President’s Message

Vision Community Must Maximize Political Will for Funding Increases

First, I wish to commend NAEVR/AEVR Executive Director James Jorkasky and Director of Government Relations and Education David Epstein for two recent accomplishments:

- At least $5 million more for vision research in Fiscal Year (FY2012), consisting of the net $2 million National Eye Institute (NEI) increase and $3.2 million Vision Trauma Research Program (VTRP) funding in Department of Defense (DOD) appropriations. In light of the discussion of draconian cuts due to deficit reduction, as well as a Senate bill that would have cut funding, this is a notable achievement. This edition of the Report summarizes the final FY2012 appropriations on the next page.

- In a January 10 letter, National Institutes of Health (NIH) Director Francis Collins, M.D., Ph.D. applauded the Alliances’ work to convey the importance of sustained funding for NIH and NEI.

Last month, President Obama released a proposed FY2013 budget (see story, inside middle) that would level-fund the NIH and cut the NEI—the latter primarily due to the NIH Office of AIDS Research no longer funding NEI clinical studies on cytomegalovirus (CMV) retinitis. Per NEI’s comprehensive Congressional Justification (CJ), it will increase Research Project Grant (RPG) funding such that it retains one of the highest success rates—29 percent as compared to 18 percent for NIH overall. I encourage you to read NEI’s CJ, since it offers an excellent summary of NEI’s priorities and features several examples of breakthrough research.

The proposed FY2013 budget still means that NIH/NEI funding would decrease when biomedical inflation is factored in. After nearly a decade of budgets below inflation, NIH’s inflation-adjusted funding is close to 20 percent lower than in FY2003. This doesn’t even take into account the threat of sequestration—the budget cuts mandated by the Budget Control Act totaling $1.2 trillion over 10 years to defense and non-defense discretionary spending since the Joint Select Committee on Deficit Reduction was unable to make recommendations. The cuts, estimated at eight to ten percent for NIH, are scheduled to begin in January 2013 unless Congress acts to void them or find alternative cuts or sources of revenue.

As NAEVR Legislative Counsel John Porter has often reminded the NAEVR Board, Congress must first have the “political will” to get anything done. In that regard, NAEVR will be working with the vision community and its coalition partners to strengthen the political will of Congress to adequately fund vision research at NEI and DOD. Stories featured herein demonstrate the foundation that has been laid in the first quarter of the year:

- A EVR’s Congressional briefing to educate about the impact of glaucoma, which also featured the release of The Silver Book®: Vision Loss Volume II reference book on aging eye disease incidence and the NEI-funded research to diagnose and treat it.

- NAEVR’s meeting with the Food and Drug Administration (FDA) to ensure the timely approvals of ophthalmic drugs and continued involvement in the joint NEI/FDA Endpoints Symposia.

- NAEVR’s meeting with the White House’s Wounded Warrior Project to seek its support for adequate funding for deployment-related vision trauma research.

I can’t stress strongly enough how, in each case, the Alliances’ efforts to garner political will were enhanced and amplified by the partnership and participation of member organizations and coalition partners.

Second quarter 2012 will offer numerous other opportunities, built around upcoming appropriations hearings, the release of the Cost of Military Blindness Study, and the ARVO Annual meeting, where the NAEVR Central booth will once again serve as the “Town Hall” for vision research advocacy. That effort will be enhanced even further through NAEVR’s partnership with Research!America’s Your Candidates, Your Health educational program. Vision community members will be able to review candidates’ positions on medical research and customize their email letters to those offices regarding requested support.

I appreciate the commitment of financial and manpower resources that members have already made to the Alliances in 2012. We look forward to maintaining that level of engagement as we work to maximize political will in this pivotal year.

Stephen J. Ryan, M.D.
President, NAEVR/AEVR Boards
sryan@doheny.org

NAEVR Executive Director James Jorkasky with NIH Director Francis Collins, M.D., Ph.D., who has applauded the Alliances’ efforts
On March 7, AEVR joined the Alliance for Aging Research (AAR) and the glaucoma community in releasing *The Silver Book®: Vision Loss Volume II* during the 2012 World Glaucoma Week Congressional Briefing entitled Glaucoma: Blindness Incidence and Progress Towards Individualized Treatments.

Clinician-scientist Arthur Sit, S.M., M.D., an Associate Professor of Ophthalmology at the Mayo Clinic, spoke about the impact of glaucoma, the second leading cause of preventable visual loss in the United States, affecting 2.2 million individuals. He described glaucoma as a group of complex neurodegenerative diseases that affect the optic nerve, initially robbing patients of their peripheral vision and eventually leading to central vision loss and irreversible blindness. Patient advocate Jerry Duvall, a leading advocate for patient education, described what it is like to live with glaucoma (see box).

To demonstrate the impact of the diagnostic and drug/device therapies which have emerged from research funded by the NEI over the past forty years, Dr. Sit presented data from the NIH-funded Rochester Epidemiology Project (REP). From 1965 to 2000, the REP tracked the medical records of virtually all residents of Olmstead County, Minnesota—the center of the tri-state area (Minnesota, Wisconsin and Iowa) and home to Mayo Clinic—which represents a relatively homogeneous population of primarily Caucasian Americans. Analyzing blindness data in this population, Dr. Sit observed that 25.8 percent of patients diagnosed with glaucoma between 1965 and 1980 developed blindness in one eye over a 20-year period, as opposed to only 13.5 percent for patients diagnosed between 1981 and 2000. Although he recognized that this is initial evidence that improving glaucoma management strategies may reduce glaucoma blindness on a population basis, he cautioned that a significant number of patients continue to go blind, and a more individualized approach to treatment may be required. He also noted that access to healthcare and ethnic differences in glaucoma risk and incidence are also factors, especially in the African American and Hispanic populations where glaucoma is the leading cause of blindness.

Regarding individualized treatments, he described research to measure and better understand variations in the physiologic factors that affect fluid flow within the eye and the resulting intraocular pressure (IOP)—the pressure inside the eye that can damage nerve tissue when elevated. He noted that researchers are also looking at other factors, including blood flow into the eye, the immune system, the body's inflammatory response, and intracranial pressure. Finally, he acknowledged current NEI-funded research into the genetic basis of glaucoma that could lead to predictive parameters of treatment response that will enable therapy to be tailored to individual patients.

A significant number of patients continue to go blind from glaucoma, and a more individualized approach to treatment may be required. – Dr. Sit

Glaucoma patient Jerry Duvall described living with the disease since it was first diagnosed in his left eye in 1996. Although both of his parents had glaucoma that developed late in life and progressed slowly, his form developed early, at age 52, and progressed rapidly causing optic nerve damage. He had minimal success with pressure-lowering drops and laser trabecular surgery, but a trabeculectomy—a surgical procedure where a type of “drain pipe” is installed in the eye to improve fluid flow that in turn reduces eye pressure—was successful, and he has avoided further vision loss.

“My diagnosis prompted an emotional response that I had never experienced before in my life, namely a deep sense of foreboding and depression. Living with glaucoma is a life of adaptation, vigilance, and a strict adherence to the treatment regimen,” said Mr. Duvall, who offered an analogy to the telecommunications world. “I liken one’s ability to see as a type of human ‘Internet connection’ where, in a healthy eye, the optic nerve is a high-speed, broadband access line connecting the eye to the brain. Glaucoma has the effect of destroying a significant portion of the broadband connection, resulting in the failure of the optic nerve as a broadband channel to transport all, or even most, of the visual data received by the eye.”

He remains hopeful, however. “Glaucoma patients today, although their vision is dimmed, nevertheless can begin to see clearly the benefits of sustained research that promises a future where the disease will no longer rob people of their most precious sense—one that provides the magnificent panorama of everything that this wondrous world has to offer.”

A significant number of patients continue to go blind from glaucoma, and a more individualized approach to treatment may be required. – Dr. Sit

DECADE OF VISION
2010-2020
Alliance for Aging Research

A significant number of patients continue to go blind from glaucoma, and a more individualized approach to treatment may be required. – Dr. Sit

Living with Glaucoma

Glaucoma patient Jerry Duvall described living with the disease since it was first diagnosed in his left eye in 1996. Although both of his parents had glaucoma that developed late in life and progressed slowly, his form developed early, at age 52, and progressed rapidly causing optic nerve damage. He had minimal success with pressure-lowering drops and laser trabecular surgery, but a trabeculectomy—a surgical procedure where a type of “drain pipe” is installed in the eye to improve fluid flow that in turn reduces eye pressure—was successful, and he has avoided further vision loss.

“My diagnosis prompted an emotional response that I had never experienced before in my life, namely a deep sense of foreboding and depression. Living with glaucoma is a life of adaptation, vigilance, and a strict adherence to the treatment regimen,” said Mr. Duvall, who offered an analogy to the telecommunications world. “I liken one’s ability to see as a type of human ‘Internet connection’ where, in a healthy eye, the optic nerve is a high-speed, broadband access line connecting the eye to the brain. Glaucoma has the effect of destroying a significant portion of the broadband connection, resulting in the failure of the optic nerve as a broadband channel to transport all, or even most, of the visual data received by the eye.”

He remains hopeful, however. “Glaucoma patients today, although their vision is dimmed, nevertheless can begin to see clearly the benefits of sustained research that promises a future where the disease will no longer rob people of their most precious sense—one that provides the magnificent panorama of everything that this wondrous world has to offer.”

A significant number of patients continue to go blind from glaucoma, and a more individualized approach to treatment may be required. – Dr. Sit

Living with Glaucoma
Legislative Scorecard Issues
—Fiscal Year (FY) 2012 Funding
Congress Finalizes FY2012 Appropriations, President Signs into Law

On Friday, December 16, 2011, in the House, and Saturday, December 17, in the Senate, Congress voted to adopt the conference agreement (H.R. 2055, H. Report 112-331) for a nine-bill FY 2012 spending package that finalized the appropriations process. This action came after the Congress passed its fifth Continuing Resolution (CR) to fund the government through December 23, the date on which President Obama signed the conference agreement into law [P.L. 112-74]. NIH/NEI highlights include (see funding chart):

- Increases NIH program funding by $299 million to $30.7 billion, reduced to $30.6 billion by a 0.189 percent across-the-board rescission for all Labor, Health and Human Services, and Education (LHHS) programs.
- Increases NEI funding by $3.2 million to $704.04 million, which is reduced to $702.7 million by the 0.189 percent LHHS rescission.
- Reduces the salary cap from Executive Level I ($199,700) to Executive Level II ($179,700) of the Federal Executive Pay scale and does not provide an inflationary adjustment to non-competing awards.
- Approves and funds the new National Center for Advancing Translational Sciences (NCATS) and funds the Cures Acceleration Network (CAN) within it at $10 million.
- Requires a multitude of update reports on NCATS and CAN implementation; a study on NIH-wide implementation of the 2010 Institute of Medicine (IOM) recommendations on the design, implementation, and management of clinical trials; and a pilot study on third-party reimbursement for clinical services incurred in NIH research facilities.

Due to Congressionally negotiated cuts in the Budget Control Act to FY2012 spending that were below FY2011 levels, the series of CRs that funded the government until the spending bill was signed into law had imposed a 1.503 percent cut on all agency programs, including the NIH/NEI. For NEI, this meant it operated at a funding level of $690.3 million, a reduction of $10.5 million, through the first one-third of the fiscal year. In FY2011, Congress did not finalize appropriations until April 2012 after a series of eight CRs.

Salary Cap Issue

Every year since 1990, Congress has legislatively mandated a provision limiting the direct salary that an individual may receive under an NIH grant. Despite opposition from the medical research advocacy community to any changes in the salary cap in the FY2012 appropriations process, for the first time Congress restricted the amount of direct salary to Executive Level II of the Federal Executive Pay scale ($179,700), down from Executive Level I ($199,700). The community has already expressed concern about the impact of this action. The Association of American Medical Colleges (AAMC) has stated that reducing the cap “will have a significant impact on individual investigators and their institutions,” while the Association of American Universities (AAU) has noted that the change “would disproportionately affect physician scientists, who are critical to advancing breakthrough discoveries into the next generation of medical advancements.”

Both NAEVR and ARVO have joined an AAMC-led effort to advocate for a resumption of the salary cap at Executive Level I in FY2013 appropriations.

Whither Sequestration?

Since the Joint Select Committee on Deficit Reduction, which was created by the Budget Control Act of 2011 (P.L. 112-25), did not offer up recommendations for budget cuts of $1.2 trillion over ten years, sequestration is scheduled to begin in January 2013. About half of these cuts are slated from defense, and the other half from non-defense discretionary spending, which includes NIH. The Congressional Budget Office (CBO) has estimated potential NIH budget cuts of eight percent below final FY2013 appropriations. NIH Director Dr. Collins has noted that, due to NIH’s out-year commitments, sequestration would have the greatest impact on funding for new grants.

Congress has been uncharacteristically silent about sequestration, except for defense supporters who are concerned about its impact on the nation’s military preparedness. To avoid these cuts, Congress would need to void all or part of its prior mandate or find the $1.2 trillion in other cuts or new revenue.

Visit the NIH/NEI funding section of NAEVR’s Web site at www.eyeresearch.org for full details.
Legislative Scorecard Issues —FY2013 Funding

NIH Director Dr. Collins Discusses the President’s Proposed FY2013 Budget

On February 14, NIH Director Dr. Collins hosted a briefing for medical research advocates at which he and his senior team discussed the President’s proposed FY2013 budget, which had issued the previous day. Highlights include:

- NIH funding at the same programmatic level as FY2012 (funding chart on previous page).
- Increases number of new and competing Research Project Grants (RPGs).
- Funds CAN at $50 million.
- Provides additional support for Alzheimer’s disease research from the Public Health and Prevention Fund (not NIH budget), specifically $80 million, as part of a Department of Health and Human Services (DHHS) initiative.

Dr. Collins stated up-front that he was pleased with the level funding for FY2013, especially in light of the current fiscal environment and the fact that, just a few months back, NIH was working on budget scenarios that included a five percent cut, per guidance from the Office of Management and Budget (OMB). He focused his initial comments on FY2013 funding for RPGs, since they are the primary mechanism for funding of investigator-initiated research and represent 53 percent of the NIH budget. NIH estimates that it will support 9,415 new and competing RPGs in FY2013, an increase of 672 above FY2012, bringing the total number of RPGs at NIH to 35,888. NIH-wide, the average cost of a new and competing RPG in FY2013 is estimated to be $431,000.

Dr. Collins described a number of factors that affect the funds available to increase the number of RPGs, including the natural “ebb and flow” of grants cycles and the shortening of the average age of grants from five years to a period of three-to-four years, primarily due to the rapid pace of science. In FY2013, for example, there is a larger turnover of grants than in FY2012, freeing up additional funds. He also described the proactive steps that NIH was taking to maximize resources for investigator-initiated grants, including those for young, first-time researchers, which include:

- Reducing the cost of non-competing RPGs by one percent below the FY2012 level.
- Negotiating the budgets of competing RPGs to avoid growth in the average award size.
- Eliminating inflationary increases in out-year budgets of both competing and non-competing RPGs.
- Initiating review by the Advisory Council for the respective Institute or Center (I/C) of applications from principal investigators (PIs) who already receive in excess of $1.5 million per year in total costs.
- Continuing the NIH policy of funding applications from early-stage investigators at the same success rate as established investigators for new R01 equivalent applications.

He also spoke about NCATS (see story next page), the funding for which will increase to $639 million in FY2013, driven in part by an increase of $40 million in CAN funding. While acknowledging that NCATS holds great promise for discovery, Dr. Collins emphasized that NIH will maintain its commitment to basic research, which reflects 54 percent of NIH funding as opposed to 46 percent for applied research.

Dr. Collins will appear before the House LHHS Appropriations Subcommittee on March 20 and the companion Senate Subcommittee on March 28. The House has scheduled a Citizen Witness hearing for March 29, and NAEVR has requested to appear to support increased NEI funding.

NIH/NEI Funding Increases

NAEVR has urged Congress to fund NIH at $32 billion and NEI at $730 million, reflecting a 4.5 percent increase over FY2012, which consists of biomedical inflation of 2.8 percent plus modest growth. NAEVR noted that after nearly a decade of budgets below biomedical inflation, NIH/NEI inflation-adjusted funding is close to 20 percent lower than in FY2003, significantly limiting the ability to sustain current research capacity and encourage promising new areas of science. NAEVR also emphasized that the looming sequestration threatens further cuts, estimated at eight percent. NAEVR concluded by noting that NIH, the nation’s biomedical research enterprise, is unique in that:

- Its basic and clinical research has helped to understand the basis of disease, thereby resulting in innovations in healthcare to save and improve lives.
- Its research serves an irreplaceable role that the private sector could not duplicate.
- It has been shown through several studies to be a major force in the economic health of communities across the nation.

FY2013 Budget Proposes NEI cut of $8.86 Million

The President’s budget proposes NEI funding at $693.02 million, an $8.86 million or 1.2 percent decrease. The cut is driven primarily by an $8.2 million reduction in funding by the NIH Office of AIDS Research, which had supported a series of NEI clinical trials known collectively as the Studies of the Ocular Complications of AIDS (SOCA). These trials established the efficacy of combination antiviral drug therapy in treating cytomegalovirus (CMV) retinitis, a sight threatening complication of advanced AIDS.

Despite the cut, NEI proposes to support a total of 1,098 RPGs, with noncompeting RPGs increasing by 28 awards and competing RPGs funded approximately at the FY2011 level. NEI’s Congressional Justification details the planned spending in each of the program areas and highlights several recent examples of breakthrough research which NAEVR has already used in developing draft Report Language submitted to the appropriators.

On February 15, NAEVR’s James Jorkasky and David Epstein (far left and far right) joined ARVO’s Bobbie Austin, Ph.D. (second right) in meeting with NEI Director Paul Sieving, M.D., Ph.D. (second left) and his senior team to better understand NEI’s FY2013 budget plans.
Translational Research

NIH Establishes NCATS

On December 23, NIH announced the establishment of NCATS per the FY2012 appropriations conference agreement signed into law that day as P.L. 112–74 (see page 2 story). National Institutes of Mental Health (NIMH) Director Thomas Insel, M.D., is serving as the Acting NCATS Director and Kathy Hudson, Ph.D. as Deputy Director. For FY2012, NCATS funding is $575 million and consists primarily of reallocated funds from programs located within the Office of the NIH Director, the National Human Genome Research Institute (NHGRI), and the National Center for Research Resources (NCRR), which has been abolished. New funding is reflected in the $10 million Congress approved to support the Cures Acceleration Network (CAN) Board and related activities. In addition to CAN, other major NIH programs that will comprise NCATS include:

- Bridging Intervventional Development Gaps
- Clinical and Translational Science Awards (CTSA)

NAEVR Meets with FDA on Ophthalmic Drug Review Changes

On January 6, NAEVR participated in an American Academy of Ophthalmology (AAO) and American Glaucoma Society (AGS) meeting with representatives of the U.S. Food and Drug Administration (FDA) to discuss the implications for ophthalmic drug reviews from the May 2011 reorganization of the Office of Antimicrobial Products (OAP) within the Office of New Drugs (OND) in the Center for Drug Evaluation and Research (CDER). In the reorganization, OAP re-aligned its three reviewing divisions, moving ophthalmic review from the previous Division of Anti-Infective and Ophthalmology Products and transplant product review from the previous Division of Special Pathogen and Transplant Products and combining these into a new Division of Transplant and Ophthalmology Products (DTOP), directed by Renata Albrecht, M.D. Wiley Chambers, M.D. continues to serve as the Deputy Director in this new division.

Michael Repka, M.D. (Johns Hopkins University School of Medicine), who serves as the AAO’s Medical Director for Government Affairs and as Chair of the FDA’s Dermatologic and Ophthalmic Drugs Advisory Committee, led the discussion, which focused on the potential impact of the reorganization on the timeliness of new ophthalmic drug reviews. OND Director John Jenkins, M.D. and OAP Director Edward Cox, M.D., M.P.H., described the OAP reorganization, noting it was primarily done for greater efficiencies in the use of limited resources. Although the pairing of transplant products and ophthalmic products was not designed to be a match—it resulted because each area did not have sufficient volume of reviews to warrant a separate division—OAP is tracking the workload associated with each type of product review so that they can properly align resources. Generally, OND is also centralizing several of the disciplines needed in review (for example, pharmacology, chemistry, statistics) so that they are available to all divisions. Since these centralized reviewers may not have had past experience with a specific division and its products, OND has also established an internal dispute resolution process.

NAEVR used the meeting as an opportunity to discuss the importance of the joint NEI/FDA Endpoints Symposium, managed by ARVO and engaging representatives from CDER and the Center for Devices and Radiological Health’s (CDRH) Division of Ophthalmology, Neurology, and Ear, Nose and Throat Devices. To date, five Symposia have been held, including two on Glaucoma, and one each on Age-related Macular Degeneration (AMD), Visual Prostheses, and Patient Reported Outcomes.

Hageman Receives 2011 Pisart Award

On January 19, during a meeting of the Atlantic Coast Retinal Club and Macula 2012 Scientific Symposium, Lighthouse International President and CEO Mark Ackermann presented Gregory Hageman, Ph.D. (Moran Eye Center/University of Utah) with the 2011 Pisart Award in recognition of his pioneering work on the association between the complement pathway and development of AMD. AEVR has featured Dr. Hageman’s work at Congressional briefings in 2005 and 2008, and has invited him to once again speak on September 19 at AEVR’s International AMD Awareness Week briefing to update Congress on his research.

AUPO Session Focuses on Translation

Left to right: On January 27, at the Association of University Professors of Ophthalmology (AUPO) Annual Meeting, J. Mark Petrash, Ph.D. (University of Colorado School of Medicine/Denver and immediate-Past ARVO President) joined Scott Cousins, M.D. (Duke University School of Medicine) in hosting a session entitled Different Models for Translating Research into Clinical Innovations. Both Dr. Petrash and Dr. Cousins serve as Research Director members of AUPO.
Deployment-Related Vision Trauma Research

FY2011:

TATRC Plans Notification of Awards

The Department of Defense’s (DOD) Telemedicine and Advanced Technology Research Center (TATRC), which manages the Vision Trauma Research Program (VTRP) in defense appropriations, is finalizing peer and programmatic review of full proposals and plans to issue awards in late April 2012. Although the Congressional appropriation was $4 million, TATRC plans to support at least $8.7 million of awards in two categories—investigator-initiated awards at $1 million each and Hypothesis Development Awards at $250,000 each. The additional funding reflects that made available from other DOD programs, primarily Traumatic Brain Injury (TBI), due to the past quality and responsiveness of vision research proposals. NAEVR’s James Jorkasky and David Epstein and ARVO’s Bobbie Austin, Ph.D. serve on TATRC’s Program Committee.

FY2012:

Congress funded the VTRP at $3.2 million, a 20 percent cut from the FY2011 appropriation. All Defense Health Programs were cut by 20 percent except for orthopedics, prostate cancer, and TBI. TATRC will likely add funds transferred from other DOD programs and release a FY2012 Program Announcement mid-year.

FY2013:

NAEVR has again requested $10 million in funding since the VTRP is military-relevant, addresses DOD-identified vision research gaps, and potentially results in rapid translation of research into battlefield diagnostic and therapeutic applications. For FY2013, NAEVR is ramping up its efforts to garner the “political will” of Congress for vision trauma research:

- On February 14, the Veterans Service Organizations (VSOs) once again called for increased VTRP funding in the 26th annual edition of the Independent Budget, which is an annual set of recommendations to Congress regarding Department of Veterans Affairs (VA) and DOD funding. The Independent Budget also calls on the VA to maintain the current bed capacity and full staffing levels in its Blind Rehabilitation Service (BRS) centers.
- On February 22, the Blinded Veterans Association (BVA), a NAEVR member, sent a letter to Congressional defense appropriators also requesting FY2013 VTRP funding at $10 million. BVA was joined by six signatories, including Paralyzed Veterans of America, Military Order of the Purple Heart USA, Inc., Veterans of Foreign Wars, Jewish War Veterans of the USA, National Association for Uniformed Services, and AMVETS.
- On February 27, U.S. Medicine, a monthly publication that serves healthcare professionals working in the VA, DOD, and U.S. Public Health Service, posted an article on the joint DOD/VA Vision Center of Excellence (VCE), especially its development of the Defense and Veterans Eye Injury and Vision Registry to track the occurrence, treatment, and outcomes of military eye-related injuries and vision impairment. The article also describes NAEVR advocacy for VTRP funding.

Upcoming Events:

March 22:

AEVR Deployment-Related Vision Research Congressional Briefing and release of the Cost of Military Blindness Study being conducted by Kevin Frick, Ph.D. (Johns Hopkins University Bloomberg School of Public Health). 12 Noon, House Rayburn B-340

May 6-9: ARVO Annual Meeting

NAEVR Central will host TATRC representatives (appointment sign-up on site) in the Fort Lauderdale Convention Center

May 7: ARVO Annual Meeting

Defense Vision Briefing at the 7:30 am, Palm B, Fort Lauderdale Convention Center

Visit the Defense-related Vision Research section of NAEVR’s Web site for more details

Executive Director
James F. Jorkasky
240-221-2905 james@eyeresearch.org

Director, Government Relations and Education
David H. Epstein
240-221-2902 depstein@eyeresearch.org

1801 Rockville Pike, Suite 400
Rockville, Maryland 20852-1606
www.eyeresearch.org

NAEVR Meets with White House on Defense Vision Research Funding

On February 17, NAEVR was joined by BVA and the American Academy of Ophthalmology (AAO) in meeting with White House staff engaged in outreach efforts to military families through the Wounded Warriors Project. Although the vision community primarily advocates with Congressional appropriators, it wants to ensure that the Obama administration is fully informed of the long-term implications from military eye injuries on veterans and their families.