exams, and x-rays, but still do not have answers to my symptoms. This has become very frustrating because I must continue these tests and exams on a daily basis to be eligible to receive basic needs such as new prescriptions and now I am beyond more glasses. Many times doctors have false diagnosed me. In one instance Florida Eye Clinic, one doctor said that there was nothing they could do for me and I was a difficult patient. Another doctor at Bascom Palmer Eye institute said I might be malingering.

In summary, I have no reason or explanations on why my eyes have continued to deteriorate. I have been to countless doctors' appointments, exams, many of my family members, and friends have had to request for time off from work to drive me to my appointments. In addition my appointments sometimes exceed 10 to 15 appointments a month at various locations. I try to schedule multiple appointments in the same day in order to cut down the number of days needed for visits, but many times this is not an option. I believe if we had a center specializing in vision and TBI Injury out of one central location a patient could either be admitted or out—patient care could be given under one roof. This would eliminate the countless exams and testing that had to be redone due to not being able to get medical records released from one doctor to the other in a timely manner. Testing could range from 1 month to the end of a patients testing and then evaluated. Then if necessary, the center could bring a patient back for follow-up exams for further evaluation and to listen to patient about what is going on with his/her concerns of their conditions. A central database accessible to VA, DoD and any Civilian Doctor that care is outsourced to by VA or DoD would also be extremely beneficial to people in my condition. And this will spot a lot of unnecessary exam and may be able to diagnose the patient condition sooner.

If this was you, when would you say enough is enough, with countless doctors, exams, and testing with no results because of the government inability to start a TBI/Vision Center.

Prepared Statement of Sherry Magallanes, on behalf of Master Sergeant Gilbert Magallanes, Jr., USA (Ret.), Clarksville, TN (Spouse and OEF Veteran)

My husband is Retired Master Sergeant Gilbert Magallanes Jr; he is a 45-year old veteran of the United States Army who served in both the Gulf War and Operation Enduring Freedom. He is a Green Beret that served with 5th Special Forces Group at Fort Campbell, KY. He is now medically retired after 21 years of active duty service due combat wounds he sustained in Afghanistan during Operation Enduring Freedom.

He sustained his injuries from a friendly fire incident where the U.S. Air Force dropped a 2000 pound JDAM (smart bomb) on his Special Forces Team (ODA574) while they were guarding the President of Afghanistan, Hamid Karzai on December 05, 2001. My husband, Gilbert incurred an open traumatic brain injury with a loss of skull and brain matter around the occipital lobe that was larger than a 50 cent

piece, the skull has been repaired by craniotomy, but the brain damage is permanent; resulting in homonymous hemianopsia (complete loss of his left field of vision bilaterally), slight left sided hemi paresis, cognitive thinking dysfunction and disorder, seizure disorder, migraine disorder, loss of digits 2 and 3 and part of his palm on the left hand, nerve damage to his left wrist, severe hearing loss, and he is now in Stage 3 Chronic Kidney Failure.

My husband, Retired Master Sergeant Gilbert Magallanes, Jr., spent over 1½ years in hospitals having multiple surgeries and recovering, and have had numerous hospitalizations since. He has had to relearn how to walk, had to learn his left from his right and just how to cope with his injuries. At first he was very angry, depressed and mad at the world. He had no motivation or want to do anything, much less set goals for any achievements. He felt he was at the top of his game, a Green Beret, in the best shape of his life with a goal of promotions in the Army and having his own Special Forces Team. That goal/dream was taken away from him when that 2000 pound bomb landed on December 05, 2001.

After his wounds were stabilized in Landstuhl Germany, my husband, Gilbert was sent to Walter Reed Army Medical Center where he resided in the Intensive Care Unit in a coma for several weeks. At the end of January he was sent for traumatic brain injury rehabilitation at the Palo Alto VA in California. In April he was sent to Sharps Medical Rehab in San Diego, CA for a community re-entry course for his Traumatic Brain Injury. It was our understanding that he would obtain vision training for him to adapt for his vision loss and improve his independent living skills. However, once he completed the course in San Diego he had the craniotomy to repair the skull deficit at Balboa Navy Medical Center in San Diego and was then sent back to Fort Campbell, Kentucky. I assumed his care would be transferred to the Blanchfield Army Community Hospital at Fort Campbell, Kentucky at this time. However, my husband, Gilbert's records were not completely transferred each time he was transferred between a military medical facility and a Veterans Affairs medical facility therefore causing a break in his continuity of care. The case manager my husband was assigned when he reached Blanchfield Army Community Hospital in Fort Campbell, Kentucky was not aware of the extent of his injuries and Blanchfield Army Community Hospital could not provide the adequate care he needed. At the time Blanchfield Army Community Hospital did not have a Neurologist on staff to treat the effects of the Traumatic Brain injury or neurological disorders. My husband, Gilbert was assigned to a staff physician who in turn told us traumatic brain injury and neurological disorders were not her specialty but she would do the best she could. He was no longer followed by Speech therapy, occupational therapy, physical therapy, vision care, nor did he receive any additional cognitive training. When his seizure disorder worsened we went to Gilbert's Company Commander at 5th Special Forces Group, Colonel Mulholland who helped arrange, at the expense of 5th Special Forces Group for Gilbert to return to Walter Reed Army Medical Center to be treated by a Neurologist.

We were not married at the time; I had no knowledge of the military, how to handle a medical board proceeding or the procedure for retirement. I do not have a background in the medical field to understand the extent of Gilbert's injuries, diagnosis or required treatment and proper protocol for therapy. Therefore a lot of phone calls where made to his Commander at the time. My husband was added to the Temporary Retirement Disability List (TDRL) upon the findings of the Army Medical Evaluation Board (MEB) and the Physical Evaluation Board (PEB) in 2004. At this time all of his care was to be transitioned to the Department of Veterans Affairs. Since my husband's medical records were not transferred with him each time he transferred to a different medical facility, we had to request copies to begin the process of the compensation and pension exams as ordered by the Department of Veterans Affairs to identify all of his injuries and on going medical problems as defined in the findings of the Army Medical Evaluation Board and Physical Evaluation Board. Gilbert was seen at the Veterans Affairs Medical Center in Nashville, Tennessee for each injury and diagnosis. At that time he had a vision exam to confirm the field vision loss, and told him to be happy that at least the vision he does have is good. After he was assessed and given a 100 percent disability rating through the Department of Veterans Affairs, we were told that any care he would need would be provided by them. Later he felt that his vision was changing, I called the vision clinic at the Veterans Affairs Medical Center in Nashville, Tennessee for an appointment, and I was told Gilbert couldn't be seen in the vision clinic. I then went to the hospital administration office to find out the problem, and was told my husband required a visit to his primary care doctor at the Veterans Affairs Outpatient Clinic, a referral, and then he would be given an appointment. It took quite a while to get him into the clinic. No one ever asked us if Gilbert had vision training/rehab or if he was assigned a coordinator with the Vision Impairment Services Team (VIST)

at our local Veterans Affairs Medical Center; when he was finally seen in the vision clinic they only did a routine exam. Gilbert was also not assigned to the speech clinic, occupational therapy or physical therapy for additional treatment.

In 2008, we attended a paralympic sporting event for soldiers with vision impairments in Alabama where we were fortunate enough to meet Travis Fugate. He forwarded our contact information to the Blind Veterans Association we got a call from Christina Hitchcock who invited us to the Blind Veterans Association conference in Phoenix, Arizona in August of 2008. It was then that we were told that he could and should have been able to attend one of the blind centers that would teach my husband how to compensate for his vision loss.

Although it took almost 7 years, we were finally introduced to our Vision Impairment Services Team (VIST) coordinator at the Nashville VA in 2008. We were also sent back to the Palo Alto VA in November 2008 for some extensive vision testing by Dr. Cockerham who identified a dimple in Gilbert's optical nerve and now has to be watched closely for glaucoma due to the Traumatic Brain Injury, when normally he would not have been a candidate for glaucoma. We are currently scheduled to attend the Blind Center in Palo Alto on March 25th 2009 for vision loss training.

Although my husbands vision impairment stems from the loss of brain matter and brain damage not an actual disease or damage to his eyes, I still feel things may have been easier for him and our family if he was taught how to compensate for the visual loss in the beginning. I feel—and actually thought there to be some process to prevent events like this. I know from our experience, I was wrong. If we had not met Travis Fugate and been introduced to the Blind Veterans Association my husband, Gilbert still would not be receiving the vision testing and training that he has waited almost 7 years for.

It is our hope there will be a plan implemented not only for Traumatic Brain Injury but also for Vision impairments and care coordination. We would like to see a system that tracks and follows patients through their course of care during active duty, and as they transition to the retired ranks of the Veterans Administration to ensure they are receiving the proper care and training as their injuries indicate. Therefore, no one would have to wait for 7 years to receive care and training as we did. This in turn would mean additional educational training in visual impairments caused by Traumatic Brain Injury for the staffs of both the military facilities and the Department of Veterans Affairs facilities providing the care.

In closing, I would just like to say that my husband, being the loyal, and dedicated Ranger that he is, has absolutely no regrets about his service to our great country, he would be back in uniform and on the frontlines if he was medically able to do so, but he is not. It is only our hope that he be offered the necessary training and medical care to help him live his life as independently as he can with the injuries that he has sustained.

Thank you for your time and for allowing me to speak on this matter.

Prepared Statement of Thomas Zampieri, Ph.D.,
Director of Government Relations, Blinded Veterans Association

INTRODUCTION

Chairman Mitchell, Ranking Member Roe, and Members of the House Veterans Affairs Subcommittee on Oversight and Investigations, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present our testimony regarding the large numbers of military vision injuries and the bureaucratic problems associated with implementing the Congressionally mandated National Defense Authorization Act (NDAA) of 2008. The legislation established the joint Department of Defense (DoD) and Department of Veterans Affairs (VA) Vision Center of Excellence (VCE) and Eye Trauma Registry.

Established in 1945 and Congressionally chartered in 1958 as the only Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families, BVA sincerely appreciates the invitation extended to our organization to present testimony. We are also grateful that the Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) blinded veterans present this morning, and who will later share their stories, have also been welcomed.

OBSTACLES TO VCE IMPLEMENTATION

OIF and OEF servicemembers with both penetrating eye trauma and Traumatic Brain Injury (TBI) visual impairment have had to wade through a DoD bureaucracy. DoD has given us the impression that, for them, an entire year's time to create

an organizational charter is actually not that long. Persistent excuses for lack of action range from "no plan was approved for VCE" to, of course, "no funding has been found to create VCE."

When NDAA was enacted in January 2008, an immediate reaction from senior level Assistant Secretary of Defense for Health Affairs officials was that VCE was an "unfunded mandate by Congress" that would cost "an estimated $5 million that we do not have built into this year's budget." If this were the case, Congress should have then asked why these funds were not requested in either last year's May 2008 War Supplemental (H.R. 2462) when $162 billion was provided for, among other things, "wounded warrior care" or, better yet, in the FY 2009 Defense Appropriations to cover this year's startup costs. Instead, both in June and again in early August at the Skyline Drive office of the Assistant Secretary of Defense for Health, and then once again on September 24, senior officials repeated the claim that finding even the bare minimum of $3 million to fund startup costs for the Vision Center of Excellence presented a very tough challenge.

For 4 years, BVA has attempted to bring to the attention of the Armed Services Committees, the Defense Appropriations Committees, both VA Committees, DoD Health Affairs, and the Veterans Health Administration (VHA) the ever-increasing prevalence of combat eye trauma and TBI visual dysfunction among servicemembers. We have become increasingly concerned about the growing numbers of both the battle wounded who have penetrating direct eye trauma (13 percent of all evacuated wounded have experienced eye trauma) and/or TBI-related visual complications (64 percent with TBI have tested positive for visual dysfunction).

Responses to these pleas have included "the need to wait until the next plan is approved," "NDAA reports come late for review," "inability to find office space," and the aforementioned "lack of requested funding." The cumulative result of these responses has been delayed action.

The Pentagon did appoint the first Director of VCE in November 2008. Colonel Donald Gagliano is a highly qualified and dedicated 29-year Army career ophthalmologist who served in Iraq for 1 year. Also appointed was an equally well-qualified VA Deputy Director of VCE, Dr. Claude Cowan. BVA fully supported both appointments. The two officials have entered these challenging positions with virtually no office space, little staffing support, zero funding for 3 months, no organizational charter, and thousands of combat eye-wounded servicemembers and veterans spread across various military medical facilities and VA medical centers. Thanks to MILCON/VA Appropriations Chairman Chet Edwards, VA received a $2 million appropriation for IT support. Although Senate MILCON/VA Appropriations Chairman Tim Johnson also helped provide an additional $6.9 million to VHA, questions persisted for months regarding a plan on how to use these funds.

The OIF and OEF eye wounded who have recently enrolled in the VA health care and benefits system never should have encountered this difficult process. Quick action by Secretary Gates, in cooperation with Secretary Shinseki and with the full attention of the Senior Oversight Committee, is now vital to correct this mess.

BVA emphasizes that the clinical skills of the DoD professional eye care providers, both ophthalmology and optometry, have been excellent. In many cases, they have been no less than outstanding. Ophthalmology surgery not possible during previous wars has saved the vision of many Soldiers and Marines. Nevertheless, the system that organizes and administers such treatment must become accountable for all battle eye wounded and TBI patients affected. It must answer for the lack of action inherent in its failure to begin staffing procedures that will eventually reach 12 positions, failure to locate office space, and failure to address the issue of construction renovation funding for the National Naval Medical Center.

PREVALENCE AND INCIDENCE OF VISUAL IMPAIRMENTS

As of September 2008, VHA reported 8,747 diagnoses of TBI with approximately 7,500 in diagnostic testing for possible TBI. Improvised Explosive Device (IED) blasts contributed to more than 64 percent of these injuries. As of January 30, 2009, a total of 43,993 servicemembers had been wounded or injured by accidents in Iraq. The number of those wounded in hostile operations and requiring air medical evacuation from Iraq between March 19, 2003 and January 30, 2009 from one early report was 9,375, of which an estimated 13 percent (1,219) had sustained combat penetrating eye trauma. Some 135 of this number have enrolled in VA Blind Rehabilitation Service (BRS) programs. This past November, however, the Military Surveillance Monthly Report contained an article from DoD on eye injuries among members of active components (U.S. Armed Forces, 1998–2008) that detailed, by ICD, diagnostic code searches turning up 4,970 perforating and penetrating eye trauma cases, 4,294 chemical or thermal burns, and 686 damaged optic nerves, most of which were from among OIF and OEF injured.

The number of direct battle eye injuries does not include estimates of all moderate-to-severe TBI servicemembers or veterans who have visual dysfunction, according to VA research of those tested by either neuro-ophthalmologists or low-vision optometrists at a few military and VA centers. We stress that while only a small percentage of the eye injured meet the legal blindness definition of 20/200 or less of visual acuity, those with neurological vision dysfunction from mild, moderate, or severe TBI will require long-term VA eye care follow-up in low-vision clinics. Veterans with a history of ocular battle injuries are also at high risk of developing retinal detachments, traumatic cataracts, glaucoma, and other delayed TBI neuro-visual complications that can occur years after the initial injury.

The top three contributors to combat eye injuries have been Improvised Explosive Devices (IEDs), Rocket-Propelled Grenades (RPGs), and Mortars, with IEDs causing 56.5 percent of all eye injuries in Iraq. Just how many servicemembers have actually sustained moderate-to-severe TBI injuries to the extent that they are experiencing neuro-sensory visual complications is anyone's guess. The estimates in professional journals and other publications indeed change from month to month. The 64 percent figure (those with TBI who have experienced visual dysfunction) represent those with associated neurological visual disorders of diplopia, convergence disorder, photophobia, ocular-motor dysfunction, color vision loss, and an inability to interpret print. Some TBIs result in visual field defects with enough field loss to meet legal blindness standards. We are also finding ever increasing numbers of TBI-caused "functionally blinded" OIF and OEF veterans who, while not legally blind, are unable to perform normal daily activities because of loss of vision. More TBI visual screening, diagnosis, treatment, and new outcome studies should be initiated without delay.

One early VA research study (2005) of OIF and OEF servicemembers who had entered the VA system with an ICD–9 (diagnostic code) search found 7,842 individuals with a traumatic injury of some kind. Consistent with recent media articles and VA reports, the most common traumatic injury diagnoses were hearing loss and tinnitus (63.5 percent). We now know that 94,191 of the more than 1.3 million troops who have served in OIF and OEF are now service-connected for tinnitus while 78,076 are service-connected for hearing loss. A major cause of this hearing loss (60 percent of the cases) is exposure to IEDs. The second most common VA diagnostic code was for visual impairment (27.9 percent). We submit to this Subcommittee that the cases of sensory loss of hearing and visual impairment as a result of TBI constitute a "silent epidemic" not widely reported by media. They are, nevertheless, the #1 and #2 injuries from OIF and OEF combat.

NEUROLOGICAL IMPACT OF TBI DYSFUNCTION

Perception plays a major role in an individual's ability to live life. Although all senses play a significant role in perception, the visual system is critical to perception, providing more than 70 percent of human sensory awareness. With hearing being another critical component, IED blast injuries can obviously impair markedly these two key sensory systems.

Vision provides information about environmental properties. It allows individuals to act in relation to such properties. In other words, perceptions allow humans to experience their environment and live within it. Individuals perceive what is in their environment by a filtered process that occurs through a complex, neurological visual system. With various degrees of visual loss comes greater difficulty to clearly adjust and see the environment, resulting in increased risk of injuries, loss of functional ability, and unemployment. Impairments range from loss in the visual field, visual acuity changes, loss of color vision, light sensitivity (photophobia), and loss of the ability to read and recognize facial expressions.

Although one can acquire visual deficits in numerous ways, one leading cause is injury to the brain. Damage to various parts of the brain can lead to specific visual deficits. Some cases have reported a spontaneous recovery but complete recovery is unlikely and early intervention is critical. Current complex neuro-visual research is being examined in an attempt to improve the likelihood of recovery. The re-training of certain areas and functions of the brain has improved vision deficits in some disorders. Nevertheless, the extent of the recovery is often limited and will usually require long-term follow-up with specialized adaptive devices and prescriptive equipment.

The brain is the most intricate organ in the human body. The visual pathways within the brain are also complex, characterized by an estimated two million synaptic connections. About 30 percent of the neocortex is involved in processing vision. Due to the interconnections between the brain and the visual system, damage to the brain can bring about various cerebral visual disorders. The visual cortex has its own specialized organization, causing the likelihood of specific visual disorders

if damaged. The occipitotemporal area of the brain is connected with the "what" pathway. Thus, injury to this ventral pathway leading to the temporal area of the brain is expected to affect the processing of shape and color. This can make perceiving and identifying objects difficult. The occipitoparietal area (posterior portion of the head), is relative to the "where," or "action" pathway. Injury to this dorsal pathway leading to the parietal lobe will increase the likelihood of difficulties in position (depth perception) and/or spatial relationships. In cases of injury, individuals find it hard to determine an object's location and may also discover impaired visual navigation.

It is highly unlikely that a person with TBI will have only one visual deficit. A combination of such deficits usually exists due to the complexity of the organization between the visual pathway and the brain. The most common cerebral visual disorder after brain injury involves visual field loss. The loss of peripheral vision can be mild to severe and requires specific visual field testing to be correctly diagnosed. In turn, a number of prescribed devices are frequently necessary to adapt to this loss.

Accompanying such complex neurological effects on the patient is the overwhelming emotional impact of brain injury on the patient and his/her family. BVA would ask Members of the full House Committee to seriously consider the ramifications of such injuries. Brain injuries are known for causing extreme distress on family members who must take on the role of caregivers. According to a **New England Journal of Medicine** report of January 30, 2008, TBI "tripled the risk of PTSD, with 43.9 percent of those diagnosed with TBI also afflicted with PTSD."

At present, the current system of screening, treatment, tracking, and follow-up care for TBI vision dysfunction is inadequate. Adding visual dysfunction to this complex mix, especially if undiagnosed, makes attempts at rehabilitation even more daunting and potentially disastrous unless there are significant improvements in the screening, treatment, tracking, and follow-up care through the proposed and legislated Vision Center of Excellence.

VCE TO ADDRESS CRITICAL ISSUES

BVA believes that the VCE Eye Trauma Registry is where vital components for research, best practices, outcome measures, and education can be developed and refined for the eye trauma wounded and those with TBI vision dysfunction. Critical vision research coordinated with the Defense Veterans Brain Injury Centers (DVBIC) and Defense Centers of Excellence for TBI can facilitate effective eye trauma research between DoD and VA. We predict that the number of TBI-injured will again increase beginning this spring as the troop surge into Afghanistan gets underway.

BVA wishes to clear up false misinformation about VCE that has recently become commonplace: First, VCE is not to be one large clinical eye treatment center for all combat eye injured. It is better understood as "a virtual center with connectivity" to the four major military trauma centers (National Naval Medical Center, Brooke Army Medical Center, Madigan Medical Center, and San Diego Naval Medical Center), the soon-to-be five VA Polytrauma Centers, and the hundreds of other medical centers where the highest proportion of eye-injured and TBI-wounded are already receiving high quality, specialized surgery care and low-vision optometric services.

Second, VCE is not a DoD blind center or rehabilitation facility. It will, however, coordinate its work with the already existing, skilled, multidisciplinary VA Blind Rehabilitation Centers (BRCs) and low-vision clinics with decades of experience treating blinded veterans. The VCE Eye Trauma Registry will track all eye injured and TBI visually impaired, coordinate joint vision research, promote best practices, and develop educational information on vision services for both providers and families.

VA BRS AND LOW-VISION SERVICES

A positive note is that the challenges inherent in the growing number of returning OIF and OEF servicemembers needing screening, diagnosis, treatment, and a coordinated Seamless Transition of services can be met, at least to some extent, by the existence of world-class VA BRCs. The programs provided at such centers now have a 60-year history. In the larger picture of VA programs for blind and visually impaired veterans, BVA began working more than 4 years ago to ensure that VA expand its current capacity to serve blinded veterans. Such expansion became necessary as the aging population of veterans with degenerative eye diseases requiring specialized services has continued to increase.

As a result of efforts to broaden and increase services, 54 new outpatient intermediate low-vision and advanced blind rehabilitation outpatient programs already have specialized staffing in place. Many of these new programs are opening with

veteran-centered, low-vision specialized teams providing the full range of basic, intermediate, and advanced rehabilitation services. Accompanying these gains is special VA emphasis on outcome measurements and research projects within VHA. The VA approach of coordinated team methods for rehabilitation care has unlocked strategies for new treatments and provided the most updated adaptive technology for blinded veterans. The new, specialized low-vision and blind programs already existing within the VA system must be utilized by DoD through VCE. The eye injured must receive high quality health care with proven outcomes that include constantly emerging vision research.

The mission of each Visual Impairment Services Team (VIST) program is to provide blinded veterans with the highest quality of vision loss services and blind rehabilitation training that truly help them adjust to the major changes they have experienced in their lives. To accomplish this mission, VISTs have established mechanisms to facilitate more completely the identification of blinded veterans and to offer a review of benefits and services for which they are eligible. The VIST concept was created in order to coordinate the delivery of comprehensive medical and rehabilitation services for blinded veterans. VIST Coordinators can assist not only newly blinded veterans with timely and vital information leading to psychosocial adjustment, but can also provide similar assistance to their families.

Seamless Transition from DoD to VA is best achieved through the dedicated work of VIST Coordinators and Blind Rehabilitation Outpatient Specialists (BROS). They are in a unique position to provide comprehensive case management services to returning OIF/OEF service personnel for the remainder of their lives. VIST Coordinators are now following the progress of 135 recently blinded veterans who are being served on an outpatient basis. The VIST system currently employs 112 full-time and 43 part-time Coordinators. There are 39 full-time BROS teams who also manage cases and serve as blind instructors for OIF and OEF blinded veterans.

The VA BROS is a highly qualified professional. Many BROS hold Masters Degrees in both Orientation and Mobility and Rehabilitation Teaching. BROS also receive extensive cross-training at one of the ten BRCs nationwide. The training prepares such individuals to provide, in the veteran's home environment, the full range of mobility, living, adaptive, manual, and other skills essential to blind rehabilitation. VIST/BROS teams are also well equipped to provide excellent local services on a continuing basis when a veteran returns home from an inpatient stay at a BRC.

Advanced Outpatient Rehabilitation Programs occur in "Hoptel" settings, as VA calls them. Hoptel sleeping arrangements function perhaps more like hotels than hospitals. Such programs offer Skills Training, Orientation and Mobility, and Low-Vision Therapy for veterans who need treatment with prescribed eye wear, magnification devices, and adaptive technology to enhance remaining vision. Those returning from blind centers benefit from these outpatient services when they require additional training. A VIST Coordinator with low-vision credentials manages the program with other key staff consisting of certified BROS, Rehabilitation Teachers, Low-Vision Therapists, and a part-time Low-Vision Ophthalmologist or Optometrist. Medical, surgery, psychiatry, neurology, rehabilitative medicine, pharmacy, physical therapy, and prosthetics services can all be consulted as needed within the VA Medical Center, effectively providing the full continuum of care for the OIF and OEF veterans. DoD and VA are in the process of developing a bi-directional electronic health care record that exchanges medical records and clinical eye trauma surgery information. Private agencies that offer blind rehabilitation would rarely have full medical services, surgical subspecialties, and psychiatry all co-located within one facility, meaning veterans and families would have to travel additional distances to obtain needed outpatient care for other conditions, adding to wait times for consultants, delays in obtaining prescribed medications, or waiting on new treatment plans. BVA strongly recommends that private agencies utilized for services provide outcome studies. We also recommend that they be accredited by the Commission on Accreditation of Rehabilitation Facilities, that they be required to utilize VA electronic health care records for clinical care, and that they meet specific outcome measures for future contracts.

Another important model of service delivery that does not fall under VA BRS is the VICTORS program, or the Visual Impairment Center to Optimize Remaining Sight. VICTORS is an innovative program that has been operated by VA Optometry Service for more than 18 years. The program consists of specialized services to low-vision veterans who, though not legally blind, suffer from visual impairments. Veterans must generally have a visual acuity of 20/70 through 20/200 to be considered for VICTORS. The program, entirely outpatient, typically lasts 3–5 days. Veterans undergo a comprehensive, low-vision optometric evaluation. They receive prescribed low-vision devices and are trained in the use of adaptive technology to optimize functional independence.

The Low-Vision Optometrists employed in the Intermediate Low-Vision programs are ideal for the highly specialized skills necessary for the assessment, diagnosis, treatment, and coordination of services for Iraq and Afghanistan returnees with TBI visual symptoms. This is because such veterans often require long-term follow-up services. The programs also assist the aging population of veterans with degenerative eye diseases. Such programs often enable working individuals to maintain their employment and retain full independence in their lives. They also provide testing for and research into the effectiveness of adaptive low-vision technology aids that have recently become available through training, review, and research. In conjunction with a wide network of VA eye care clinics existing in VA medical centers nationwide, combined VIST/BROS teams and Intermediate/Advanced Outpatient programs can provide a wide network of specialized services for veterans and their families in.

All of these programs test the effectiveness of new adaptive low-vision technology aids through training, review, and research. Programs requiring long-term follow-up services, such as the new Advanced and Intermediate programs, are cost effective for high-need, low-vision OIF/OEF veterans with residual vision from TBI. Combined VIST/BROS teams and Intermediate/Advanced Outpatient programs can provide a wide network of specialized services for servicemembers and their families in coordination with existing VA Eye Care clinics within VA medical centers. VCE is critical to the success of all of the aforementioned specialized VA services.

CONCLUSIONS

Serious combat eye trauma and visual dysfunction associated with TBI among OIF and OEF service personnel have become the second most common injury resulting from the two conflicts. More than 9,940 visual injuries have occurred and thousands more have visual dysfunction stemming from TBI. We urge Members of the full House Committee to demand compliance with the existing NDAA requirements. Both DoD and VA should provide the $5 million funding for the remainder of FY 2009 for joint professional and administrative staffing, joint office space for no fewer than 12 staff members, construction, information technology, and funding oversight of all activities of the Vision Center of Excellence and Eye Trauma Registry. Congress indeed expected compliance 13 months ago. The establishment of the Defense Intrepid Center of Excellence for Mental Health and the TBI Center of Excellence, along with VCE, would substantially improve the multidisciplinary coordination, treatment, rehabilitation, and research into eye trauma and TBI-related visual impairment experienced by servicemembers and veterans throughout the DoD and VA systems.

BVA again expresses sincere gratitude to this Subcommittee for the opportunity to present our testimony. We hope that you understand the deep sense of frustration we have felt over the course of the 13 months since NDAA established VCE. Simply put, the time for DoD and VA to implement VCE, as intended by the 110th Congress, is now. With the large numbers of veterans suffering direct eye injury from battle and TBI visual dysfunction, further delay is unacceptable. Because the population of war wounded servicemembers and veterans is widely diverse geographically, it is not appropriate or reasonable that one military or VA medical treatment facility become a clinical center for all eye-wounded servicemembers or for TBI patients with visual dysfunction. Depending on such an idea would be cost prohibitive and delay care for literally thousands of men and women.

We request that the House VA Committee require that both Secretary Gates and Secretary Shinseki get VCE on track again. The Defense Appropriations War Supplemental in April should present the next feasible and excellent opportunity to add additional directed funding.

RECOMMENDATIONS

- The Secretary of Defense and Secretary of Veterans Affairs must immediately direct the Senior Oversight Committee Executive Director to approve the organizational structure and charter for VCE and provide DoD/VA clinical/administrative staff teams. He must oversee the securing of temporary office space for at least 12 staff members and see that financial resources are in place to begin to begin full implementation of the operations of VCE. He should then report back to this Committee within 30 days. VHA was directed to spend $6.9 million in FY 2009 for VCE. These funds should be utilized now for at least some of the expenses associated with VCE's establishment.
- The military director of VCE, Colonel Gagliano, and VA Deputy Director Dr. Cowan need immediate administrative and information technology staff support, office equipment, travel funding, and educational support resources from

both DoD and VHA to implement the new VCE joint program, with no less than $5 million to cover FY 2009.
- Congressional oversight should ensure that MILCON/VA and Defense Appropriations Chairmen and Ranking Members review budgets for FY 2010 to ensure that they provide no less than $6.5 million for staffing, $10 million for FY 2010 vision research, and no less than $2 million for information technology. Some $6 million is urgently needed at present to fund a Navy construction project that will renovate office space and other facilities at National Naval Medical Center in Bethesda, Maryland, where VCE Headquarters is to be located. All Program Operational Management initiatives should then be funded for FY 2011, FY 2012, and FY 2013 as mandated by the reporting clause in the National Defense Authorization Act of 2009.
- VCE must be patient and family centered, comprehensively coordinated, and compassionate. It should be a virtual center providing real Seamless Transition that ensures electronic bi-directional registry exchange of both inpatient and outpatient eye care clinical records that both DoD and VA eye care staff can update and share with the Veterans Benefits Administration so that benefits for service-connected injuries can be assessed.
- All DoD/VA case managers need educational updates on the various VA specialized vision programs for eye trauma and TBI visual dysfunction. Veterans and family members need information on locations of vision services within DoD and VA. VIST/BROS teams must be notified early in the treatment process of transfers to their local area of any eye-injured servicemember. All DVBIC and VA TBI Centers must report data to VHA on eye trauma or TBI vision dysfunction cases.
- Private agency involvement in the treatment and rehabilitation process should be narrowly limited to those meeting strict accreditation, certification, educational, and university peer—reviewed research criteria. Such agencies should be equipped with multidisciplinary staff support and meet all Health Insurance Portability and Accountability (HIPPA) requirements.
- VCE should become involved in the DoD peer-reviewed Congressionally Directed Medical Research Program (CDMRP) in order to encourage additional TBI visual dysfunction research. More eye trauma research in conjunction with DoD, VA, NIH, and universities with VA academic affiliations is desperately needed now. Potential long-term consequences of mild-to-moderate TBI in OIF/OEF veterans are still unknown. Discoveries of such consequences will require new technology and diagnostic research support. BVA, supported by the current Veterans Service Organization Independent Budget, requests $10 million for CDMRP in FY 2010 as directed vision research.

Prepared Statement of Madhulika Agarwal, M.D., MPH,
Chief Officer, Patient Care Services, Veterans Health Administration,
and James Orcutt, M.D., Ph.D., Chief of Ophthalmology,
Office of Patient Care Services, Veterans Health Administration,
U.S. Department of Veterans Affairs

Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA's) collaborations and accomplishments with the Department of Defense (DoD) concerning the Vision Center of Excellence. We are accompanied today by Dr. Claude Cowan, Deputy Director of the Vision Center of Excellence.

VA has been working jointly with DoD to implement the components of the 2008 National Defense Authorization Act to: 1) establish a Vision Center of Excellence (VCE) in prevention, diagnosis, mitigation, treatment and rehabilitation of military eye injuries; 2) implement a Defense and Veterans Eye Injury Registry; and 3) coordinate care and benefits between DoD and VA. We appreciate Congress' support in this, area and we are proud to say the broad concepts of a VCE and registry were already in development prior to the passage of this landmark piece of legislation.

DoD has been an important partner in developing the VCE, and is the lead agency in the implementation process. In the summer of 2008, the Office of the Assistant Secretary of Defense for Health Affairs accepted a joint VCE proposal from both VA and DoD. By August of the same year, applications were solicited for the VCE Director position. Shortly thereafter, a Deputy Director was named. Colonel Don Gagliano and Dr. Claude Cowan have accepted these respective responsibilities. With leadership from both DoD and VA, the Departments have institutionalized our commitment to cooperate, and is emblematic of the new culture of collaboration between

the two agencies. This leadership team is currently recruiting additional staff members (including administrative staff, an optometrist and a blind rehabilitation specialist) to supplement and support the mission.

The primary goals of the VCE are to monitor patterns of care and the utilization of standard protocols (such as the traumatic brain injury, or TBI, specific eye exam) to ensure consistency of care, to identify gaps in care delivery, and to find areas where collaboration and coordination can be improved. This includes not only care for ocular injuries sustained during active duty and management of patients with visual symptoms related to TBI, but also the full continuum of care extending rehabilitation services for those with vision loss. VA blind rehabilitation services include 10 intensive inpatient Blind Rehabilitation Centers, 157 Visual Impairment Service Team Coordinators, who provide care management, 75 Blind Rehabilitation Outpatient Specialists, who serve in Veterans' homes and communities, and 55 newly established low vision and blind rehabilitation outpatient clinics across the United States. Both Veterans and active duty personnel will be able to receive vision rehabilitation services at these sites.

Follow-on care and family re-integration training for Veterans are important issues to VA and these efforts undergo constant revision and expansion as needs dictate so that when Veterans leave our facilities, they and their family are better prepared for adjusting to life at home.

The VCE is not only focused on supporting facilities that provide treatment, diagnosis and the continuum of care, it will also work to identify servicemembers with visual injuries as early as possible. Since 2002, VA has assigned a Blind Rehabilitation Outpatient Specialist at Walter Reed Army Medical Center and Bethesda national Navel Medical Center to identify, coordinate and provide direct rehabilitative care for Veterans and active duty servicemembers. The VCE will also work to facilitate care coordination within and between VA and DoD for those with multiple injuries, including vision loss, and to ensure that appropriate eye assessments are provided. VA's Polytrauma Centers continue to conduct comprehensive assessments of TBI-related vision function—this ensures a comprehensive approach to visual impairment identification, treatment and rehabilitation.

The VCE will review the existing literature for strong practices that will provide guidelines for management of patients with ocular injuries and visual symptoms related to TBI. Through review of existing literature and the assessment of the effectiveness of current DoD and VA treatment protocols, the VCE will identify and refine strong practices for the management of patients with ocular injuries or visual disability. In addition the VCE will facilitate the dissemination of these practices through the use of written guidance documents and combined conferences with VA and DoD.

Where the literature has not identified essential components of appropriate management, the VCE will work with both VA and DoD research programs to provide guidance and to support new research. The VCE will educate providers about new findings on eye trauma and the visual symptoms of TBI. VA and DoD organized a joint meeting in San Antonio in December 2008 on the visual consequences of TBI and are planning a second conference in December 2009 to educate providers in VA and DoD on the Visual Consequences of Traumatic Brain Injury. Research priorities were defined during a consensus validation project in December 2008. In addition, VA's Office of Research and Development sponsored a State of the Art Conference on TBI in June 2008. This led to a request for applications for research in traumatic brain injury, including research specifically related to vision and hearing loss.

During the summer and fall of 2008, VA began developing the eye trauma registry. In VA and DoD discussions, participants began outlining the requirements for a Concept of Operations for the registry, which included participants from VA, DoD and the Joint Theater Trauma Registry. The Concept of Operations addresses the registry structure, the components required within the registry, and the system requirements to make the registry functional. VA and DoD have agreed to endorse using a central database with input from the Joint Theater Trauma Registry, VA's electronic health record, and DoD's electronic health record. Essential to this plan was the commitment that this registry would be accessible and updated by VA and DoD providers and end users. VA approved this concept in January 2009, and DoD's approval is pending.

The Departments recognized the registry needed to include more than just Veterans and servicemembers with direct ocular damage from service in Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF). We also needed to include Veterans and servicemembers who sustained TBI with resulting visual symptoms. The VCE will maintain the registry and will continue monitoring and improving it while ensuring care for injured Veterans and servicemembers.

VA's Office of Information and Technology (OI&T) is providing critical support for the development of the registry and has assigned an implementation program director for this effort. Participants from VA, DoD and the Joint Theater Trauma Registry will meet in early April, 2009 to begin implementation of the registry.

VA is financially committed to the initiation of the registry project. VA's OI&T provided funding for a consultant to develop the Concept of Operations; similarly, DoD extended support to their providers who helped develop the Concept of Operations. The 2009 VA budget included $2 million for the registry and $6.9 million for the VCE. The registry funding was provided to OI&T to support the implementation of the registry. The VCE's funding supported hiring staff and fully administering the educational conferences noted above.

Thank you again for this opportunity to speak about VA's role in supporting the VCE and the eye injury registry. These are exciting programs that hold great promise for providing the highest quality care our Nation expects and our Veterans and servicemembers deserve. Our medical health care system is recognized as one of the best in the world, and we will continue to lead in all areas, including specialized care.

Prepared Statement of Jack W. Smith, M.D., M.M.M., Acting Deputy Assistant Secretary for Clinical and Program Policy, U.S. Department of Defense, and Colonel Donald A. Gagliano, Executive Director, Vision Center of Excellence

Mr. Chairman, Members of the Committee, thank you for the opportunity to discuss with you the Department of Defense (DoD) and Department of Veterans Affairs (VA) Vision Center of Excellence (VCE) current initiatives and way forward. Vision complications, such as loss of vision and blindness, are the "silent epidemic" of Operation Iraq Freedom and Operation Enduring Freedom, but there are also typical eye injuries and diseases affecting our soldiers and Veterans that must be addressed.

DoD's primary focus is to provide expert services to our servicemembers, our Veterans and their families in all areas of vision care (prevention, diagnosis, mitigation, treatment, rehabilitation and research). Developing and implementing innovative ways of managing eye injuries is crucial. The Department is committed to improving the quality of care for our wounded warriors, who deserve the very best for the sacrifices they have made for our Nation. We are pleased to be here to talk about this significant initiative.

Establish a Vision Center of Excellence

Due to the increase in vision injuries and diseases sustained by the men and women of our Armed Services, Congress directed that the Department establish a Vision Center of Excellence to ensure the full spectrum of care is fully supported. It is our duty to protect our servicemembers and assist them with all their medical needs, including vision.

There is much to accomplish, establish, implement, and set in motion in order to achieve the goals and objectives of the VCE. I want to share with you some of the VCE accomplishments to date.

The Department envisions that the VCE's permanent headquarters will be integrated with the vision capabilities in the National Capital Region. The current goal is to secure long—term space in the same area as the Eye Clinic (Ophthalmology and Optometry) in the new Walter Reed National Military Medical Center. This will allow for synergies between vision care providers and patients in the National Capital Area, and will benefit from proximity to the new National Intrepid Center of Excellence building and to the National Eye Institute.

VA and DoD have developed a process for collaboration at Walter Reed Army Medical Center (WRAMC) for blind rehabilitation care while servicemembers are still receiving DoD care. This effort will enhance the continuum of care and better integrate a continuum of care across the DoD and VA for vision rehabilitation. The next steps are:

- Finalize a Memorandum of Understanding (MOU) for collaboration at WRAMC for blind rehabilitation care while servicemembers are still receiving DoD care; and
- Establish approval for privileging rehabilitation care providers in DoD facilities.

To enhance continuity of care between DoD and VA vision centers, we have worked together to define common vision care data exchange protocols for the DoD

Bilateral Health Information Exchange developers. We also plan to develop a training program for the use of the DoD/VA Bilateral Health Information Exchange to continue the collaboration effort to support optimal DoD/VA transitional vision care. We will continue to do this since health information exchange is key to successful collaboration.

We have established priorities for vision research based on identified requirements by working with the Congressional Special Interest Vision Research Administrators and the Congressionally Directed Medical Research Program (CDMRP). We plan to host a meeting with vision research entities to establish priorities for vision research through the Congressional Special Interest Vision Research Administrators and CDMRP.

The VCE involves the coordinated effort of the DoD, VA, institutions of higher education and various commercial, academic and non-profit entities. The VCE will have the opportunity to transform the way we provide vision care through these collaboration efforts. We plan to:

- Promote affiliation with research institutes, including the National Eye Institute, FDA, and other academic institutions; and
- Develop an eye trauma training center affiliated with an academic institution with a high volume of trauma patients to enhance the readiness of the vision care teams.

Implement the Defense and Veterans Eye Injury Registry

Currently, we do not have an optimal mechanism to capture long-term data for eye injuries and diseases that are affecting our servicemembers returning from theater and our Veterans undergoing long-term care. This registry will support care coordination for servicemembers and Veterans with significant eye injuries, provide data necessary to measure longitudinal outcomes, and provide statistical and accurate data requested by Congress and Veterans Service Organizations.

VA and DoD developed a Defense and Veterans Eye Injury Registry Concept of Operations (CONOPS). Included in this CONOPS is the development of an eye trauma module that will be incorporated into the Joint Trauma Tracking Registry (JTTR). The next step is to begin populating the Defense and Veterans Eye Injury Registry by late 2009.

The Defense and Veterans Eye Injury Registry will drive innovation forward. It will provide those with eye injuries, diseases and those with visual loss associated with Traumatic Brain Injury (TBI) many opportunities as it will allow for sharing studies outcomes, establishing best practices and clinical guidelines.

Conclusion

The VCE is designed to improve the care of American military personnel and Veterans affected by combat eye trauma, to bring back those suffering from vision loss, injuries and vision anomalies to a fully functional capability, and to create a Joint Defense and Veterans Eye Injury Registry that will drive research and innovation in vision care. We are working diligently to ensure the VCE becomes the leader in vision care as we understand how important this mission is for our servicemembers and Veterans.

We are grateful to the Members of the House Veterans' Affairs Committee for your efforts to assist our soldiers. We have come a long way, but now our work intensifies.

Thank you for your time and the opportunity to update you on the VCE. We look forward to answering your questions.

MATERIAL SUBMITTED FOR THE RECORD

SEC. 1623. CENTER OF EXCELLENCE IN PREVENTION, DIAGNOSIS, MITIGATION, TREATMENT, AND REHABILITATION OF MILITARY EYE INJURIES.

(a) *In General*—The Secretary of Defense shall establish within the Department of Defense a center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries to carry out the responsibilities specified in subsection (c).

(b) *Partnerships*—The Secretary shall ensure that the center collaborates to the maximum extent practicable with the Secretary of Veterans Affairs, institutions of higher education, and other appropriate public and private entities (including international entities) to carry out the responsibilities specified in subsection (c).

(c) *Responsibilities*

(1) IN GENERAL—The center shall——

(A) implement a comprehensive plan and strategy for the Department of Defense, as developed by the Secretary of Defense, for a registry of information for the tracking of the diagnosis, surgical intervention or other operative procedure, other treatment, and follow-up for each case of significant eye injury incurred by a member of the Armed Forces while serving on active duty;

(B) ensure the electronic exchange with the Secretary of Veterans Affairs of information obtained through tracking under subparagraph (A); and

(C) enable the Secretary of Veterans Affairs to access the registry and add information pertaining to additional treatments or surgical procedures and eventual visual outcomes for veterans who were entered into the registry and subsequently received treatment through the Veterans Health Administration.

(2) DESIGNATION OF REGISTRY—The registry under this subsection shall be known as the 'Military Eye Injury Registry' (hereinafter referred to as the 'Registry').

(3) CONSULTATION IN DEVELOPMENT—The center shall develop the Registry in consultation with the ophthalmological specialist personnel and optometric specialist personnel of the Department of Defense and the ophthalmological specialist personnel and optometric specialist personnel of the Department of Veterans Affairs. The mechanisms and procedures of the Registry shall reflect applicable expert research on military and other eye injuries.

(4) MECHANISMS—The mechanisms of the Registry for tracking under paragraph (1)(A) shall ensure that each military medical treatment facility or other medical facility shall submit to the center for inclusion in the Registry information on the diagnosis, surgical intervention or other operative procedure, other treatment, and follow-up for each case of eye injury described in that paragraph as follows (to the extent applicable):

(A) Not later than 30 days after surgery or other operative intervention, including a surgery or other operative intervention carried out as a result of a follow-up examination.

(B) Not later than 180 days after the significant eye injury is reported or recorded in the medical record.

(5) COORDINATION OF CARE AND BENEFITS—

(A) The center shall provide notice to the Blind Rehabilitation Service of the Department of Veterans Affairs and to the eye care services of the Veterans Health Administration on each member of the Armed Forces described in subparagraph (B) for purposes of ensuring the coordination of the provision of ongoing eye care and visual rehabilitation benefits and services by the Department of Veterans Affairs after the separation or release of such member from the Armed Forces.

(B) A member of the Armed Forces described in this subparagraph is a member of the Armed Forces as follows:

(i) A member with a significant eye injury incurred while serving on active duty, including a member with visual dysfunction related to traumatic brain injury.

(ii) A member with an eye injury incurred while serving on active duty who has a visual acuity of 20/200 or less in the injured eye.

(iii) A member with an eye injury incurred while serving on active duty who has a loss of peripheral vision resulting in 20 degrees or less of visual field in the injured eye.

(d) *Utilization of Registry Information*—The Secretary of Defense and the Secretary of Veterans Affairs shall jointly ensure that information in the Registry is available to appropriate ophthalmological and optometric personnel of the Department of Defense and the Department of Veterans Affairs for purposes of encouraging and facilitating the conduct of research, and the development of best practices and clinical education, on eye injuries incurred by members of the Armed Forces in combat.

(e) *Inclusion of Records of OIF/OEF Veterans*—The Secretary of Defense shall take appropriate actions to include in the Registry such records of members of the Armed Forces who incurred an eye injury while serving on active duty on or after September 11, 2001, but before the establishment of the Registry, as the Secretary considers appropriate for purposes of the Registry.

(f) *Traumatic Brain Injury Post-Traumatic Visual Syndrome*—In carrying out the program at Walter Reed Army Medical Center, District of Columbia, on traumatic brain injury post-traumatic visual syndrome, the Secretary of Defense and the Department of Veterans Affairs shall jointly provide for the conduct of a cooperative program for members of the Armed Forces and veterans with traumatic brain injury by military medical treatment facilities of the Department of Defense and medical centers of the Department of Veterans Affairs selected for purposes of this subsection for purposes of vision screening, diagnosis, rehabilitative management, and vision research, including research on prevention, on visual dysfunction related to traumatic brain injury.

SEC. 1624. REPORT ON ESTABLISHMENT OF CENTERS OF EXCELLENCE.

(a) *In General*—Not later than 180 days after the date of the enactment of this Act, the Secretary of Defense shall submit to Congress a report on—

(1) the establishment of the center of excellence in prevention, diagnosis, mitigation, treatment, and rehabilitation of traumatic brain injury under section 1621;

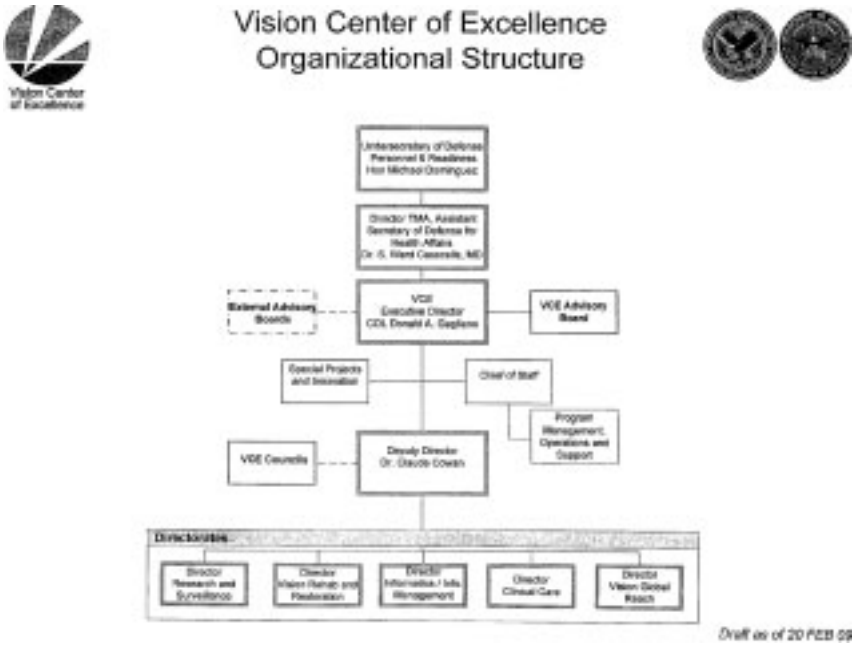
(2) the establishment of the center of excellence in prevention, diagnosis, mitigation, treatment, and rehabilitation of post-traumatic stress disorder and other mental health conditions under section 1622; and

(3) the establishment of the center of excellence in prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries under section 1623.

(b) *Matters Covered*—The report shall, for each such center—

(1) describe in detail the activities and proposed activities of such center; and

(2) assess the progress of such center in discharging the responsibilities of such center.



U.S. Department of Defense
Office of the Assistant Secretary of Defense for Health Affairs
Washington, DC.
March 12, 2009

Hon. Harry Mitchell
Chairman, Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman,

In accordance with section 1623 of the National Defense Authorization Act for Fiscal Year 2009 (P.L. 110–181) to establish a center of excellence in prevention, diagnosis, mitigation, treatment and rehabilitation of military eye injuries, the Fiscal Year 2009 Defense Health Program Operation and Maintenance Budget for the establishment and operation of the Vision Center of Excellence is $3 million. The Director, Vision Center of Excellence, is authorized to incur financial obligations as a result of hiring civilian personnel, acquiring contractual services and supplies, and conducting travel requirements necessary to ensure mission accomplishment. The Director's funding needs will be monitored throughout the fiscal year to ensure that funding is available to support mission requirements.

My point of contact is the Director, Program, Budget and Execution Division, Dave Moonan, 703–681–4341.

Sincerely,

Allen W. Middleton
Acting Deputy Assistant Secretary of Defense
Health Budgets and Financial Policy

Committee on Veterans' Affairs
Subcommittee on Oversight an Investigations
Washington, DC.
April 22, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki:

Thank you for the testimony of Madhulika Agarwal, M.D., Ph.D., Chief Officer, Patient Care Services, Veterans Health Administration, James Orcutt, M.D., Ph.D., Chief of Ophthalmology, Veterans Health Administration and Claude Cowan, M.D., Deputy Director of the Military Eye Trauma Vision Center of Excellence, U.S. Department of Veterans Affairs at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Oversight and Investigations hearing that took place on March 17, 2009, on "The Vision Center for Excellence: What Has Been Accomplished in Thirteen Months?"

Please provide answers to the following questions by June 2, 2009, to Todd Chambers, Legislative Assistant to the Subcommittee on Oversight and Investigations.

1. When did the four Polytrauma Centers begin tracking eye injuries? Please explain why the tracking has not been a focus as it has with TBI and PTSD patients.
2. Other types of injuries such as the 817 amputees, 580 burns, 8,780 VA diagnosed TBI, 43,000 PTSD, are and have been reported, published, and briefed in the past year. Why has there not been any briefings or reports on eye injuries?
3. Are the four VA Polytrauma Centers staffed with vision teams of Optometry and Ophthalmological with Blind Rehabilitative Outpatient Specialists and Visual Impairment Service Team (VIST) Coordinators? If so, please provide the dates of implementation of the VIST Team Coordinators.
4. When are servicemembers with Vision Impairment being referred to VA VIST Coordinators?
5. What are the current requirements for continuing education of DoD and VA medical staff (to include VIST and VA Bros) on screening for vision complications from TBI?
6. Please outline individually the plans, timeline and estimated costs for the VCE to perform the functions as stated in the NDAA. Specifically address the areas of research, registry and family and patient education.
7. Those with visual dysfunction and legal blindness should be reported by DoD to VA. Explain how this is being reported between departments today. How will compliance be assured so that servicemembers with eye injuries are accounted for and care provided by the VA?
8. Replication of the Palo Alto VAMC Vision Screening program for TBI seems to be a key priority across the VA polytrauma sites. How is VHA going to ensure that this occurs? What is the timeline of implementation for each of the three other polytrauma centers?
9. Are there plans on having key TBI/PTSD military staff visit and train at the VA blind centers to begin the process of sharing resources and information? If so please provide a timeline for when this will occur.
10. Who has been designated by the Secretary to be the OI&T implementation director for the Vision Center of Excellence program (VCE), and have the appropriate resources been allocated to support the program?
11. Please provide a timeline for the full implementation of the VCE program, including the following items: 1) completion of the Concept of Operations; 2) sharing VA and DoD electronic health records in an interoperable manner; and 3) coordination of care between the VA and DoD for blinded veterans and servicemembers.
12. Will additional funding be requested in the President's FY 2010 budget request for VA to support the Vision Center of Excellence?
13. From the testimony received at the hearing, it appears that there is still a lack of contact between severely injured servicemembers and the Federal Care Coordination Program. What is the status on this program, and how is the Department reaching out to these servicemembers to make them aware of the services and benefits available to them?

14. Please provide the Committee with the names of Case Managers and the Federal Care Coordinators who have been assigned to the three veterans who testified at this hearing. Please also provide the dates in which these individuals were assigned to assist the veterans.
15. Please provide the planned budget obligations for the $6.9 million appropriated to the Department of Veterans Affairs for the Vision Center of Excellence.

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers. If you have any questions concerning these questions, please contact Subcommittee on Oversight and Investigations Staff Director, Martin Herbert, at (202) 225–3569 or the Subcommittee Republican Staff Director, Arthur Wu, at (202) 225–3527.

Sincerely,

Harry E. Mitchell
Chairman

David P. Roe
Ranking Republican Member

Questions for the Record

Hon. Harry E. Mitchell, Chairman
Hon. David P. Roe, Ranking Republican Member
House Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
The Vision Center of Excellence: What Has Been Accomplished in 13 Months
March 17, 2009

Question 1: When did the four Polytrauma Centers begin tracking eye injuries? Please explain why the tracking has not been a focus as it has with TBI and PTSD patients.

Response: Initial discussions with the Department of Defense (DoD) began in September 2007 during a joint meeting at the Madigan Army Medical Center in Tacoma, WA. During this meeting, the need for an eye injury registry was identified. Subsequent meetings were conducted in December 2007 at the *Visual Consequences of Traumatic Brain Injury* conference and at the American Lake Department of Veterans Affairs (VA) Medical Center in April 2008. At this meeting, VA and DoD determined DoD would be able to track eye injuries through the DoD joint trauma theater registry staff. As a result, the Defense and Veterans eye injury registry (DVEIR) is now being developed as part of the vision center of excellence (VCE) action plan. Polytrauma rehabilitation centers (PRC) are tracking their patients with blindness and vision loss, but VA currently does not have an effective mechanism for tracking eye injuries except for patients admitted to the PRC. Patients admitted to the PRC have always had their eye injuries identified, annotated in the electronic medical record and treated. VA also identifies and treats all other associated injuries and conditions and provides ongoing follow-up care and services as appropriate for their condition. In 2008, VA implemented policies and procedures to perform Traumatic brain injury (TBI) specific eye examinations for every TBI patient admitted at each PRC [VHA Directive 2008–065, Performance of Traumatic Brain Injury Specific Ocular Health and Visual Functioning Examinations for Polytrauma Rehabilitation Center Patients, October 20, 2008]. A standardized template was developed and deployed to Veteran Health Administration (VHA) eye care practitioners to document the examination. For patients with TBI admitted to the PRCs prior to 2008, the PRCs are contacting each patient to coordinate to perform the TBI-specific eye examination for them. Reports on completion of the TBI specific ocular health and visual functioning exam for prior and current patients are submitted monthly by each PRC to VHA Office of Rehabilitation Services. This exceptional step of performing TBI-specific eye examinations was implemented based upon work by VA clinical providers at Palo Alto PRC, who first reported in 2007 that patients with blast-related TBI may be at higher risk for visual function abnormalities than might be found by conventional visual acuity testing.

Question 2: Other types of injuries such as the 817 amputees, 580 burns, 8,780 VA diagnosed TBI, 43,000 PTSD, are and have been reported, published, and briefed in the past year. Why has there not been any briefings or reports on eye injuries?

Response: VA blind rehabilitation service and visual impairment service teams currently track 596 unique Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) servicemembers and Veterans with eye injuries, and/or visual conditions

following TBI. A total of 101 unique OEF/OIF servicemembers and Veterans have been served in inpatient blind rehabilitation centers, of which:

48 were active duty at the time of treatment;
52 were discharged from the military at the time of treatment and;
1 was an active duty foreign military servicemember.

As additional Veterans with eye injuries are identified, either through delivery of medical care at VA or through referral from the DoD, VA will continue to add and track these Veterans as appropriate.

As discussed in response to question # 1 the existence of a systems-wide eye registry that includes all TBI patients is presently not available and thus data for reports or briefings related to eye injuries will not be available until the full implementation of DVEIR.

Question 3: Are the four VA Polytrauma Centers staffed with vision teams of Optometry and Ophthalmological with Blind Rehabilitative Outpatient Specialists and Visual Impairment Service Team (VIST) Coordinators? If so, please provide the dates of implementation of the VIST Team Coordinators.

Response: Yes, the four VA PRCs are staffed with vision teams that include: optometry and ophthalmology (including low vision optometry, and neuroophthalmology), blind rehabilitative outpatient specialists (BROS), and visual impairment service team (VIST) coordinators. VIST coordinators are at each PRC, and these positions have existed at each PRC location since before 2005 when the VA polytrauma system of care was established (prior to 2005, the PRCs existed with designation as lead traumatic brain injury centers).

Question 4: When are servicemembers with Vision Impairment being referred to VA VIST Coordinators?

Response: Servicemembers with vision impairment are being referred to VIST coordinators when first identified so that they can benefit from visually impaired services through the VA. This happens at several possible stages:

- At the military treatment facilities (MTF) where VA liaisons are located, the liaisons participate with the interdisciplinary military treatment teams and upon discussion of patients with vision impairments, liaisons may suggest treatment options within VA.
- As identified and appropriate, VA liaisons collaborate with the MTF treatment team and enlist the services of a VIST coordinator or BROS to begin working with a servicemember onsite at the MTF.
- If a person is obtunded and the discovery is not determined until their cognitive skills improve, then referral to a VIST coordinator may occur at a later stage, possibly when at a PRC.
- As a servicemember transitions from the MTF to VA, the VA liaison coordinates health care, including visual impairment services at a health care facility closest to the servicemember's home or most appropriate for their condition.

Question 5: What are the current requirements for continuing education of DoD and VA medical staff (to include VIST and VA BROS) on screening for vision complications from TBI?

Response: VA has provided, and continues to provide, training to medical staff and VIST and BROS through several VA conferences: visual consequences of TBI (December 2007); blind rehabilitation service national conferences (August 2008, August 2009); blind rehabilitation continuum of care conference (February 2009); and the visual consequences of TBI II conference (scheduled for December 2009). Newly hired VIST and BROS staff are provided training through national program consultants, and receive ongoing mentoring for continued education and professional preparation specific to vision conditions in TBI. Additionally, Blind Rehabilitation Service hosts monthly conference calls for VIST and BROS, and maintains a Web-share access site addressing questions and distributing information about this topic.

Question 6: Please outline individually the plans, timeline and estimated costs for the VCE to perform the functions as stated in the NDAA. Specifically address the areas of research, registry and family and patient education.

Response: VA and DoD are conducting discussions to finalize a timeline for full implementation of the VCE. The budget is being revised as additional information becomes available related to staffing, supplies, travel and training. DoD was provided $1 million in fiscal year (FY) 2008 and $3 million in FY 2009 for the VCE. VA had provided funding for the VCE for staffing and set up costs (office equipment, etc) of $1.6 million for FY 2009. Congress provided the VA $6.9 million for VCE and $2 million for DVEIR. The $2 million is budgeted for IT costs thru early FY 2010. VA funding is for staffing, infrastructure and educational meetings for providers, and will be will be used to fund the VCE approximately thru FY 2013. The Director

(DoD) and Deputy Director (VA) are collaborating on the identification of areas that will require additional research opportunities to assist with improving overall services and treatment options. The consensus document from blind rehab and the technical advisory group is nearing completion and outlines what is needed in research with an anticipated date of approval by no later than December 31, 2009. (draft document in the review stage).

The Office of Research and Development held the "state-of-the-art" meeting in June 2008 which led to the request for proposal for research in this area. Funding for the registry is proceeding. VHA held a teleconference with the Office of Information and Technology (OI&T) program manager on May 12, 2009 and is proceeding with a proof of concept registry document while waiting for the concept of operations (CONOPS) from DoD.

Patient and family education will be a continuous process and will be implemented to meet the individual needs of each Veteran from a multi-disciplinary perspective.

Question 7: Those with visual dysfunction and legal blindness should be reported by DoD to VA. Explain how this is being reported between departments today. How will compliance be assured so that servicemembers with eye injuries are accounted for and care provided by the VA?

Response: At the major continental United States sites, such as Walter Reed Army Medical Center (WRAMC) and Naval Medical Center San Diego, there are VIST coordinators in place and the eye care professionals refer patients directly to them. In the past, coordinators were asked to participate in medical staff rounds for inpatients to help identify referrals, however due to potential Health Insurance Portability and Accountability Act violations, DoD requested this be re-evaluated and that practice has not been reinstated. DoD has stated that they would begin credentialing VIST coordinators to include them in staff rounds in the future, and VA is negotiating with DoD to begin credentialing VIST as soon as possible.

Currently, the only formalized method of reporting servicemembers with visual dysfunction and legal blindness from DoD to VA is through the VA liaison for health care referral process. The VA blind rehabilitation outpatient specialist who services WRAMC and the National Naval Medical Center (NNMC) has participated in the inpatient multidisciplinary trauma/blast team meetings at those two MTFs. The VA BROS continues to attend these meetings as needs arise.

Question 8: Replication of the Palo Alto VAMC Vision Screening program for TBI seems to be a key priority across the VA polytrauma sites. How is VHA going to ensure that this occurs? What is the timeline of implementation for each of the three other polytrauma centers?

Response: Since December 1, 2008, all patients admitted to a PRC with a diagnosis of TBI are provided a TBI-specific ocular health and visual functioning examination that was first established at Palo Alto PRC. VA has implemented policies and procedures to perform TBI specific eye examinations for every TBI patient admitted at each PRC [VHA Directive 2008–065, Performance of Traumatic Brain Injury Specific Ocular Health and Visual Functioning Examinations for Polytrauma Rehabilitation Center Patients, October 20, 2008]. A standardized template was developed and deployed to VHA eye care practitioners to document the examination. Since December 2008, 113 such patients have been in the PRCs, of which 96 have completed the examinations; 17 are currently unable to complete testing due to their medical condition.

For patients with TBI admitted to the PRCs prior to December 1, 2008, the PRCs are contacting each patient to coordinate to perform the TBI-specific eye examination for them. Reports on completion of the TBI specific ocular health and visual functioning exam for prior and current patients are submitted monthly by each PRC to VHA Office of Rehabilitation Services. Between February 2005 and December 2008, a total of 652 patients with TBI went through the PRCs; a total of 481 of these patients were discharged without having completed the examination prior to discharge. A total 419 of these patients have been referred for examination, and 219 have completed the TBI eye examinations so far. The remainder have either been contacted and provided referral (201), or declined referral or are deceased (61).

Question 9: Are there plans on having key TBI/PTSD military staff visit and train at the VA blind centers to begin the process of sharing resources and information? If so please provide a timeline for when this will occur.

Response: DoD staff have visited 5 of the 10 VA inpatient blind rehabilitation centers at Chicago, IL; West Haven, CT; American Lake, WA; Augusta, GA, and Palo Alto, CA. While there are currently no DoD visits planned to VA blind rehabilitation centers, VA remains open and readily accessible to DoD sending staff who work with TBI or post-traumatic stress disorder patients to visit and train at VA blind rehabilitation centers. VA and DoD typically collaborate to provide joint train-

ing at conferences such as the visual consequences of TBI conference (December 2007), and the upcoming visual consequences of TBI II conference (December 2009).

VA also provides staff at major MTFs to support the provision of services, training and interaction with regard to blind rehabilitation. Since 2002, a BROS has supported blind rehabilitation services to WRAMC and NNMC. This has entailed the VA BROS attending the WRAMC TBI meetings and NNMC trauma rounds, and providing in-service training to staff at NNMC and WRAMC on multiple occasions. Since February 2009, the BROS have been attending the weekly TBI clinic at the WRAMC Military Advanced Treatment Center (MAT–C) to work with patients who are blind, visually impaired, or have visual disturbances as the result of a TBI.

VA social work care liaisons at Naval Medical Center San Diego and Brooke Army Medical Center work with VIST coordinators at supporting VA medical centers in San Diego or San Antonio to coordinate services or referrals for visually impaired servicemembers as appropriate. The supporting BROS at VA medical centers will also provide blind rehabilitation care on site at these DoD medical centers.

Question 10: Who has been designated by the Secretary to be the OI&T implementation director for the Vision Center of Excellence program (VCE), and have the appropriate resources been allocated to support the program?

Response: There is a program manager, and a development manager for VA's OI&T efforts in support of the DVEIR. VA received $2 million for fiscal 2009, which should be sufficient. A support contract was awarded to Patriot Technologies in September 2008 for all VA registries. These contract resources are in place and provide support for VA's portion of the DVEIR.

Question 11: Please provide a timeline for the full implementation of the VCE program, including the following items: 1) completion of the Concept of Operations; 2) sharing VA and DoD electronic health records in an interoperable manner; and 3) coordination of care between the VA and DoD for blinded veterans and servicemembers.

Response: VA and DoD are collaborating to finalize a timeline for full implementation of the vision center of excellence (VCE). The initial draft of the timeline allows for a period of 3 years for full activation of the VCE, however it may take longer to meet all milestones. A fully developed timeline is scheduled to be presented for approval in the fourth quarter of FY 2009, with initial actions in the 1st Quarter of FY 2010.

The Director (DoD) and Deputy Director (VA) are closely collaborating on VCE implementation, to include hiring the Deputy Chief of Staff and administrative support, which will positively impact the ability to move forward with the program. Agreement on the development of standards and requirements for a blind rehabilitation specialist and optometrist are complete and the recruitment process has begun. Progress has been made on defining the standards and requirements for the Chief of Staff position as well as initiating the recruitment action. Temporary space has been identified since the testimony of March 17, 2009. VA completed the CONOPS for the registry. It was reviewed by DoD and is being used as a guide to develop a DoD CONOPS for the establishment of the eye registry.

VA has allocated staff to prepare the CONOPS and other requirements documents. Significant VCE and DoD technical approach decisions are pending and ultimately will define our project efforts. VA and DoD maintain close coordination and discussion on the VCE and the structure of the required registry. VA is coordinating care as noted above through BROS, VIST and care coordinators.

Question 12: Will additional funding be requested in the President's FY 2010 budget request for VA to support the Vision Center of Excellence?

Response: VA has no current plans to request additional funding in the President's FY 2010 budget request for the Vision Center of Excellence.

Committee on Veterans' Affairs
Subcommittee on Oversight an Investigations
Washington, DC.
April 22, 2009

Honorable Robert M. Gates
Secretary of Defense
U.S. Department of Defense
1000 Defense Pentagon
Washington, DC 20301

Thank you for the testimony of Jack Smith, M.D., Deputy Assistant Secretary of Defense for Clinical Policy and Programs, U.S. Department of Defense and Colonel

Donald A. Gagliano, USA, M.D., Executive Director for the Military Eye Trauma Center of Excellence, U.S. Department of Defense at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Oversight and Investigations hearing that took place on March 17, 2009 on "The Vision Center for Excellence: What Has Been Accomplished in Thirteen Months?"

Please provide answers to the following questions by June 2, 2009, to Todd Chambers, Legislative Assistant to the Subcommittee on Oversight and Investigation.

1. Plans reported to this Committee in June 2008 by Mr. Michael Dominguez, Principal Deputy Under Secretary for Personnel at DoD, regarding the new Vision Center of Excellence (VCE), included four designated clinical Vision Centers of Excellence at Bethesda NNMC, Brooke Army Medical Center, Madigan Army Medical Center, and Balboa Naval Medical Centers, all military major polytrauma centers. What are the specific staffing, funding, and space costs approved and when will those be implemented?
   a. What are the estimated IT costs for FY09 and FY10?
   b. What are the estimated costs to renovate office space?
   c. What are the cost projections for the Center in FY09, FY10 and FY11?
2. Please provide the numbers of servicemembers with TBI visual impairments that DoD is tracking? Currently, how is data being collected so research or clinical outcomes can be tracked?
3. How much of the $3 million that was obligated from DoD to the VCE has been used?
4. Will additional funding be requested in the President's FY 2010 budget request for DoD to support the Vision Centers of Excellence?
5. VA has already approved the Concept of Operations in January 2009. When will the Department of Defense approve the Concept of Operations? Please provide to the Committee a timeline for execution of the Vision Centers of Excellence with key milestones highlighted.

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers. If you have any questions concerning these questions, please contact Subcommittee on Oversight and Investigations Staff Director, Martin Herbert, at (202) 225–3569 or the Subcommittee Republican Staff Director, Arthur Wu, at (202) 225–3527.

Sincerely,

Harry E. Mitchell
Chairman

David P. Roe
Ranking Republican Member

Questions for the Record

Hon. Harry E. Mitchell, Chairman
Hon. David P. Roe, Ranking Republican Member
House Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
The Vision Center of Excellence: What Has Been Accomplished in 13 Months
March 17, 2009

Question 1: Plans reported to this Committee in June 2008 by Mr. Michael Dominguez, Principal Deputy Under Secretary for Personnel at the Department of Defense (DoD), regarding the new Vision Center of Excellence (VCE), included four designated clinical VCEs at Bethesda national Naval Medical Center (NNMC), Brooke Army Medical Center, Madigan Army Medical Center, and Balboa Naval Medical Centers, all military major polytrauma centers. What are the specific staffing, funding, and space costs approved and when will those be implemented?

Response: Initial plans envisioned a single Vision Center of Excellence (VCE) in Bethesda, with satellite treatment centers. Our vision is still to have the headquarters office of the VCE in the Walter Reed National Military Medical Center (WRNMMC) in Bethesda, alongside the Ophthalmology Clinics and the Refractive Surgery Center. The VCE is developing the Defense and Veterans Eye Injury Registry (DVEIR) to track occurrences and outcomes and it will be accessible to all DoD and Department of Veterans Affairs (VA) polytrauma centers such as Brooke Army Medical Center, Madigan Army Medical Center, and Balboa Naval Medical Centers.

To establish the VCE headquarters, it will cost approximately $4.0 millionth renovate existing spaces at WRNMMC and relocate existing tenants. An additional $0.3

million in initial operations and maintenance costs will be required to purchase equipment and furniture.

The DoD analyzed and reviewed necessary requirements and identified $3 million in funding that was available at the beginning of FY 2009 to commence initial operating activities. Since their selection in November 2008, Colonel Donald Gagliano, Executive Director, and Dr. Claude Cowan, Deputy Director, have made significant progress in strategic and operational planning and identified primary resource requirements. The funding for FY 2009 will be used for personnel, temporary duty (TDY) travel, and equipment.

The VCE is taking steps to ensure members of the Armed Services and veterans who are visually impaired receive appropriate vision rehabilitation quickly and effectively.

Question 1(a): What are the estimated IT costs for FY 2009 and FY 2010?

A portion of the $3 million allocated for the VCE in FY 2009 will be used for DVEIR requirements. The VA allocated $2 million in FY 2009 for the implementation of the DVEIR, including IT support and hardware. The $6.8 million requested for the VCE in the Defense Health Program (DHP) FY 2010 budget includes funding for the VCE IT initiatives.

Question 1(b): What are the estimated costs to renovate office space?

Response: DoD has determined that space at the present NNMC can be renovated to house the VCE, such that it can be collocated with the WRNMMC. This location allows for collaboration and synergies with the vision care providers and patients in the National Capital Region and will allow the VCE to best meet its congressional mandate by being in close proximity to the new National Intrepid Center of Excellence for Traumatic Brain Injury, the National Eye Institute of the National Institutes of Health (NIH), the Uniformed Services University, and the National Military Advanced Training Center, a facility for the reintegration and rehabilitation of injured servicemembers. The current estimate is $4.0 million in military construction the first fiscal year and $0.3 million in operations and maintenance the next fiscal year to outfit the facility.

Question 1(c): What are the cost projections for the Center in FY 2009, FY 2010 and FY 2011?

Response: The DoD identified $3 million in funding during FY 2009 to provide for the VCE's initial operating activities, specifically for personnel, DVEIR support, operational costs, TDY travel, supplies and services necessary for administration and support.

The DoD requested $6.8 million in FY 2010 for the VCE in the DHP budget request, specifically, full-time equivalents to carry out initiatives and support each directorate in the areas of Research and Surveillance, Rehabilitation and Restoration, Informatics and Information Management (the DVEIR), Clinical Care and Global Outreach, and to support the Chief of Staff in operational development and program management activities; maintenance and support for the DVEIR; TDY travel to participate in conferences and perform outreach; and other operational requirements.

Question 2: Please provide the numbers of servicemembers with traumatic brain injury (TBI) visual impairments that the Department of Defense is tracking? Currently, how is data being collected so research or can clinical outcomes be tracked?

Response: The Vision Center of Excellence (VCE) is developing the congressionally mandated Defense and Veterans Eye Injury Registry (DVEIR) to assist in research and data collection to provide accurate statistics. The DVEIR is a critical component of the VCE's plan to meet the needs of our wounded warriors. At this time, there is no standardized way to track information on our servicemembers who have visual impairments and TBI.

The DVEIR is an ongoing project planned under the authority of the VCE Executive Director, Colonel Don Gagliano. The DVEIR will support care coordination for servicemembers and veterans with significant eye injuries and visual dysfunction from TBI and provide statistics necessary to measure longitudinal outcomes. The specific requirements for an interoperable eye injury registry are currently under active development. Once complete, the DVEIR will contain statistics for members of the Armed Forces who incurred an eye injury while serving on active duty on or after September 11, 2001.

Question 3: How much of the $3 million that was obligated from the Department of Defense (DoD) to the Vision Center of Excellence (VCE) has been used?

Response: The DoD analyzed and reviewed the necessary requirements and identified $3 million in funding that was available at the beginning of Fiscal Year (FY) 2009 to commence initial operating activities. VCE leadership has identified primary resource requirements, including personnel, Defense and Veterans Eye Injury Registry, temporary duty travel expenses, equipment, and operational support to appropriately obligate the funding available. Twenty thousand dollars has been obli-

gated to date; however, the VCE is expediting the expenditure of the remaining funds as the resource requirements are now clearly defined. We expect to obligate most of the remaining funds by the third quarter of FY 2009.

Question 4: Will additional funding be requested in the President's Fiscal Year (FY) 2010 budget request for the Department of Defense (DoD) to support the Vision Center of Excellence?

Response: A budget was proposed for FY 2010 through FY 2015 for Vision Center of Excellence (VCE) requirements that included projected costs of VCE personnel, necessary office space and professional equipment, temporary duty travel expenses, Defense and Veterans Eye Injury Registry support, and other operational expenses. The proposal was reviewed by the Wounded, Ill, and Injured Senior Oversight Committee Staff Office and approved by the DoD's senior level review and governance body, the Deputy's Advisory Working Group.

Question 5: The Department of Veterans Affairs (VA) has already approved the Concept of Operations in January 2009. When will the Department of Defense (DoD) approve the Concept of Operations? Please provide to the Committee a timeline for execution of the Vision Center of Excellence (VCE), with key milestones highlighted.

Response: The VCE has taken a leadership role in the development of implementation strategies for the Congressionally mandated Defense and Veterans Eye Injury Registry (DVEIR). The DVEIR will support the coordination of care between the DoD and VA for servicemembers and veterans with significant eye injuries and visual dysfunction traumatic brain injury and provide the data necessary to accurately measure longitudinal outcomes.

An ophthalmology, optometry, and information technology workgroup from the VA and the DoD has been meeting since March 2008 and has developed a Concept of Operations for the DVEIR. The Concept of Operations examines development options and details a recommended approach to implementing the DVEIR. Ongoing coordination efforts between the VCE, DoD, VA, and other established trauma registries will provide further guidance for the refinement of the Joint Concept of Operations and the development and implementation of the DVEIR. The DoD is hosting a meeting with VA in June for further development and implementation of the Joint Concept of Operations and the DVEIR. The DoD estimates the Joint Concept of Operations will be approved by the fourth quarter of Fiscal Year (FY) 2009.

KEY MILESTONES

The DoD and VA established the Congressionally directed VCE in recognition of the increased rate of ocular injuries and visual impairment incurred during Operation Iraqi Freedom and Operation Enduring Freedom conflicts. The VCE has made significant progress to fulfill its mission of improving the health and quality of life for members of the Armed Forces and veterans through advocacy and leadership in the development of initiatives focused on the prevention, diagnosis, mitigation, treatment and rehabilitation of disorders of the visual system. Specifically:

Operations: The VCE directors are developing a plan to align priorities with strategic objectives and establish the foundation of the VCE. The strategic plan is an iterative process that will provide the proper structure needed to fulfill the VCE's mission with maximum efficiency and emphasize its importance. This comprehensive approach will consider VCE requirements, National Defense Authorization Act mandates, and industry best practices. Creation of the VCE strategy is moving forward with the development of drafts of the VCE Charter and the DoD Directive. The documents have been sent forward for approval. These governance documents will identify the high-level roles of the VCE and are required to ensure funding, manpower, and the future development of the VCE.

As part of the strategic planning efforts, the VCE will finalize position descriptions for the initial hiring actions for submission and approval by the third quarter of FY 2009.

DVEIR: The DVEIR will provide data necessary to measure rates of injuries and longitudinal outcomes. This will support the VCE efforts to ensure the ongoing improvement in care and care processes and to foster consistency across the entire continuum of care. As mentioned before, the Joint DVEIR workgroup will finalize a joint strategy for the DVEIR and Joint Concept of Operations by the fourth quarter of FY 2009. The DoD is hosting a meeting with the VA in June for further development and implementation of the Joint Concept of Operations and the DVEIR.

Research and Surveillance: VCE leadership established research priorities for the Congressional Special Interest Vision Research Programs and the Congressionally directed Medical Research Program through collaboration with health professionals from the DoD, VA, National Institutes of Health (NIH), Food and Drug Administration, other Federal health entities, and the private sector. Grant funding will be awarded based on those priorities. In June 2009, the VCE Executive Director

is hosting the Vision Research Scientific Steering Committee meeting to finalize the Request for Proposal announcements for the FY 2009 Congressional Special Interest Vision Research Program grants. The VCE will continue to work with DoD, VA, and other external entities to move research forward and assist those in need.

Outreach: VCE staff members interact with visually impaired warriors and veterans to identify unaddressed needs and help close those gaps. Colonel Don Gagliano and Dr. Cowan have visited wounded warriors and veterans at Walter Reed National Military Medical Center (WRNMMC) and other vision care centers and listened to their concerns and experiences. VCE leadership has solicited input from other centers of excellence, related Federal health agencies, multiple vision/veterans advocacy organizations, and affected members of the Armed Services and veterans for the VCE way ahead. VCE leadership has participated in numerous meetings and conferences on visual impairment for warriors, including the Defense Centers of Excellence Strategic Planning Summit. The VCE Executive Director was appointed as the DoD ex officio member of the NIH National Eye Advisory Council, which will further expand the VCE's outreach efforts. Additionally, the VCE is coordinating with the VA Blind Rehabilitation Service to establish a Memorandum of Understanding.

Rehabilitation and Restoration: A process was developed for collaboration between the VA and Walter Reed Army Medical Center for blind rehabilitation care while servicemembers are still receiving care from the DoD. Efforts are underway to establish this collaboration across other vision centers to enhance the continuum of care and better integrate seamless care across the DoD and VA for vision rehabilitation.

Facilities: The VCE acquired short-term space near the TRICARE Management Activity Headquarters in Falls Church, VA, to begin initial operations and is working to secure funding for a long-term facility in WRNMMC. The $4.052 million military construction (MILCON) project was not finalized in time to be included in the FY 2010 medical MILCON budget and will now be considered for the FY 2011 MILCON budget.