UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

FEB 21 2023

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's response to House Report 117–118, pages 180-181, accompanying H.R. 4350, the National Defense Authorization Act for Fiscal Year (FY) 2022, "Ocular Trauma Specialized Care," is enclosed.

The report reflects input from the Army, Navy, and Air Force Ophthalmology and Optometry Medical Services and summarizes the feasibility analysis, which resulted in the establishment of four Defense Health Agency market locations for establishing regional Ocular Trauma Centers within the Military Health System. The Ophthalmology and Optometry Medical Services met all national defense strategy scenarios with FY 2022 warfighter readiness, staffing requirements, and capabilities for ocular trauma and vision care, including training and Graduate Medical Education.

Thank you for your continued strong support for the health and well-being of our Service members, veterans, and their families. I am sending a similar letter to the Committee on Armed Services of the House of Representatives.

Sincerely,

Gilbert R. Cisneros, Jr.

cc:
The Honorable Roger F. Wicker
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

FEB 21 2023

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Thank you for your continued strong support for the health and well-being of our Service members, veterans, and their families. I am sending a similar letter to the Committee on Armed Services of the Senate.

Sincerely,

Gilbert R. Cisneros, Jr.

cc:
The Honorable Adam Smith
Ranking Member

Report to the Congressional Armed Services Committees

Ocular Trauma Specialized Care

February 2023

The estimated cost of this report for the Department of Defense (DoD) is approximately $53,000.00 for Fiscal Years 2021–2022. This includes $0.00 in expenses and $53,000.00 in DoD labor.

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EXECUTIVE SUMMARY

This report is in response to House Report 117–118, pages 180-181, accompanying H.R. 4350, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2022, which requests that the Secretary of Defense, in coordination with the Chairman of the Joint Chiefs of Staff and the Secretaries of the Military Departments, submit a report to the Committees on Armed Services of the Senate and the House of Representatives on ocular trauma specialized care. House Report 117–118 requests that the report include the following:

1) A review of medical manpower warfighter readiness, requirements, and capabilities for vision trauma and ocular care to include training and Graduate Medical Education (GME) as they relate to all national defense strategy scenarios.

2) Any planned military medical manning divestitures in all areas of ocular to include sensory injuries with ophthalmology and optometry requirements by Service and location.

3) The feasibility of establishing at least four regional medical hubs for enhanced treatment of ocular trauma and traumatic brain injury (TBI) vision dysfunction injuries with the hubs associated with a major military medical center as the primary center for providing specialized medical services in that region and co-located with major aerial debarkation points within the medical evacuation system.

4) An analysis of access standards and funding for ocular services over the last 5 years in both the direct care system and purchased care.

The report further states, "The [House Armed Services Committee] understands the goals of the Department of Defense [DoD] Vision Center of Excellence [VCE] are to improve vision health, optimize readiness, and enhance quality of life for [S]ervice members and veterans. However, the committee is concerned that recent medical manning divestitures taken on by the military medical departments of the [S]ervices may adversely impact the availability of ocular services throughout the DoD."

The Army, Navy, and Air Force Ophthalmology and Optometry Medical Services met all national defense strategy scenarios with FY 2022 warfighter readiness, staffing requirements, and capabilities for ocular trauma and vision care, including training and GME. The Department will address information regarding national defense strategy scenarios and any planned military medical manning divestitures in a future response, pursuant to the requirements in section 741 of the James M. Inhofe NDAA for FY 2023.

The Defense Health Agency (DHA) VCE conducted a feasibility study regarding the establishment of regional centers to address the comprehensive treatment of ocular trauma and TBI vision dysfunction injuries. Initial analysis demonstrated the capabilities, staffing, infrastructure, standardization, and numbers of centers for the treatment of "ocular trauma" would differ from the care necessary to treat "traumatic brain injury vision dysfunction injuries." Following its analysis, the VCE identified the following four DHA market locations for establishing regional Ocular Trauma Centers (OTCs) within the Military Health System (MHS): 1) Brooke Army Medical Center (BAMC)/Wilford Hall Ambulatory Surgical Center (WHASC);

2) Walter Reed National Military Medical Center (WRNMMC)/Fort Belvoir Community Hospital (FBCH); 3) Madigan Army Medical Center (MAMC); and 4) Naval Medical Center San Diego (NMCSD). In November 2022, the Director, DHA formally established the four OTCs to address the "enhanced treatment of ocular trauma" under clearly defined metrics of performance and effectiveness. Future efforts will also include coordination with the Department of Veterans Affairs (VA) and partner civilian rehabilitation centers to augment DoD low vision care for Service members, veterans, retirees, and beneficiaries at each OTC. Additional analysis of the proposed regional centers for the "enhanced treatment of traumatic brain injury vision dysfunction injuries" (i.e., Centers for Visual Dysfunction associated with TBI) determined these sites should be co-located with (or in close proximity to) the National Intrepid Center of Excellence (NICoE) and the Intrepid Spirit Centers (ISCs). The Centers for Visual Dysfunction associated with TBI will be established under the auspices of the NICoE and the DHA Deputy Assistant Director for Medical Affairs (DAD-MA) Neuro-Musculoskeletal Clinical Community. As needed, the DHA TBI Center of Excellence (TBICoE) and TBI Advisory Committee (TAC) will provide consultation support to properly assess and treat Visual Dysfunction associated with TBI (VDTBI). Developing and implementing the appropriate capabilities, infrastructure, clinical procedural standardization, and staffing (e.g., optometrists trained in a Federal DoD or VA optometric residency in Vision Rehabilitation with emphasis in Brain Injury Rehabilitation) will need to occur prior to initial operating capability (IOC) for the Centers for Visual Dysfunction associated with TBI.

During FY 2016-FY 2021, all direct care facilities managed average initial appointment wait times within the 28-day specialty care expectation. The average wait time for an initial ophthalmology visit in 2016 was 12.9 days and this wait time remained stable through FY 2021 (13.5 days). Average wait times for initial optometry appointments were 7.7 days in FY 2016 and 10.9 days in FY 2021. Private sector access-to-care times were only available from January 2018 (at the start of the purchased care contract). From purchased care sources, accessing optometry services averaged 21.2 days, while ophthalmology services averaged 26.4 days. Initial appointment wait times were stable for both ophthalmology and optometry services across the 3.5 years of available data. A notable exception for access-to-care in both optometry and ophthalmology purchased care services occurred in the spring of 2020. This period coincided with the coronavirus disease-2019 (COVID-19) pandemic affecting widespread areas of the United States. Between FY 2016-FY 2020, funding declined steadily for both ophthalmology and optometry direct care services. Paid active duty Service member (ADSM) claims for ophthalmology and optometry services each rose gradually from FY 2016-FY 2019, before declining in FY 2020. Reduced supply and demand for purchased care services during the COVID-19 pandemic predominantly drove the recent trend in FY 2020.

In summary, the Army, Navy, and Air Force Ophthalmology and Optometry Medical Services met all national defense strategy scenarios with FY 2022 warfighter readiness, staffing requirements, and capabilities for ocular trauma and vision care, including training and GME; however, funding for both ophthalmology and optometry direct care services has declined over the past 5 years. The Department will address information regarding national defense strategy scenarios and any planned military medical manning divestitures in a future response, pursuant to the requirements in section 741 of the James M. Inhofe NDAA for FY 2023.

PURPOSE

This report contains comprehensive input from the Ophthalmology and Optometry Service Consultants representing the three Military Departments; an overview of the feasibility study results regarding establishment of regional centers to address the comprehensive treatment of ocular trauma and TBI vision dysfunction injuries; and data on access-to-care wait times for ADSMs who received ophthalmology and optometry services. This report also provides funding data for the provision of direct and purchased care ocular services.

REVIEW OF MEDICAL MANPOWER WARFIGHTER READINESS, REQUIREMENTS, AND CAPABILITIES

The Army, Navy, and Air Force Ophthalmology and Optometry Services met all national defense strategy scenarios with FY 2022 warfighter readiness, staffing requirements, and capabilities for ocular trauma and vision care, including training and GME. Information regarding specific scenarios will be addressed in a future response, pursuant to the requirements in section 741 of the James M. Inhofe NDAA for FY 2023.

PLANNED MILITARY MEDICAL MANNING DIVESTITURES IN ALL AREAS OF OCULAR SERVICES BY SERVICE AND LOCATION

The Department will address any planned military medical manning divestitures in accordance with the requirements in section 741 of the James M. Inhofe NDAA for FY 2023.

FEASIBILITY OF ESTABLISHING AT LEAST FOUR REGIONAL MEDICAL HUBS FOR ENHANCED TREATMENT OF OCULAR TRAUMA AND TRAUMATIC BRAIN INJURY VISION DYSFUNCTION INJURIES

Beginning in June 2020, the DHA VCE conducted a feasibility study regarding the establishment of regional centers to address the comprehensive treatment of ocular trauma and TBI vision dysfunction injuries. Initial analysis demonstrated the capabilities, staffing, infrastructure, standardization, and numbers of centers for the treatment of "ocular trauma" would differ from the care necessary to treat "traumatic brain injury vision dysfunction injuries." As a result, the VCE determined the two regional center concepts should undergo separate assessments. Due to the volume of VDTBI, the number of potential Centers for Visual Dysfunction associated with TBI would be greater than the DHA regional OTCs to encompass wider geographic areas for primary eye care clinicians to provide initial diagnostic and treatment capability for VDTBI. If necessary, adequate capacity would be available to refer VDTBI patients from the Centers for Visual Dysfunction associated with TBI to the OTCs (or local military medical treatment facilities (MTFs) with required capabilities) for more definitive evaluation and treatment.

In June 2021, the VCE concluded its analysis and identified four potential DHA market locations for establishing OTCs within the MHS. Sites include 1) BAMC/WHASC; 2) WRNMMC/FBCH; 3) MAMC; and 4) NMCSD. These four locations met capability criteria and are in close proximity to major aerial debarkation points within the medical evacuation system.

OTC designations will dually promote decreased variability and increased standardization of care for ocular/vision-related services. Long-term goals for the OTCs include improving quality of care and optimizing patient outcomes for Service members, veterans, beneficiaries, and retirees. The designation of OTCs will also formalize a framework to re-direct the management of eye injuries (and associated procedures) from purchased (network) care to the direct care system, reducing cost and increasing ocular trauma volume to enhance Ready Medical Force capabilities of DoD providers.

In November 2022, the Director, DHA formally established the four OTCs to address the "enhanced treatment of ocular trauma" under clearly defined metrics of performance and effectiveness. Future efforts will also include coordination with the VA and partner civilian rehabilitation centers to augment DoD low vision care for Service members, veterans, retirees, and beneficiaries at each OTC.

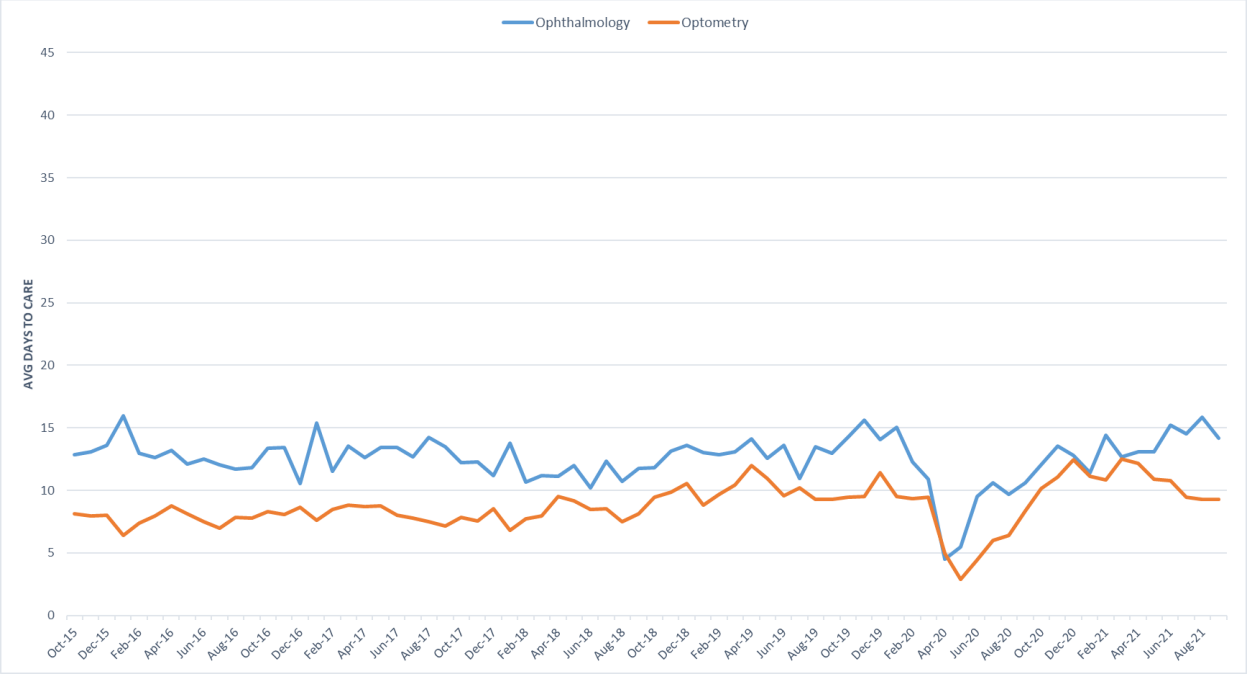
Analysis of the proposed regional centers for the "enhanced treatment of traumatic brain injury vision dysfunction injuries" (i.e., Centers for Visual Dysfunction associated with TBI) determined these sites should be co-located with (or near) the NICoE and the ISCs. The Centers for Visual Dysfunction associated with TBI will be established under the auspices of the NICoE and the DHA DAD-MA Neuro-Musculoskeletal Clinical Community.

As needed, the DHA VCE, TBICoE, and TAC will provide consultation support to properly assess and treat VDTBI. Developing and implementing the appropriate capabilities, infrastructure, clinical procedural standardization, and staffing (e.g., optometrists trained in a Federal DoD or VA optometric residency in Vision Rehabilitation with emphasis in Brain Injury Rehabilitation) will need to occur prior to IOC for the Centers for Visual Dysfunction associated with TBI.

ANALYSIS OF ACCESS STANDARDS AND FUNDING FOR OCULAR SERVICES IN THE DIRECT AND PURCHASED CARE SYSTEMS

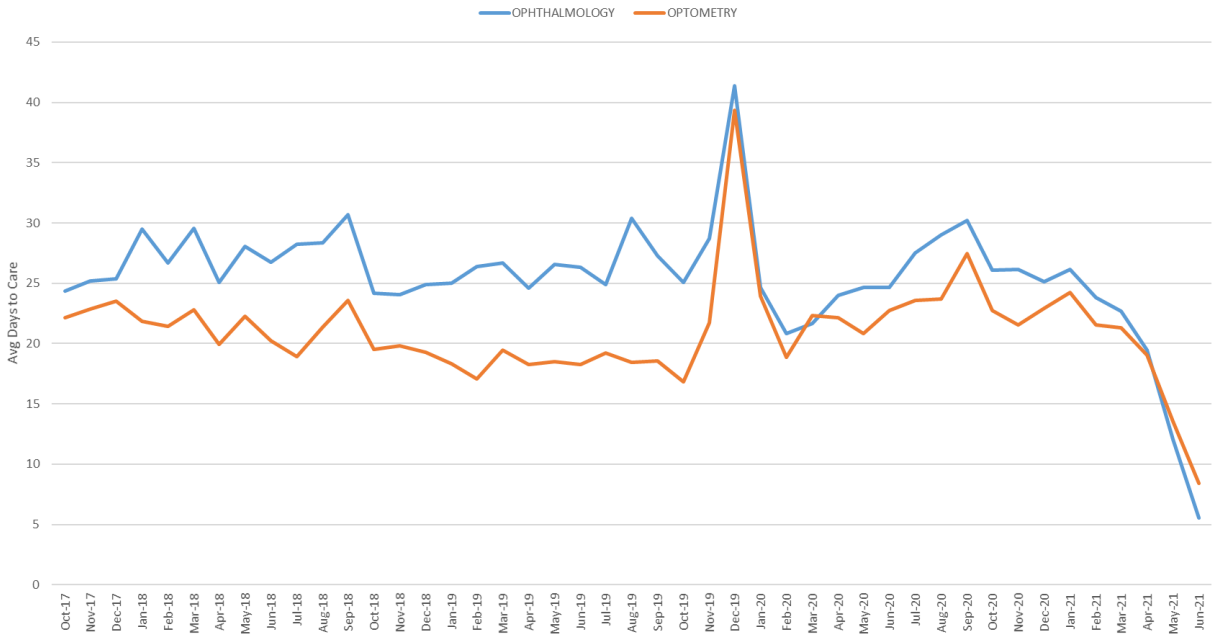
The following section provides data on access-to-care wait times for ADSMs who received ophthalmology and optometry services, both within MTFs and in private sector (purchased) care for the past 5 years. Private sector access-to-care times were only available from January 2018 (at the start of the purchased care contract). Expense data for the provision of direct and purchased care ocular services are also included.

Figure 1. Average Wait for Initial Appointment – Ophthalmology/Optometry (Active Duty/Direct Care – All MHS)



Within the direct care system (Figure 1), the average wait time for an initial ophthalmology visit in 2016 was 12.9 days and remained stable through FY 2021 (13.5 days). Average wait times for initial optometry appointments were 7.7 days in FY 2016 and 10.9 days in FY 2021. All direct care facilities managed average initial appointment wait times within the 28-day specialty care expectation.

Figure 2. Average Wait for Initial Appointment – Ophthalmology/Optometry (Active Duty/Direct Care – Private Sector Care)



Accessing optometry services from purchased care sources averaged 21.2 days (Figure 2). Access to ophthalmology services was slightly longer at 26.4 days. Initial appointment wait times were stable for both ophthalmology and optometry services across the 3.5 years of available data. A notable exception for access-to-care in both optometry and ophthalmology purchased care services occurred in the spring of 2020. This period coincided with the COVID-19 pandemic affecting widespread areas of the United States.

Figure 3. Ocular Services Direct Care Funding – Direct Expenses by Fiscal Year

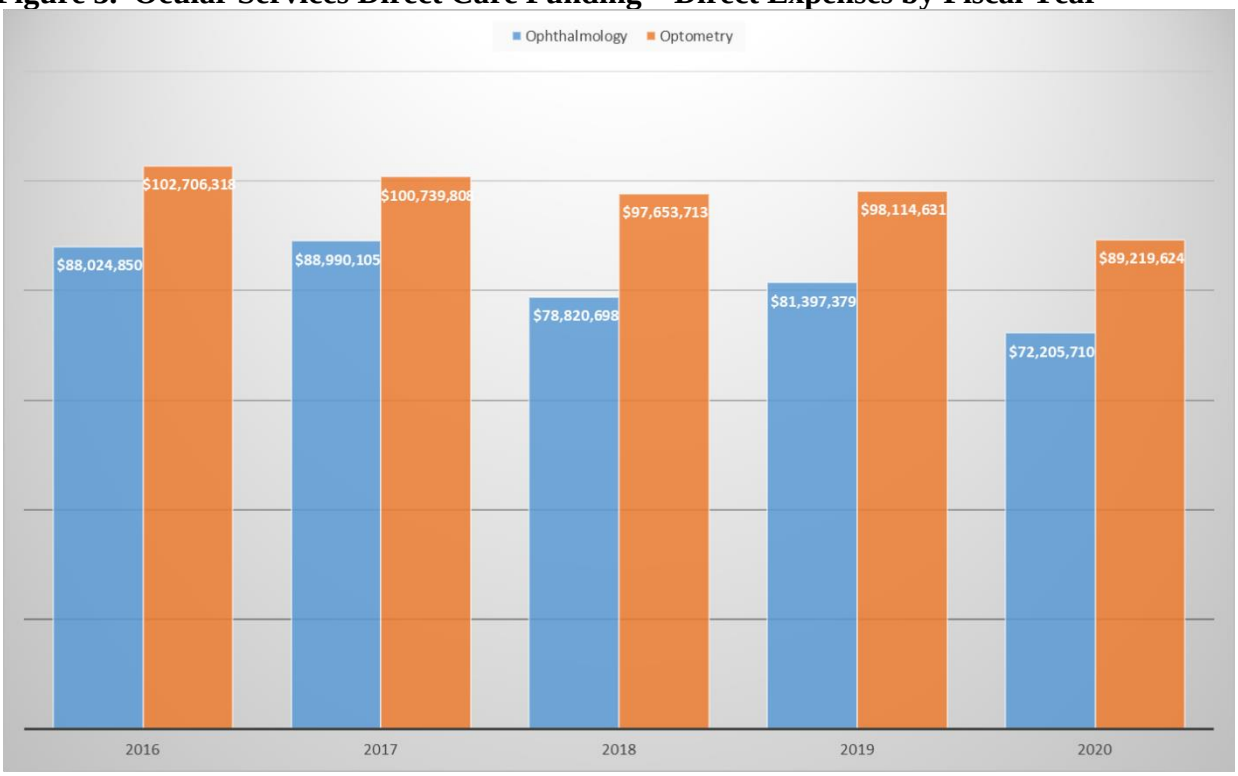


Figure 3 lists direct care funding information for ophthalmology and optometry services from FY 2016-FY 2020. Direct care funding incorporates expenses for clinic operations, including personnel costs, necessary for the delivery of care across all beneficiary categories. In general, there has been a steady decline in funding for both ophthalmology and optometry direct care services over the past 5 years.

Figure 4. Purchased Care Cost for ADSM Receiving Ocular Services in Private Sector

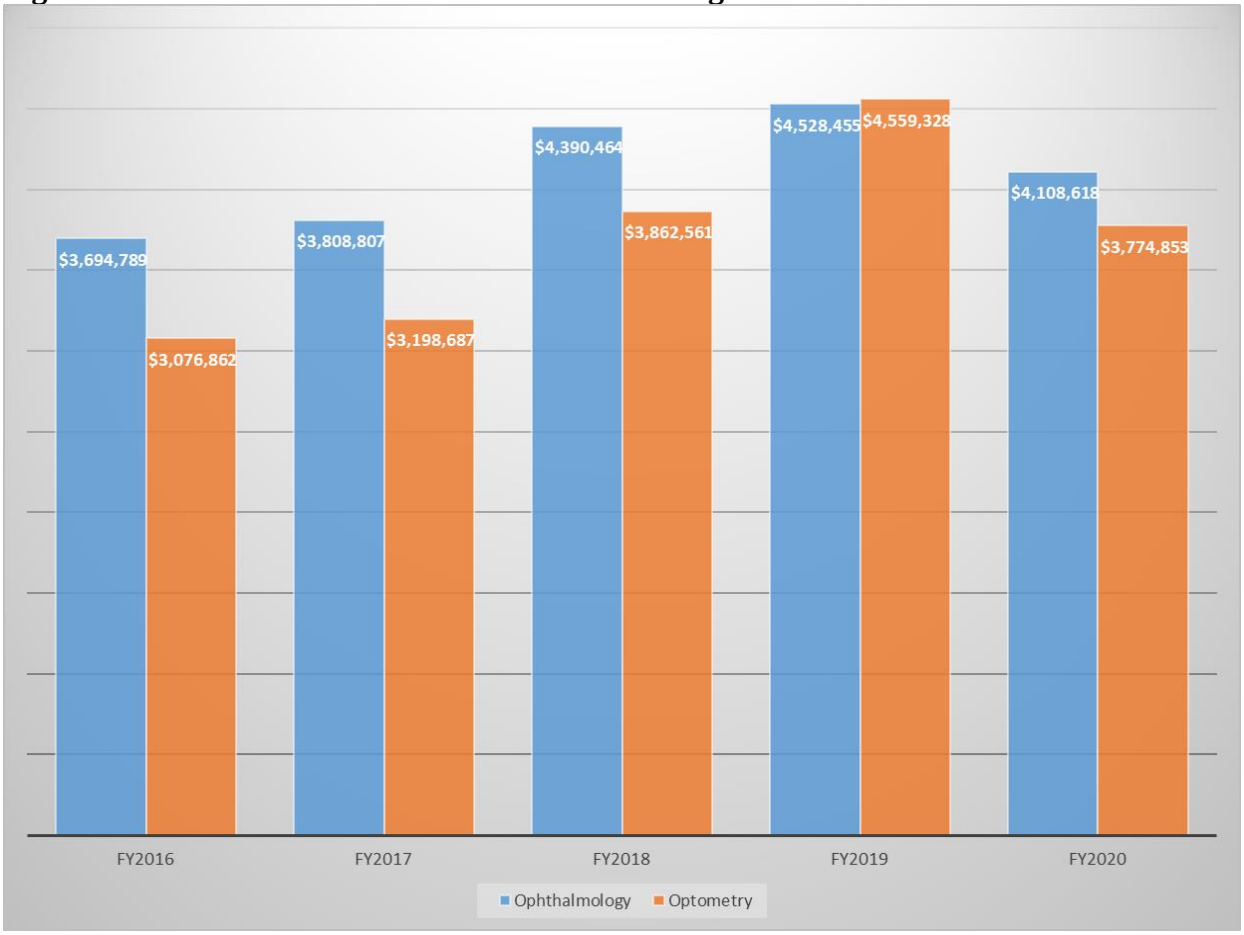


Figure 4 provides purchased care funding information for ophthalmology and optometry services from FY 2016-FY 2020. Data points represent the actual amount of paid claims for ADSM purchased care. Claims for both ophthalmology and optometry services rose gradually from FY 2016-FY 2019, before falling in FY 2020. Reduced supply and demand for purchased care services during the COVID-19 pandemic predominantly drove the recent trend in FY 2020.

CONCLUSION

The Army, Navy, and Air Force Ophthalmology and Optometry Medical Services met all national defense strategy scenarios with FY 2022 warfighter readiness, staffing requirements, and capabilities for ocular trauma and vision care, including training and GME, however, funding for both ophthalmology and optometry direct care services has declined over the past 5 years. The Department will address information regarding national defense strategy scenarios and any planned military medical manning divestitures in a future response, pursuant to the requirements in section 741 of the James M. Inhofe NDAA for FY 2023.

ACRONYMS

ADSM	active duty Service member
BAMC	Brooke Army Medical Center
COVID-19	Coronavirus Disease-2019
DAD-MA	Deputy Assistant Director for Medical Affairs
DHA	Defense Health Agency
DoD	Department of Defense
FBCH	Fort Belvoir Community Hospital
FY	Fiscal Year
GME	Graduate Medical Education
IOC	initial operating capability
ISC	Intrepid Spirit Centers
MAMC	Madigan Army Medical Center
MHS	Military Health System
MTF	military medical treatment facility
NICoE	National Intrepid Center of Excellence
NDAA	National Defense Authorization Act
NMCSD	Naval Medical Center San Diego
OTC	Ocular Trauma Center
TAC	TBI Advisory Committee
TBI	traumatic brain injury
TBICoE	Traumatic Brain Injury Center of Excellence
VA	Department of Veterans Affairs
VCE	Vision Center of Excellence
VDTBI	Visual Dysfunction related to Traumatic Brain Injury
WHASC	Wilford Hall Ambulatory Surgical Center
WRNMMC	Walter Reed National Military Medical Center