

**STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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Chairwoman Buerkle, Ranking Member Michaud and Members of the Subcommittee:

On behalf of the 1.2 million members of the Disabled American Veterans (DAV), all of whom are wartime disabled veterans, I am pleased to present our views at this hearing to examine the capabilities of the Department of Veterans Affairs (VA) to deliver state-of-the-art care to veterans suffering from amputations. I will focus my remarks on the VA's Amputation System of Care (ASoC)—the demand, utilization and quality of that specialized care; impact of VA's procurement reform and suitability of acquisition and management policies; and, veterans' satisfaction with VA prosthetic services. DAV appreciates the Subcommittee's interest and oversight of these issues. Many DAV members have experienced limb loss due to their wartime service and are high-intensity users of VA health care and its specialized services. This topic of prosthetic services is very important to DAV and our members.

War is the primary cause of traumatic limb loss and amputation in large population cohorts. Advances in military medicine, forward-deployed emergency capabilities and faster triage, along with the government's mission to care for and rehabilitate wounded service members, have corresponded with development of specialized systems of care for veterans with polytrauma and amputations in both the Department of Defense (DOD) and VA. Throughout history, wars have led to advancements in military medicine, saving more lives, and creating conditions that advance development of prosthetics and post-injury rehabilitation care. Our newest generation of war veterans from wars in Iraq and Afghanistan (OEF/OIF), many of whom have suffered catastrophic injuries, including limb loss, has again spurred research and development of new prosthetic technologies.

In the aftermath of the current wars, both DOD and VA have been charged by Congress with ensuring that veterans with these types of injuries have every opportunity to regain their health, functioning, overall well-being and quality of life. As in previous generations of veterans who have experienced limb loss, OEF/OIF veterans want not only to gain their independence following an amputation; they want to follow meaningful careers, pursue new occupations or in some cases retain their positions in the military ranks. Likewise, many veterans, especially those from OEF/OIF, want to continue to be physically fit, highly active and participate in competitive sports. This variety and intensity of needs and interests requires a team of specialists and lifelong care.

Over the recent past, media attention has been focused primarily on DOD and the types of computerized and innovative prosthetic devices that this new generation of war veterans has been furnished. As the first injured troops began to arrive home from Iraq and Afghanistan in 2002, we saw a paradigm shift in the way these veterans were medically handled by DOD. In the Vietnam War, most wounded, ill and injured personnel were discharged from the military as soon as they were medically stabilized. Their subsequent care was provided at VA medical centers (VAMCs) around the nation. Today, most seriously wounded OEF/OIF veterans are being cared for by DOD at military medical treatment facilities from months to years post-injury, and are maintained on active duty status while continuing their rehabilitation at Walter Reed National Medical Center and select other regional military medical facilities where state-of-the-art prosthetics laboratories have been established to provide for their customized needs. This new generation of war veterans is being provided the best and newest prosthetic items available on the market today and their rehabilitation begins immediately within DOD, not VA. Unfortunately, newly injured service personnel (and to an extent, DOD officials) were under the false impression that VA could not provide these new-technology prosthetic items or assist young veterans in their rehabilitation needs. DAV agrees that VA did not seem well prepared as the first war-injured veterans began their transitions from DOD into VA's rehabilitation services, including prosthetic care. Also, many veterans were not familiar with VA's long history in prosthetics and the transformation VA had undergone to improve quality of care across the realm of primary, acute, rehabilitative and long-term care.

Historical Perspective of VA Prosthetics and Sensory Aids Service

At the end of World War II, prosthetics were only rudimentary aids for disabled people, at best. The few sensory aids that existed were primitive. Tens of thousands of war veterans with amputations and other severe injuries poured into VA and demanded earlier versions of many of the kinds of assistive devices we see today's veterans demanding, but VA fell short of their expectations. The old Veterans Administration procured prosthetics on the basis of cheapest bid price and as a result furnished inferior quality and ill-fitting devices to wounded war veterans with much higher expectations. The veterans service organization community, including DAV, expressed our collective outrage at such shoddy VA treatment of our wounded, and Congress responded by granting the prosthetics program a highly flexible authority (title 38, United States Code, section 8123) to manufacture and procure prosthetic, assistive and orthotic devices without regard to any other provision of law, including cost. After the war, under the leadership of VA Administrator Omar Bradley and Dr. Paul Hawley, Chief Medical Director, VA had formalized a Prosthetics and Sensory Aids Service in every VA hospital, and staffed these activities with disabled veterans (primarily amputees) who themselves were users of prostheses. Also, later VA broadened the mission of its biomedical research and academic affairs programs to include a focus on research related to prosthetics and sensory aids and rehabilitation from traumatic injuries.

These changes created a true, modern renaissance in development of sophisticated prosthetic devices. VA became and remains the world leader in prosthetics development and distribution. Our new wars simply continued and accelerated that legacy at VA.

2012 Report from the Office of the Inspector General: *Prosthetic Limb Care in VA Facilities*

On March 8, 2012, the VA Office of Inspector General (OIG), issued its report of an inspection, entitled “Prosthetic Limb Care in VA Facilities” (report no. 11-02138-116), raising one of the Subcommittee’s concerns about VA’s prosthetics program.

This inspection evaluated VA’s capacity to deliver prosthetic care, VA’s credentialing requirements for prosthetists and orthotists, demand for health care services, and psychosocial adjustments and activity limitations of OEF/OIF and Operation New Dawn (OND) veterans who had suffered amputations. The inspectors also studied and reported these veterans’ overall satisfaction with VA prosthetic services.

It found that this subgroup of veterans was adapting to living with their amputations, and that those with lower extremity limb loss were noted to exhibit good mobility. Veterans with upper extremity amputations were found to function similarly to those in the general population; however, over half of veterans with upper extremity amputations reported moderate to severe pain, and the inspection reported that they did not fare as well as those with lower extremity amputations in their psychosocial adaptation, physical abilities and prosthetic satisfaction.

The OIG narrowed its focus to 838 living veterans of OEF/OIF/OND with major amputations. It found that veterans with amputations have a variety of co-existing medical conditions and are high users of VA health care services—not only prosthetic services. Of the data reviewed from 500,000 veterans they found that 99 percent of OEF/OIF veterans with traumatic amputations transitioned to VA care within five years following discharge. As of September 30, 2011, approximately 92 percent were service connected with an average disability rating of 100 percent and 88 percent receiving a disability rating of 70 percent or higher. Over 80 percent of this group had diagnoses in each of the following categories; mental disorders, diseases of the musculoskeletal system and connective tissue, and diseases of the nervous system and sense organs in addition to their unique category of injury. Notably, 35 percent of these veterans were diagnosed with traumatic brain injury (TBI). Likewise, the percentage of post-traumatic stress disorder (PTSD), mood disorders, substance-related disorders all increased after discharge.

The OIG conducted in-person visits for a sample of the group evaluated to assess their psychosocial adjustment, physical abilities, and prosthetic satisfaction. Some of the veterans reported receiving excellent care at VA facilities but many indicated that VA needed to improve. Concerns with VA prosthetic services centered on VA’s approval process for fee basis and contract services, prosthetic expertise and difficulty accessing VA services. Many veterans reported the VA process should be more streamlined, simplified and require fewer visits to get approval for a new prosthetic limb. They did not understand VA’s requirement for multiple in-person visits, since the diagnosis was known and the need for the device was so clear. Others expressed concern about the timeliness and reliability of paperwork for processing prosthetic requests, particularly between the VA and outside vendors, and when difficulties arose reported having to act as a liaison between VA and the vendor.

However, despite the challenges of major limb amputation, 91 percent of lower limb and 80% of upper limb-only veterans agreed or strongly agreed that “life is full,” and the OIG researchers reported they were inspired by the high spirits of veterans they visited. An estimated 55% of OEF/OIF veterans with lower extremity amputations strongly agreed that they had become accustomed to wearing an artificial limb, but only 23 percent of those with upper limb extremity amputations agreed. Nearly half of both groups agreed that having an artificial limb makes one more dependent on others than desired.

We appreciate the OIG’s comprehensive report on prosthetic limb care in VA facilities and were pleased that VA concurred with all recommendations. We agree that VA can improve the overall quality of care to veterans with amputations if it works to adjust the provision and management of health care services to this population; improves satisfaction for veterans with traumatic upper limb amputations; and re-evaluates its approval process for fee-basis and contract prosthetics services. The “open comments” part of the OIG report provides VA with thoughtful comments and feedback from these amputees. One veteran suggested VA should arrange a meeting with all upper extremity amputees to gain better insight about how to improve functioning for this group. Another veteran asked that VA be more sensitive to child care issues, difficulties in getting time off from work to access care and long wait times for getting into primary care for needed referrals to specialized prosthetics appointments. We urge VA to establish a simple mechanism to receive continued feedback from this population to provide more patient-centered care, and to improve identified hurdles in their accessing care for routine maintenance and repair of prosthetic items.

VA’s Amputation System of Care

VA has an extensive program for amputation care and rehabilitation. In fiscal year (FY) 2011, 6,026 veterans underwent amputations, with 2,248 having major amputations. Within this total, 107 (1.8%) were women and 24 of these women were OEF/OIF/OND veterans. In 2007, in response to the growing need to provide patient-centered amputation care to a younger population of combat-injured veterans, VA developed the ASoC. By 2009, this specialized program was operational and functions to ensure that there were a sufficient number of VA facilities system-wide with the expertise to handle the most complex patients and act as leaders in the field of amputation rehabilitation; decrease the variance in amputation rehabilitation care provided across the VA system and improve access to specialized care for veterans with amputation.

Four Components of ASoC:

The ASoC consists of four-division levels of responsibility to care for new amputees making a military-to-VA transition, as follows:

- **Regional Amputations Centers (RACs).** These are seven primary VA facilities for amputation care in VA that offer the highest level of expertise and clinical care and use the latest prosthetic concepts and designs in dealing with new injuries. RACs have highly developed accredited prosthetic laboratories and services as well as specialized rehabilitation equipment. These Centers provide comprehensive rehabilitation services

through an interdisciplinary team of physical and occupational therapists, physiatrists, nurses, recreational therapists and case managers.

- **Polytrauma Amputation Network Sites (PANS).** The 15 PANS provide a full range of clinical and supplementary services and consultations for other facilities within the Veterans Integrated Service Networks (VISN). They provide prosthetic services through accredited labs or via contracts with private fabricators. PANS are assigned responsibility to provide for the lifelong needs of veterans with amputations.
- **Amputation Clinic Team (ACT).** Over 100 ACTs are situated across the VA health care system. These clinics are located at smaller VA facilities. These facilities offer a core interdisciplinary team but locally may not have available an accredited inpatient rehabilitation program or accredited prosthetic laboratory. Typically, these facilities refer amputees to PANS, RACs or community contract providers for specialized services.
- **Amputation Point of Contact (APOC).** An APOC is an individual who is knowledgeable about the ASoC and refers amputees to facilities that can best meet their needs, based on individual case assessment.

VA's specialty amputation programs outside of the four primary treatment divisions are:

- **The Servicemember Transitional Amputation Rehabilitation Program.** Located in Richmond, Virginia, this program assists service members in returning to unrestricted military, federal or civilian employment and is designed to reduce the time required for disability evaluations to be completed. The program highlights a care coordination approach, and provides individualized physical and amputation-related rehabilitation services in a residential setting.
- **VA Center of Excellence for Limb Loss Prevention and Prosthetic Engineering.** Located in Seattle, Washington, this center's aim is to improve prosthetic manufacturing by developing novel approaches to improve the current standard of care. The goal of the center is to improve an amputee's mobility and comfort and to prevent further injury.
- **Prosthetic and Sensory Aids Service (PSAS).** System wide, VA provides veterans with equipment and limb manufacturing through PSAS and is the world's largest and most comprehensive provider of prosthetic devices and sensory aids. In FY 2010, PSAS served about 43,000 individuals with limb loss. However, VA defines a prosthetic device as *any* device that supports or replaces a body part or function and includes items such as artificial limbs; supportive braces; hearing aids; wheelchairs; wheelchair ramps; home improvements and structural alterations; surgical implants or devices; low-vision or blindness aids; service dogs; certain medical equipment and supplies, and sports and recreational equipment adapted for use by disabled veterans, including amputees.

With regard to VA's definition of "prosthetic," DAV recommends VA consider partitioning or grouping these devices by some non-generic categorization scheme so that artificial limbs, for example, will not be seen as the same as heart stints. Their criteria for use are vastly different, yet under VA's definition they are both considered prostheses. The same holds true for many other devices, such as implantable pacemakers, bone marrow, and orthopedic surgical supplies.

VA expects amputee veterans to use existing VA prosthetic and orthotic laboratories as their primary sources for prosthetic limbs, but VA will authorize eligible veterans to purchase

prosthetics from any commercial artificial limb fabricator under VA local contract or with a veteran's preferred private prosthetist, provided that supplier of services agrees to accept Medicare rates from VA for the service involved.

In 2011, the OIG conducted a survey of its ASoC and received 124 facility responses. According to the OIG, all of VA's 56 prosthetists and orthotists from the RACs and PANS were verified to be board certified in their fields. Likewise, all prosthetic laboratories were properly certified. In our opinion, VA's ASoC is fully established and functioning properly. We concur with the IG that due to the number of co-existing medical conditions of this patient population VA should pay special attention to coordinating services to ensure comprehensive and interdisciplinary care. We urge VA to continue to follow this population through time to better understand their complex and evolving health care needs and adjust services accordingly.

The VA OIG issued a second report in March concerning VA's prosthetics program, entitled "Veterans Health Administration: Audit of the Management and Acquisition of Prosthetic Limbs," (report no. 11-02254-012).

This audit was conducted to examine VA management and acquisition practices in procuring prosthetic limbs. According to the OIG, the VHA serves nearly 12,000 amputees annually, and obtains most prosthetic limbs from private vendors, but that some limbs are fabricated in VA accredited prosthetic laboratories. Based on the audit, OIG reported a system-wide weakness of internal controls and routine overpayments for prosthetic limbs—with overpayments found at each of the 21 VISNs. In FY 2010 alone, the OIG found that VA overpaid vendors about \$2.2 million—23 percent of all payments and that if new procedures are not implemented immediately VA would be overpaying about \$8.6 million over the next four years.

The OIG also argued that VA is not receiving the best value for the prosthetic limbs it is purchasing and that VISN contracting officers (COs) are not negotiating discounts in pricing with vendors and are at times purchasing without appropriate pricing guidance. For example, in FY 2010, VHA spent \$49.3 million to purchase over 4,000 limbs from vendors at a cost of about \$12,000 each—versus the average cost (\$2,900) VA's own prosthetic laboratories could fabricate the same types of limbs. The OIG concluded that VISN contracting staff were not uniformly documenting prosthetic limb contracts in the VA's mandatory Electronic Contract Management System (eCMS), a lapse that results in PSAS ineffectively balancing the combination of in-house fabrication and vendor procurement to properly meet veteran amputees' needs.

In April 2009, PSAS staff at VA Central Office requested that VISNs start requiring certified prosthetists to review vendor quotes to search for inappropriate Medicare billing codes that resulted in overpayments. At the time, we understand that many prosthetic purchasing agents (PPAs), who are subordinate to prosthetics chiefs, were not proficient in using Medicare billing codes to detect price variances. Since implementation of that policy, one VISN identified nearly \$400,000 in cost avoidance using Medicare codes, but it was noted that VACO's guidance did not address what actions local officials should take related to vendors discovered to have overcharged. The OIG concluded that in addition to VA's needing to pursue recovery of

overpayments, that segregating the work of VA's PPAs from other PSAS staff would offer an opportunity to improve its acquisition practices.

VA concurred with the OIG's recommendations and noted it is establishing a new program with a number of related processes to better manage prosthetic acquisition and management practices. Nevertheless, the Subcommittee should take note that while VA is in the process of making a major transition related to prosthetic warrants and associated staffing, PSAS has lacked permanent leadership for more than a year due to retirement of a long-term incumbent, and the person in the deputy director position has been reassigned to another program office. Given the sensitivity, scope and cost of this program, we urge VA to commit new permanent management as quickly as possible.

A third OIG report (report no.11-00312-127), also released in March and of concern to the Subcommittee, evaluated the effectiveness of VAMC management of prosthetic supply inventories.

VHA's prosthetic costs increased from \$1 billion to \$1.8 billion annually between FY 2007 and FY 2011. The OIG estimated that from April through October 2011, VA facilities were maintaining inventories of nearly 93,000 specific prosthetic items with a total value of about \$70 million. Among these stored items, almost 43,500 (47%) exceeded current needs, while PSAS was in short supply for more than 10,000 items (11%). For some prosthetics such as artificial limbs, VA facilities do not maintain formal inventories since these appliances are designed for individual veterans.

The OIG identified that facilities use two automated systems to inventory prosthetic items and that these inventory systems are not integrated with each other or other VA records systems, a situation that some attribute as the root of this problem. However, beyond a synchronization of electronic records, the OIG also cited a number of specific examples of gross mismanagement of VA's prosthetic supplies in inventory.

DAV was very disappointed to learn of the problems and failures identified in this report. It is clear that the offices that have responsibilities related to prosthetic inventory management should collectively work together and take immediate action to correct these issues. We understand, however, that PSAS has been waiting a number of years for the development and implementation of an integrated technology solution, which is yet to be funded by the Office of Information Technology (IT). We urge VA to expedite development of an IT solution to resolve this issue.

This OIG report recommended cyclical site visits to PSAS offices. We concur that VA would benefit from site visits to assess VAMC management of prosthetic inventories. The OIG estimated that if prosthetic supply inventory management were improved, VA could reduce prosthetic inventory value by approximately \$35.5 million. These resources cannot afford to be lost—particularly if they could be put to better use through a software solution for inventory control, and reinforced by occasional visits from outside entities.

VA Winter Sports Clinic – A Prosthetic and Athletic Success Story

DAV is a proponent of disabled veterans of all abilities and ages taking part in active adaptive sports, a specialized form of recreation therapy. Strong evidence validates such activities as both therapeutic and empowering to those who lost function as a consequence of war. To that end, DAV jointly sponsors the annual VA National Winter Sports Clinic in the mountains in Colorado. Participation is open to approximately 400 male and female veterans with spinal cord injuries, amputations, visual impairments, certain neurological problems, and other severe injuries. Veterans who are enrolled in VA or military treatment facilities receive first priority to attend the events and are guided by more than 180 ski instructors, including several members of the U.S. Olympic Disabled Ski Team, along with hundreds of other volunteers.

Adaptive sports have been shown to increase independence, improve health, well-being, confidence and professional goal attainment all while reducing a person's dependency on medications to address their pain and other challenges. For many veterans who attend this special event, everyday challenges of life seem much more surmountable after conquering a snow-covered mountainside or participating in the many other adaptive sports options available. Participating veterans focus their energies on "...the ability, not the disability." We firmly support VA's longstanding policy to provide adaptive sports equipment for use at the Winter Sports Clinic, and to do so through PSAS.

The Critical Prosthetics Mission of VA Research

For 85 years, VA has managed a broad and extensive intramural portfolio in biomedical and health services research that is focused on meeting the particular needs of sick and disabled veterans. According to VA's Office of Research and Development (ORD) over the past decade, the number of veterans accessing VA health care for prosthetics, sensory aids or related services has increased more than 70 percent. For these reasons, VA's research portfolio includes studies on traditional prosthetics, for example replacing an amputated limb, to more advanced neural prostheses that actually integrate into a person's tissues. Since 2008, VA has been involved in a study to obtain needed data to advance the development and refinement of the DEKA arm system that enables a person with an upper extremity amputation to control an artificial arm and fingers in a highly sophisticated fashion, even exhibiting fine motor skills and full range of motion. Information gained from this study will be used to develop training materials for prosthetic specialists, physical and occupational therapists and veteran amputees, and to lead the way to additional clinical trials. Given the difficulty many veterans have expressed related to upper extremity amputation, including residual chronic pain and loss of functionality, and the relatively poor substitution of existing prosthetic devices, the DEKA Arm could revolutionize prosthetics science. We encourage VA to continue this collaboration with industry in a remarkably important new development.

Women Veterans with Traumatic Amputations

DAV is pleased that the PSAS focuses particular attention to the needs of women veterans. In 2008, the PSAS established the Prosthetics Women's Workgroup (PWW), an interdisciplinary

collaboration of subject matter experts on Women's Health from across VA. The purpose of the PWW is to enhance the care of women veterans by focusing on their unique needs and how those needs can best be met by the range of devices provided to include a focus on technology, research, training, repair and replacement of prosthetic appliances. The PWW has established a multi-part goal of eliminating barriers to prosthetic care experienced by women veterans by:

- Providing medically necessary prosthetic devices and medical aids to women veterans in accordance with policies governing PSAS programs;
- Ensuring uniformity in the provision of prosthetic appliances across VA;
- Encouraging VA to seek legislative remedies if needed to aid women veterans;
- Exploring and improving contracting and procurement actions that provide devices made specifically for women; and
- Identifying emerging technologies applicable to women amputees and proposing ideas for research and development focused on women veterans' needs in prosthetics.

Members of VA's PWW are mostly veterans but also include an interdisciplinary team of experts from VA, DAV, PSAS, and the Office of Women's Health. We urge VA to continue this group's work to ensure VA meets the unique prosthetic needs of women veterans.

CLOSING

The OIG noted in one of its reports that many veterans praised VA for the comprehensive medical care they receive. Veterans were especially appreciative of their ability to choose a prosthetics vendor and the location in which to receive those services, for home accommodation and automobile adaptive benefits, and for the dedicated efforts of the OEF/OIF coordinator staffs in VA facilities.

In preparing for this hearing, DAV reached out to DAV members from different eras of military service who are amputees and are using the VA health care system for their primary and prosthetic health care needs. We asked them to tell us about their experiences with VA prosthetics services and if they were satisfied with that care or if VA could make improvements to better meet their needs. Similar to the OIG's report, we received a variety of comments both positive and negative. Several commenters expressed concern that PSAS retain a strong connection to clinical activities rather than be relegated to a dry, standardized and inflexible acquisition function. While contracting will always be a dominant aspect of prosthetic supply, the determination of what type of prosthetic appliance needs to remain with physical medicine and rehabilitation specialists aided by a prosthetic representative, accompanied by the full, continuing involvement of the disabled veterans being served. One of our commenters put it best: "without it [the clinical presence], veterans would surely suffer tremendously as they would only be invoice numbers and not patients."

In conclusion Madame Chairman, DAV urges VA to achieve and maintain a balance in prosthetics and sensory aids procurement versus simply expanding in-house development of limb prostheses, and we ask this Subcommittee to oversee that process. While VA could surely and significantly expand its prosthetic manufacturing capabilities with the OIG's cost-cutting views as motivation, the available supply of private fabricators has spent decades developing their arts

and crafts to a highly refined state of excellence. As these innovative prosthetic technologies seep into the public marketplace, we are confident VA will adopt them. While we strongly support the research element as indicated in this statement, VA should not in our judgment try to replicate all or even most of those advances internally. Instead, VA should improve its business relationships with the private fabrication enterprise and work to improve internal controls, prosthetic training, certification and inventory management as recommended by the OIG in these several reports. In cases in which VA laboratories are already manufacturing satisfactory limbs, however, we believe that process should continue—but we do not see this moment as justifying a large expansion of in-house VA manufacturing or fabricating, especially in high-technology devices.

While we at DAV agree that prosthetics is an expensive area of VA operations, Congress and the American public believe these expenditures are well worth their cost, to partially repay the sacrifices veterans made in military service, and as a major increment of holistic health care to veterans in general. Also, the health of the general public benefits from this progress within VA, since these VA-developed, tested and perfected devices and the research that accompanies them make their way into broader societal use in addressing rehabilitation from traumatic injury. In that regard, we believe that Administrator Bradley and Dr. Hawley would be proud to know that VA continues to carry forward their legacy.

Madame Chairman, this concludes DAV's testimony. I would be pleased to consider any questions from you or other Members related to my statement, or to PSAS.