



**TESTIMONY
PRESENTED BY**

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BVA NATIONAL PRESIDENT**

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



MARCH 3, 2021

INTRODUCTION

Chairman Tester, Chairman Takano, Ranking Member Moran, Ranking Member Bost, and distinguished Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) and its membership, we appreciate this opportunity to present our legislative priorities for 2021. As the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our nation's blinded veterans and their families, BVA first wishes to highlight "National Blinded Veterans Day," which occurs March 28. The day coincides with the 76th anniversary of the organization's founding by World War II blinded Army service members at Avon Old Farms Convalescent Hospital in Connecticut in 1945.

BVA appreciates the bipartisan support these committees demonstrated in passing three key bills: H.R. 3504 (*Ryan Kules and Paul Benne Specially Adaptive Housing Improvement Act of 2019*), H.R. 4920 (*Department of Veterans Affairs Contracting Preference Consistency Act of 2020*), and S. 3587 (*Department of Veterans Affairs Website Accessibility Act of 2019*). We sincerely thank all members for their continued support of blinded and visually impaired veterans.

BVA hopes that this first session of the 117th Congress will proactively address the following legislative priorities:

- I. Call upon Congress, the Department of Veterans Affairs (VA), and the Department of Defense (DoD) to request that the Assistant Secretary of Defense for Health Affairs (ASDHA) work with the United Kingdom (UK) Minister of Defence to provide funding for the Joint Ocular Trauma Task Group (JOTTG) established by mutual formal agreement on September 29, 2020;
- II. Request that the *National Defense Authorization Act* (NDAA) of Fiscal Year 2022 (FY22) include a mandate that the DoD Defense Health Agency (DHA) comply with Section 703 of the NDAA (Public Law 114-328) of FY17 requesting the designation of four ocular trauma specialty centers;
- III. Request FY22 appropriations of \$30 million for the DoD Congressionally Directed Medical Research Program (CDMRP) Vision Research Program (VRP), strengthening the "ONLY" research program focused on prevention and treatment of combat-related ocular trauma and Traumatic Brain Injury (TBI) visual dysfunction;
- IV. Support adequate funding of Veterans Health Administration (VHA) Blind Rehabilitation Service (BRS);
- V. Request that the VA auto grant for service-connected blinded veterans have a renewal period of every ten years;
- VI. Support the continued improvement of programs and services for women veterans;
- VII. Ensure that VA implement caregiver benefits for catastrophically "blinded" disabled veterans, mandating the modification of eligibility criteria regarding "Activities of Daily Living" to include caregivers for blinded veterans;
- VIII. Request the enactment of adequate protections for guide dogs and service dogs on federal properties;
- IX. Support the FY22-23 Independent Budget recommendations for Prosthetics and Sensory Aids;
- X. Support oversight of VA compliance with accessibility requirements.

I. ESTABLISHING A JOINT INTERNATIONAL OCULAR TRAUMA TASK GROUP (JOTTG)

In 2017, Assistant Secretary of Defense for Health Affairs (ASDHA) Thomas McCaffery signed a Joint United States (US) - United Kingdom (UK) Task Force Charter establishing an international partnership to advance interoperability between the allied military medical services. This reaffirmed the partners' commitment to mutually advancing medical care in defense of global interests by sharing information and developing opportunities for combined training and collaborative research. BVA and Blind Veterans UK subsequently met with senior UK Defence medical officials in London and the British Embassy in Washington, DC, both of whom expressed a strong desire to establish officially a dedicated Joint Ocular Trauma Task Group (JOTTG) to advance combat ocular trauma care, rehabilitation, and vision research under this partnership. On September 29, the ASDHA and UK Surgeon General both agreed to approve this historic JOTTG, supporting this strategic initiative between allies to preserve sight.

Ocular casualties account for approximately 14.9 percent of combat casualties, with a higher incidence during increased combat activity. Moreover, the Department of Veterans Affairs (VA) reports that upwards of 70 percent of Traumatic Brain Injury (TBI) patients suffer from visual symptoms. The legendary British-American military cooperation, developed over a century of shared battlefield experience, has led to a unique level of interoperability and familiarity. This extends to ocular casualty care, beginning with early battlefield treatment guidance provided by the UK in World War I and blind rehabilitation programs at St. Dunstan's for US casualties in World War II. This level of cooperation continues today but largely through individual, unofficial efforts due to lack of DoD/VA funding and support staff for the chairpersons, who are both UK and US military ophthalmologist consultants. For example, several key publications reflect joint authorship; prior research symposia included joint participants; and, during a 2019 six-month partnership, a UK-US ophthalmology team delivered ocular trauma care in Afghanistan, offering one of the most active clinical specialties. Ocular trauma care affects not only military members but also first responders—fire, police, EMTs—on a daily basis. Leadership within DoD/Defense Health Agency (DHA) policy levels should fully support funding and staffing as the incidence of eye injuries during the past 100 years of warfare is only increasing.

The *2019 John S. McCain National Defense Appropriations Act (NDAA)*, Public Law 115-232, requires DoD to provide a strategic medical research plan that describes its medical research focus areas and medical research projects. It details coordination processes across defense medical research and development (R&D) to ensure alignment with mission, promote synergy, address gaps, and minimize duplication. Public Law 115-232 also outlines efforts to coordinate with other departments and agencies of the federal government. DoD's response was sent to congressional committees on April 8, 2019.

In summary, the report identifies the need for agility and responsiveness across all levels and types of medical care and requires an R&D strategy that is nimble, responsive, and attuned to the emerging needs of the warfighter. The report is part of national strategic guidance and capitalizes on opportunities in science and medical technology. It also requires partnerships at home and abroad. This strategy offers a common framework to ensure that DoD continues to discover, develop, and deliver the medical capabilities required today and in the future. It provides the basis on which to optimize infrastructure, coordination, and information exchange among the services and defense agencies across DoD, federal interagency, and the civilian sector to continue to be responsive to both contemporary medical readiness requirements and future needs of the wounded or injured warfighter.

BVA requests that these Committees provide oversight on the support for the JOTTG and ensure specific objectives to identify opportunities for enhancing interoperability between the US and UK in ocular combat casualty care. BVA believes that the JOTTG will improve prevention, diagnosis, mitigation, treatment, rehabilitation, and reintegration of ocular injuries and TBI-associated vision loss. It would also enhance vision research exchanges. This initiative also seeks to improve civilian ocular trauma care through migration of military lessons learned, particularly regarding issues facing first responders and non-ophthalmic providers in civilian disasters or acts of terrorism, resulting in improved emergency medical services and vision trauma outcomes.

II. DESIGNATING FOUR OCULAR TRAUMA CENTERS

The enacted *FY17 National Defense Authorization Act (NDAA), Section 703*, directed the Secretary of Defense (SECDEF) to “designate a medical center as a regional center of excellence for unique and highly specialized health care services.” Although ocular injuries clearly meet that definition, no ocular injury Military Treatment Facilities (MTFs) were ever identified by DHA as designated specialized care centers to provide for improved eye injury care. The current result is that there are no DoD requirements for eye injuries to be referred to specialty treatment centers for evaluation, treatment, care coordination, vision research, or rehabilitation for military wounded personnel.

Designating four ocular trauma centers should have been accomplished more than two years ago as mandated, along with the strengthening of clinical coordination between DoD and VHA. These ocular trauma centers are important in the development of bidirectional longitudinal vision joint injury registries in cooperation with the Joint Trauma Theater Registry with up-to-date information on the diagnosis, treatment, medical evacuation, and follow-up evaluations for ocular wounded personnel. BVA points to Secretary of Defense Bill Gates’ Quadrennial Defense Report in 2010. The priorities outlined in that report included eye injury centers of excellence in MTFs along with hearing injury Centers of Excellence.¹

Ocular injuries are characterized by complex poly-trauma wherein multiple delicate eye structures are injured and remain at long-term risk. These injuries are best treated by a coordinated team of highly trained ocular subspecialists and require close follow-up, particularly when they accompany other systemic poly-trauma.

BVA requests that the FY22 NDAA include specific language to mandate that DHA shall designate four ocular trauma specialty MTFs.

III. FUNDING VISION RESEARCH

The Vision Research Program (VRP) was established by Congress in FY09 to fund impactful, military-relevant vision research with the potential to significantly improve the health care and well-being of service members, veterans, caregivers, and the American public. The VRP’s program area had previously aligned with the sensory systems task area of the JPC-8 Clinical and Rehabilitative Medicine Research

¹ **DOD Quadrennial Defense Report**, “Establishment of Eye Injury Centers,” February 1, 2010, p. 3.

Program (CRM RP), a core research program of DHA, but this program was merged into the JPC-5/MOMRP resulting in less funding for deployment related injuries.

Eye injury and visual dysfunction resulting from battlefield trauma affect many service members and veterans. Surveillance data from DoD indicate that eye injuries account for approximately 14.9 percent of all injuries from battlefield trauma sustained during the wars in Afghanistan and Iraq, resulting in more than 182,000 ambulatory patients and 4,000 hospitalizations. In addition, TBI, which has affected more than 413,898 service members between 2000 and 2019, can have significant impact on vision, even when there is no injury to the eye.

Research sponsored by VA showed that as many as 75 percent of service members who had suffered a TBI had visual dysfunction. The VA Office of Public Health has reported that, for the period October 2001 through June 30, 2015, the total number of Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) veterans with vision problems who were enrolled in VA totaled 211,350. This number included 21,513 retinal and choroidal hemorrhage injuries (retinal detachments are part of this category); 5,293 optic nerve pathway disorders; 12,717 corneal conditions; and 27,880 with traumatic cataracts. VA continues to see increased enrollment of this generation with various eye and vision disorders resulting from complications of frequent blast-related injuries.

VA data also revealed a rising number of total Post-9/11 veterans with TBI visually impaired “ICD-10 Codes” enrolled in the VHA system. In FY13, there were 39,908 enrollees identifying with symptoms of visual disturbances, and by FY15 those numbers increased to 66,968. Based on recent data (2000-2017) compiled by the TBI Defense Veterans Brain Injury Center (DVBIC), the reported incidence of TBI without eye injury with clinical visual impairment is estimated to be 76,900.

A January 2019 *Military Medicine* journal article, based on a 2018 study by the Alliance for Eye and Vision Research that used prior published data during 2000-2017, has estimated that deployment-related eye injuries and blindness have cost the US \$41.5 billion during that time frame. Some \$40.2 billion of that cost reflects present value of a lifetime of long-term benefits, lost wages, and family care.

On April 3, 2019, former DHA Director Vice Admiral Raquel Bono testified before the House Subcommittee on Defense (HACD), stressing the need for “specific research programs supporting efforts in combat casualty care, TBI, psychological health, extremity injuries, burns, vision, hearing and other medical challenges that are militarily relevant and support the warfighter.” This budget request proposes increased funding for battlefield injury research and establishes a permanent baseline for our mission-essential research.

Of note, CDMRP appropriations that fund this critical extramural vision research into deployment-related vision trauma is not currently conducted by VA, or elsewhere within DoD, including within the Joint DoD/VA Vision Center of Excellence (VCE). To meet the shortage of VRP funding, the National Eye Institute (NEI) within the National Institutes of Health (NIH) funds only two VRP grants each year. Additionally, DoD continues to identify gaps in its ability to treat various ocular blast injuries. Thus, this funding is critical to meeting those challenges.

Previously, the US Army Medical Research and Materiel Command (USAMRMC) maintained an ocular health research portfolio, the goal of which was to “improve the health and readiness of military personnel affected by ocular injuries and vision dysfunction by identifying clinical needs and addressing

them through directed joint medical research.” For more than two decades, the USAMRMC has held the only DoD J-09 internally funded active military Ocular Trauma Research Lab, located in San Antonio, Texas. BVA is alarmed that core internal funding is being shifted to other DoD research, leaving a larger gap in funding deployment-related vision injury research for our wounded service members.

Specific topics of interest in the portfolio included:

- Validated models to inform deployed treatment officials of blast ocular injuries and TBI-related visual dysfunction.
- Prolonged field-care and critical-care capabilities.
- Portable diagnostic tools for TBI vision dysfunction or penetrating injuries.
- Decision aids for unit-level, MEDEVAC en-route, and MTF care.
- Deployable ocular trauma medical treatment packages.
- Research into vision prosthetics and vision restoration devices.
- High energy weapons systems and ocular injuries.
- Regenerative medical techniques.

Most of the goals surrounding the research are also germane to international military forces. Progress on reaching those goals would be enhanced by combat experience and cooperative research with BVA’s UK allies through the JOTTG and other professional eye care organizations.

In its history, the VRP has funded two types of awards: hypothesis-generating, which investigates the mechanisms of corneal and retinal protection, corneal healing, and visual dysfunction resulting from TBIs; and translational/clinical research, which facilitates development of diagnostics, treatments, and therapies especially designed for rapid battlefield application.

CDMRP VRP funding has produced and/or developed:

- An “ocular patch,” which is a nanotechnology-derived reversible glue that seals lacerations and perforations of the eye on the battlefield, protecting it while a soldier is transported to a more robust medical facility where trained ocular surgeons can properly suture the globe.
- A validated computational model of the human eye globe to investigate injury mechanisms of a primary blast wave from an Improvised Explosive Device (IED), which has accounted for 70 percent of the blast injuries in Iraq and Afghanistan. The model determines the stresses on and deformations to the eye globe and surrounding supporting structures to enable DoD to develop more effective eye protection strategies.
- A vision enhancement system that uses modern mobile computing and wireless technology, coupled with novel computer vision (object recognition programs) and human-computer interfacing strategies, to assist visually impaired veterans undergoing vision rehabilitation to navigate, find objects of interest, and interact with people.
- A portable, hand-held device to analyze the pupil’s reaction to light, enabling rapid diagnosis of TBI-related visual dysfunction.
- 21 patents and patent applications.
- 12 clinical trials funded by the VRP and/or based on the results of VRP-funded projects.
- 216 peer-reviewed publications in highly respected scientific journals.

BVA believes the priority in DoD research is to “save life, limb, and eyesight,” which has been the motto of military medicine for decades. Therefore, along with other VSOs and MSOs, BVA respectfully requests that you support funding of the DoD/VRP Peer Reviewed Medical Research Program for extramural translational battlefield vision research in the amount of \$30 million for FY22.

IV. FUNDING BLIND REHABILITATION

In October 2020, VHA implemented a new Continuum of Care for visually impaired veterans resulting in 81,583 low-vision and legally blinded veterans comprising VIST Coordinator case management rosters. VHA research studies estimate that there are 131,580 legally blinded veterans living in the US. VHA projections indicate that there are another 1.5 million low-vision veterans in the US with visual acuity of 20/70 or worse.

VA currently operates 13 residential Blind Rehabilitation Centers (BRCs) across the country. These BRCs provide the ideal environment in which to maximize the rehabilitation of our nation’s blinded veterans. Unfortunately, Veterans Integrated Service Network (VISN) and VA Medical Center (VAMC) Directors at some sites housing BRCs are failing to replace BRC staff who retire or transfer to other facilities, thus failing to support congressionally mandated maintenance of staffing at previous levels. During the COVID-19 surge, all 13 BRCs were closed as beds were reallocated for alternative needs. As a result, rehabilitation training for blinded veterans went entirely virtual, accompanied by telehealth care. Consequently, many BRCs lack the staffing needed to help blinded veterans obtain the essential adaptive skills they require to overcome the many social and physical challenges of blindness. Without intervention, we fear that the number of BRCs in this situation will grow. Spinal Cord Rehabilitation has dedicated funding for this express purpose. Modeling BRS funding after this manner would ensure such excellence in care. VAMC Directors should not be allowed to divert BRC Full-Time Equivalents (FTEs) or funds designated by the Veterans Equitable Resource Allocation (VERA) System for these rehabilitation admissions from the blind centers to other general medical operations.

BVA is also concerned about the caseloads of VIST Coordinators and Blind Rehabilitation Outpatient Specialists (BROS). Now that the national caseload has doubled from approximately 40,000 to more than 80,000 visually impaired veterans, their capacity to meet the needs of assigned caseloads is now in doubt. BVA requests that VHA conduct a resource/demand gap analysis to identify VISTS and BROS whose caseloads are now over-capacity. The creation and staffing of additional VIST and BROS positions may be necessary to adequately address the needs of these additional 40,000 visually impaired veterans.

BVA is further concerned that community care funding contracted under the auspices of the VA MISSION Act will take funds away from VA BRCs. BVA holds that VHA must maintain the current bed capacity and full staffing levels in the BRCs that existed at the time of passage of the “Veterans’ Health Care Reform Act of 1996” (Public Law 104-262).

BVA calls on Congress to conduct oversight ensuring VHA is meeting capacity requirements within the recognized systems of specialized care in accordance with Public Law 104-262 and the “Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act of 2017,” (Public Law 114-223). Despite repeated warnings about these capacity problems, Congress has conducted minimal oversight on VA’s ability to deliver specialized health care services.

BVA requests that if VA does contract with private agencies to provide rehabilitation training to blinded veterans, VA should ensure that the private agencies with which it contracts have a demonstrated capacity to meet the peer reviewed quality outcome measurements that are a standard part of VHA BRS. We further recommend that VA require private agencies with which it contracts to be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Impaired (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Additionally, VA should require those agencies to provide veterans with instructors certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

An agency should not be used to train newly blinded combat veterans unless it can provide clinical outcome studies, evidence-based practice guidelines, mental health care counseling, and joint peer reviewed vision research. BVA also supports the FY19 Independent Budget Veterans Service Organizations Independent Budget (IBVSO) recommendation mandating that competency standards for non-VA community providers be equivalent to standards expected of VA providers, and that non-VA providers meet continuing education requirements to fill gaps in knowledge about veteran-specific conditions and military culture.

Private agencies for the blind lack the necessary specialized nursing, physical therapy, pain management, audiology, speech pathology, pharmacy, and radiology support services that are available at VA BRCs because they are located adjacent to VAMCs. In addition, most private agencies are outpatient centers located in major cities, making access for blinded veterans from rural areas difficult, if not impossible. In many rural states, there are no private inpatient blind training centers at all. Therefore, the availability of an adequately funded and staffed VA BRC is the only option. Veterans from rural areas should not be compelled to utilize alternative facilities when VHA BRS has the capacity to ensure that they have access to a program at a facility that is adequately staffed and funded.

V. SUPPORTING VETERAN TRANSPORTATION

VA currently operates 154 VAMCs and an additional 850 Community Based Outpatient Clinics (CBOCs) located in rural areas. Despite this, accessible transportation options remain a persistent problem for blinded veterans who live in rural areas and have either no options or very limited ones for getting to and from medical appointments. Blinded veterans cannot drive themselves and, for many, finding someone to drive them presents a major barrier to keeping their medical appointments. Regrettably, access to health care for rural blinded veterans remains an issue, particularly as these veterans age, as their disability worsens, or as they lose their family caregivers. Transportation has become one of the most pressing issues for rural blinded veterans. Beneficiary travel funds reimburse eligible veterans for part of their travel expenses, but the reimbursement depends upon the veteran finding an able and available driver and vehicle.

BVA supports the recommendation by the IBVSO that Congress authorize a supplementary automobile grant to eligible veterans, including eligible blinded veterans, every 10 years. BVA advocates that this grant be renewable in the amount equaling 100 percent of the current grant maximum in effect at the time of vehicle replacement, which maintains the efficacy of this vital benefit. Currently, Congress authorizes VA to provide a one-time auto grant to eligible veterans worth \$21,488. Blinded veterans with

certain disabilities that have resulted from a condition incurred or aggravated during active military service can use this grant toward the purchase of a new or used automobile.

Unfortunately, the cost of replacing vehicles purchased through the VA automobile grant program presents a financial hardship for blinded veterans. Currently, after the one-time grant, the veteran must then bear the full replacement cost once the adapted vehicle has exceeded its useful life. The divergence of a vehicle's depreciating value, the intense burden the veteran's disability places on this vehicle, and the increasing cost of living only compounds this hardship. In order to mitigate this hardship, BVA supports the enactment of a renewable automobile grant for eligible veterans that amounts to 100 percent of the funded amount at the time the grant is renewed.

BVA also urges legislative changes to eliminate partial forfeitures of the automobile grant. Currently, any unused amount of the automobile grant is forfeited if the veteran purchases a vehicle for less than the full grant amount. Part of the automobile grant is also forfeited if the veteran partially finances the vehicle and the cash due amount in the sales contract is less than the full grant amount. As a matter of equity and fairness, these unused amounts should be available to the veteran to apply to the principal balance of their car loan or be available for a future vehicle purchase. Veterans should not be forced to forfeit part of their automobile grant.

VI. SUPPORTING WOMEN VETERANS

BVA applauds the bipartisan support women veteran issues received in the 116th Congress and looks forward to that continued support in the 117th. The passage of the *Deborah Sampson Act* was a great victory for women veterans in the fight for equality of care at the Department of Veterans Affairs (VA), but there are still many concerns that BVA urges Congress to address in the upcoming session.

BVA fully supports the IBVSO FY22 recommended appropriations of an additional \$200 million for women veterans. The IBVSO recommends that \$120 million of the \$200 million go to women veteran's medical services as follows:

- \$100 million to hire the staff necessary to develop additional women's comprehensive care centers (doctors, nurses, care coordinators, peer support specialists, and administrative support); to ensure that care coordinators are available at every VAMC that lacks in-house mammography or cervical care; and to hire sufficient Women Veterans Program Managers to ensure adequate coverage at each network and medical center. This funding should also be used to support training to ensure that designated women's health providers who meet VHA practice standards are available at each VA medical facility.
- \$20 million to develop strategic plans for women veterans throughout VA, which must include appropriate training as well as consultation and awareness of these plans by key staff within each service line such as mental health, pain management/ anesthesiology, and cardiology. In addition to the above, the IBVSO has specific FY22 recommendations in other VA accounts related to VA medical facilities, research, and organizational culture to improve access for women and minority veterans that BVA supports.

BVA recommends stronger support for survivors of Military Sexual Trauma (MST), as well as greater oversight of VA's handling of MST claims to ensure that they are handled with sensitivity and fairness, as well as promptness. While MST is not exclusively a women's issue, it commonly affects women service members and veterans in greater numbers. It is also an issue that has been swept under the rug for too long. BVA urges members of Congress to continue working alongside VA to increase accountability regarding MST care needs and claims processes.

VII. SUPPORTING CAREGIVER PROGRAM EXPANSION

In October 2020, VA began the first phase of its Caregiver Assistance Program expansion to veterans who were severely injured or became ill on May 7, 1975, or earlier, finally providing this long-overdue benefit to thousands of World War II, Korean, and Vietnam War veterans and their family caregivers. However, this one-year delay means that the second phase of the expansion mandated by the VA MISSION Act would begin a year later than the law required on October 1, 2022. As discussed in the IBVSO, BVA believes that Congress must amend the statute to begin the second phase of the caregiver program expansion no later than October 1, 2021, as intended.

BVA therefore recommends an additional \$73 million to hire approximately 700 FTEs and \$361 million to cover the cost of stipends and other benefits for these newly eligible caregivers.

VIII. PROTECTING GUIDE AND SERVICE DOGS

Guide and service dogs are critical to blind, visually impaired, and other disabled veterans working toward regaining lost independence. Guide and service dogs assist blind or disabled veterans with mobility, retrieving objects, balance, and several other vital tasks. Training guide and service dogs to perform their jobs costs upwards of \$50,000 and can take up to two years to complete. Many prospective guide and service dogs do not complete the training, making successful guide and service dogs (approximately one in ten) incredibly valuable. BVA is concerned about the safety of these guide and service dogs while on federal properties. Uncertified and often untrained support animals pose a direct threat to guide and service dogs as well as disabled veterans depending on their dog for assistance. Since 2016, there has been an 84 percent spike in reported support animal incidents to include urination, defecation, and biting. This additional threat to both veteran and service animal poses health and financial risks as the costly, lengthy, and rigorous training that the animals undergo becomes less apparent to the uninformed public, which perceives as the same the rigorously trained service animal and the poorly trained support animal. The Department of Transportation (DOT) recently released a new ruling regarding service animals on airplanes. According to the rule, emotional support animals are no longer considered to be a service animal. Airlines may require travelers with service animals to provide forms developed by DOT attesting to the dog's training, health, and behavior. Implementing policies such as DOT's at VA facilities would offer a greater level of protection for guide and service dogs, as well as for their handlers and other veterans.

BVA strongly urges VA to implement stricter guidelines for animals eligible for entrance onto VA properties and to ensure the standardization across all facilities. BVA also suggests implementing training policies for VA employees on guide and service dog etiquette to increase the safety of the dogs and their

handlers while also raising awareness. BVA also requests a dedicated guide dog champion at the Veterans Affairs Central Office (VACO) and at each VAMC. The addition of these champions can ensure proper training and understanding through Standard Operating Procedures as to the expectations, roles, and responsibilities of a service animal as well as to ensure uniformity and equal treatment across locations.

IX. SUPPORTING PROSTHETICS AND SENSORY AIDS

In FY20, VA requested approximately \$3.9 billion for the Office of Prosthetic and Sensory Aid Service (PSAS) to provide prosthetic and orthotic services, sensory aids, medical equipment, and support services to veterans. However, due to the impact of the COVID-19 pandemic, many veterans deferred needed services. Therefore, actual obligations in FY20 may have been closer to \$3.5 billion. In FY21, VA requested \$4.1 billion for PSAS, which together with carryover from FY20 should be sufficient considering the continued impact of the pandemic, notwithstanding the increased needs of the disabled veteran population served by VA. For FY22, the enacted advance appropriation for PSAS was \$4.4 billion. BVA believes there will be significant deferred care and pent-up demand that manifests itself in FY22; however, the organization also anticipates significant carryover from FY21 and does not call for additional funding in FY22. BVA urges that VA and Congress carefully monitor this account to determine if supplemental appropriations may be required to meet demand.

BVA has received reports from blinded veterans who have attended rehabilitation training from certified instructors, only to experience extended delays in the delivery of the prescribed prosthetics devices. In some cases, they were denied these devices at the local prosthetic department. BVA requests that a prosthetics device prescribed by a VIST, BROS, or other BRS specialist be furnished more promptly.

X. OVERSEEING COMPLIANCE WITH ACCESSIBILITY REQUIREMENTS

BVA thanks Congress for its continued support of our nation's blind and visually impaired veterans, demonstrated most recently by the passage of S. 3587, the *VA Website Accessibility Act of 2019*. This bipartisan legislation directs VA to report to Congress on the accessibility of VA websites (including attached files and web-based applications) to individuals with disabilities. BVA requests that there continue to be strong oversight and transparency on VA's progress of updating websites, files, and applications that are still inaccessible to such individuals. The organization is discouraged to learn that platforms such as SharePoint, used throughout the VA enterprise, and other similar platforms are not being addressed by this review. Additionally, we are equally disheartened to learn that VA will take several years to address accessibility issues with respect to the check-in kiosks at VA facilities. BVA believes these challenges will continue until accessible communications becomes a top priority for VA's entire senior leadership.

CONCLUSION

Once again, Chairman Tester, Chairman Takano, Ranking Member Moran, Ranking Member Bost, and all Committee members, thank you for the opportunity to present to you today the legislative priorities of

the Blinded Veterans Association. We look forward to furthering our relationships and working with you productively during these challenging times.

THOMAS ZAMPIERI BIOGRAPHY

BVA National President

Dr. Thomas Zampieri served on active duty as an Army Medic from September 1972 until September 1975. He completed this service at the rank of Sergeant. After graduating from Hahnemann Medical University's Physician Assistant Program in June 1978, he enlisted in July 1978 in the Army National Guard. He retired in 2000 as a Major after 21 years of honorable service. His service included 13 years as a Military Aeromedical Flight Surgeon, logging more than 600 hours of flight operations.

As a civilian, he obtained a Bachelor of Science Degree from the State University of New York and graduated with a Master's Degree in Political Science from the University of St. Thomas in Houston, Texas in 2003. Dr. Zampieri completed his Political Science Ph.D. at Lacrosse University in December 2005. He was employed on April 20, 2005 as the Director of Government Relations for the Blinded Veterans Association, presenting testimonies before U.S. Congressional Committees on a variety of veterans' issues prior to his retirement on November 22, 2013.

Dr. Zampieri was appointed in January 2014 to fill a vacancy on the Association's Board of Directors as District Director of the Texas region and was later elected Vice President of BVA in August 2018. On January 29, 2019, he assumed the office of President of BVA following the resignation of the President at the time. In August 2019, he was elected National President of BVA with a full two-year term. He is also Chairman of the Association's Government Relations and Legislative Committee.

Dr. Zampieri has five percent vision in both eyes resulting from degenerative retinal disease. He has volunteered since 2010 in planning an award-winning international exchange program with the Blind Veterans UK known as Project Gemini. He has organized briefings with senior defense medical officials concerning military eye injuries, blast traumatic brain injuries with vision dysfunction, defense vision trauma research program, and rehabilitation services with the DoD, VA, and UK officials. He is also a member of the Academy of Political Science.