

**STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

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Mr. Chairman and Members of the Committee:

I am pleased to be here today to speak to you on collaboration between the Department of Veterans Affairs (VA) and the Department of Defense (DOD) in research and amputee care for veterans of current and past conflicts, and on VA's blind rehabilitation program.

I would like to begin by discussing amputee care and research, focusing particularly on our collaborative efforts with Walter Reed Army Medical Center (WRAMC). Before I do that, however, I believe it would be in order to say a few words about VA's Taskforce for the Seamless Transition of Returning Service Members, which plays a major role in coordination of health care for veterans and service members between VA and DOD. I realize that these efforts have been discussed in previous hearings, but they bear repeating, since they focus on providing a seamless transition for all veterans, including those whom need amputee and rehabilitative care.

In August 2003, VA's Under Secretary for Benefits and the Under Secretary for Health established the Seamless Transition Task Force to guide our continuing efforts to ensure that world class services are provided to service members and veterans. Since that time, we have worked closely with DoD to enhance our ability to identify and serve all returning service members that sustained injuries or illnesses while serving our country and to improve dialogue and collaboration with DoD at all levels.

Under the Task Force's guidance, each VA Medical facility and each VA regional office has identified a point of contact to coordinate activities locally and

meet the needs of returning service members and veterans. Working in collaboration with the military Surgeons General, VA has detailed full-time and part-time Veterans Service Representatives and social workers to military treatment facilities (MTF), including the Walter Reed Army Medical Center (the MTF receiving the largest numbers of casualties); the Brooke, Eisenhower, and Madigan Army Medical Centers; Darnall Army Community Hospital at Fort Hood; and the National Naval Medical Center in Bethesda. They work closely with military medical providers and DoD social workers to assure that returning service members receive information and counseling about VA benefits and programs. They also facilitate transfer of care from a DoD medical facility to a VA medical facility. Through this collaboration, we have improved our ability to identify and serve returning service members that sustained serious injuries or illnesses while serving our country.

Amputee Care

VA's Prosthetic and Sensory Aids Service (PSAS) Strategic Healthcare Group is our advocate for the core population of veterans with special needs for prostheses and sensory aids. It provides specialized patient care by furnishing properly prescribed prosthetic equipment, sensory aids, and devices in the most economical and timely manner possible. Through PSAS, VA has a program of care in place that has been serving veterans since 1946. In FY 2003, VA provided new limbs and repairs to 2,906 above knee amputees, 6,156 below knee amputees, and 732 arm amputees, for a total of 9,794 amputees served. VA spent \$44 million for new limbs and \$13 million for repairs.

VA provides new and emerging technology as it becomes available in the marketplace. It is our policy that any product available in the marketplace is available to veterans. As new technology is rolled out, VA amputee clinic teams can prescribe the new limbs. We provide this technology through a system of over 500 private contractors who are part of the VA Amputee Clinic Teams at the medical facility. As a veteran progresses through life, we refit, repair, adjust, and replace the equipment provided, to meet the veteran's changing needs.

The method of care just described is the same one used at WRAMC. Thus, VA is fully prepared to provide the high-tech prosthetic limbs that are now being provided by the Army to the amputees returning from Iraq. In fact, VA and Walter Reed have been working together since the beginning of Operation Iraqi Freedom to ensure that service members and veterans receive whatever is necessary.

The Department of the Army (DOA) receives some of the new technology directly from the manufacturers' laboratories. In cases where the amputee is fitted with a limb that is not yet available to the general market, VA will pay the amputee's travel costs to enable the amputee to return to WRAMC if he or she needs a repair or requests a new limb. In those instances where it is unclear whether VA or DOA is responsible for paying for the limb, VA and WRAMC have agreed that they will take care of the patient first. Responsibility for assuming the costs of the limb is a separate, administrative determination, in no way impacting our primary concern of providing needed care to the patient. As stated earlier, VA has employees permanently assigned to Walter Reed and other MTFs across the country to assist in the transition of the service members to the VA system. Often, service members use both health care systems as they travel home for convalescence leave, or travel back to their units. VA officials also spend time at WRAMC visiting with staff and patients, and VA and WRAMC staffs have participated in the conferences on amputees that each department has held.

VA's PSAS, Physical Medicine and Rehabilitation Service, and Rehabilitation Research and Development Service have formed a workgroup devoted to Amputee Rehabilitation and Research. This workgroup is in the process of finalizing recommendations for creating Centers of Excellence for Amputee Care and Research from among the 162 VA medical centers. Research is to be an integral part of the Centers of Excellence. Additionally, the workgroup is systematically identifying VA medical centers to be considered as Prosthetic Treatment Centers that would possess qualifications such as Commission on Accreditation of Rehabilitation Facilities (CARF) and American Board of Certification (ABC) accreditation. These Prosthetic Treatment Centers

will be defined and amputee referral guidance will be published for VA system wide usage.

Prosthetics Research

VA prosthetics research focuses on providing the best care to all veterans with limb loss and on enabling them to live complete and fulfilling lives. Current initiatives include collaborations with the Department of Defense, especially Walter Reed Army Medical Center (WRAMC); Brown University; the Massachusetts Institute of Technology; and the Rochester Mayo Clinic. In addition, VA's Office of Research and Development works closely with two VA clinical services, Physical Medicine and Rehabilitation and Prosthetics and Orthotics.

VA research was responsible for supporting development of modern prostheses such as the "Seattle Foot" and of new surgical techniques that helped ensure amputees could comfortably wear these devices. In FY 2004, VA approved 29 projects with combined funding of \$16.2 million. This fall, the Rehabilitation Research and Development Service will consider more than 20 additional proposals for funding when it conducts its Scientific Merit Review Board. Most of these proposals typically focus on technological assessment of major limb prostheses in order to provide an objective assessment of prosthetic durability, stability, cost effectiveness, long-term use, and other important factors relevant to clinical efficacy for amputees.

At this time, I would like to discuss in some detail various amputation research initiatives we are undertaking in collaboration with WRAMC. I will then briefly outline additional initiatives that are underway.

Research in Collaboration with WRAMC

VA currently collaborates with WRAMC on 10 projects involving various aspects of amputation care and outcomes. These efforts involve eight VAMCs (Baltimore, Washington, DC, Kansas City, Manhattan, Miami, Minneapolis, Puget

Sound, and San Antonio), the Rochester Mayo Clinic, the University of Maryland, Catholic University, and private industry. These efforts will evaluate existing technologies and new potential surgical treatments, including "tissue engineering" (for residual limb lengthening) and osseointegration (a procedure that places a titanium rod into the bone). In addition, VA and WRAMC are developing a special database protocol to establish electronic data sharing that documents existing and prospective prosthetic rehabilitation in young active amputees. This will optimize patient tracking and promote a "seamless" continuum of amputee patient care between VA and DoD.

One critical area of focus is research to improve lower extremity prosthesis rehabilitation. Although the lower extremity amputee represents nearly 70 percent of limb loss patients admitted to WRAMC, few studies exist investigating whether existing new technologies significantly improve overall function of casualty amputees. Several joint initiatives seek to fill this information gap. Rigorous testing will commence on commercially available above-the-knee prostheses using the vacuum assisted socket system (the VASS) to promote residual limb health. The VASS socket design has been designed to provide pressure gradients within the residual limb important for circulation and patient comfort. This study, conducted with the assistance of the manufacturer (Otto Bock Health Care Co.) and the Rochester Mayo Clinic, will evaluate how well the VASS meets that goal.

The Kansas City VAMC, WRAMC, and the Rochester Mayo Clinic are testing two other devices that are believed, but not empirically proven, to be more effective than previous prosthetics. Investigators will examine the microprocessor-controlled knee of the C-Leg® (Otto Bock Co.). Currently, all lower-limb amputees returning from Operation Iraqi Freedom and Operation Enduring Freedom receive this device, so it is vitally important to explore the limits of this new technology and to develop appropriate rehabilitation programs for its use. Similarly, researchers will examine the low profile Vari-Flex® foot from Ossur and determine how the multi-axial function of the Vari-Flex foot supports better traction and foot control during a variety activities in young active

amputees. The Vari-Flex foot is designed to facilitate walking on uneven terrain, which has proven difficult for amputees.

Additional Initiatives in Prosthetics Research

Earlier this month, VA awarded \$4.7 million over five years to researchers at the Providence VA Medical Center to develop state-of-the-art care for veteran amputees. Brown University Medical School and the Massachusetts Institute of Technology will collaborate with VA investigators in a new "Center for Rebuilding, Regenerating and Restoring Function After Limb Loss." The Center will provide patient care and conduct research in tissue engineering, neurotechnology, materials science, robotics and advanced surgical techniques.

Amputations as a result of diabetes are the greatest cause of amputation in VA patients. Recently, VA has begun funding an Evidence-Based Amputee Rehabilitation program at the Miami VAMC, which involves an exercise program to improve strength, balance, and endurance and is specifically targeted to older veterans with amputations due to vascular disease or diabetes.

Building on the highly successful Quality Enhanced Research Initiative (QuERI), a data-driven, outcomes-based, quality-improvement program, VA has directed its Health Services Research and Development and its Rehabilitation Research and Development Services to develop an Amputation QuERI. This initiative will support the translation of research discoveries into clinical care resulting in improved outcomes for veteran amputees.

In May 2004, VA held a Traumatic Amputation QuERI Workshop to activate VA and WRAMC researchers in the first phases of Amputation QuERI initiative. Special focus was placed on documenting best practices, developing strategies for implementation, and disseminating results and recommendations. Initiation of outcomes studies and Amputation QuERI Center funding are planned for fiscal year 2005.

VA Blind Rehabilitation Program

Mr. Chairman, I will now turn my attention to the second topic of this hearing, VA's Blind Rehabilitation program.

The visually impaired veteran population in the United States is estimated to be about one million. More than 150,000 are legally blind (20/200 or worse). Increasing numbers of veterans will have vision impairment in the coming years because vision impairment and blindness are frequently age related. By 2010, we estimate that the total population of severely visually impaired veterans will reach 900,000, and that 90,000 of them will be eligible for VA blind rehabilitation services. Fortunately, blind rehabilitative services have been required by a very small number of service members returning from Iraqi Operation Freedom and Operation Enduring Freedom.

The first VA Blind Rehabilitation Center (BRC) was established at the VA Hospital in Hines, IL in 1948. Today, our program has grown to include:

- 10 inpatient BRCs, which provide comprehensive individualized blind rehabilitation services to profoundly visually impaired veterans in an inpatient environment;
- 92 full-time and 74 part-time Visual Impairment Services Team (VIST) Coordinators, who manage the administrative and professional services provided to blinded veterans at medical centers;
- 23 Blind Rehabilitation Outpatient Specialists (BROS), who are multi-skilled professionals performing a wide array of blind rehabilitation services;
- 5 National Program Consultants, serving as advisors to medical center-based programs for the blind;
- 1 Visual Impairment Services Outpatient Rehabilitation (VISOR) Program, offering skills training, orientation and mobility, and low vision therapy;
- 3 Visual Impairment Service Centers to Optimize Remaining Sight (VICTORS) programs for low vision visually-impaired veterans, which are operated by VA's Optometry Service and emphasize an inter-disciplinary team approach to definitive medical diagnosis, functional vision

evaluation, prescribing and training in the use of low vision aids, counseling, and follow up; and

- Inpatient Computer Access Training (CAT) programs at medical centers throughout the country and in Puerto Rico.

Program Challenges

VA's Blind Rehabilitation Program is recognized as providing world-class care to its veterans. It is a program designed to improve the quality of life for blinded and severely visually impaired veterans through the development of skills and capabilities needed for independent living, emotional stability, and successful integration into the veteran's community and family environment. Nonetheless, we are not without challenges to enhance and improve our services to continue to meet the needs of visually impaired veterans of the 21st century.

The development of rehabilitative interventions that improve and maintain everyday function and quality of life is critical to fulfilling the VA's mission. Over the next ten years, VA will be challenged to provide cost-effective vision services to an aging veteran population. While offering a continuum of care that includes devices and training to visually impaired veterans may seem like a daunting task, it should be noted that the demands for this group are much less extensive than those required for the legally blind group.

Aging veterans with vision loss can acquire a multitude of impairments and disabilities. The co-existence of visual disabilities with other physical disabilities, including significant hearing loss, is common. These impairments and disabilities result from a complex interaction among medical conditions, related morbidity, and the environmental factors that affect the veteran and his/her caregivers. Vision care must therefore be multi-disciplinary and interdisciplinary.

Rehabilitation services designed to address the complex nature of these impairments and disabilities must be interdisciplinary. Their development requires the creative energy of multiple disciplines working in a synergistic and collaborative manner. For example, rehabilitative interventions such as

magnifiers that target poor visual acuity may improve visual performance. However, everyday function may not be enhanced if appropriate environmental or assistive technologies are not available to complement the visual performance improvements.

Similarly, improved visual function alone may not improve overall function and quality of life if these veterans also have medical conditions or other disabilities. Thus, an interdisciplinary approach to developing optimal rehabilitative interventions for this population is critical. These interventions include assistive technologies, environmental modifications, and training programs customized to the individual needs of the veteran. The comprehensive vision rehabilitation services being developed by VA are a model for a national vision/blind rehabilitation plan. The continuum of care model of services enhances the quality of care and VA's ability to provide greater access to high-quality vision rehabilitation services in the right place at the right time.

For returning OIF/OEF service personnel returning with multiple injuries, such as traumatic brain injury, traumatic visual impairment, and blindness, VA clinical program offices are working collaboratively to assist with the training and integration of services to meet the patient's needs both in VA and with Department of Defense. Thus far, VA BRCs have admitted 11 patients who served in OIF/OEF.

Waiting times to enter a VA BRC need to be reduced. One approach to creating a healthcare system without delays is promoting innovative use of technology. The CAT program is just one example of where VA has promoted that innovation. The Rehabilitation Strategic Healthcare Group (SHG) and Prosthetics and Sensory Aids Service SHG are working collaboratively to provide funds and contractors to teach CAT to veterans in their home area, where feasible. VA believes this to be a cost effective alternative, which will reduce waiting times, increase access, and benefit blinded veterans. BRCs are reviewing existing CAT waiting lists. Patients whose computer training could be provided locally will be referred to the assigned VIST Coordinator, who will arrange for CAT in the veteran's community. VA is also working on a

computerized blind rehabilitation national database that will track waiting times for all blind rehabilitation patients, both inpatients and outpatients. The database will reduce variation in the reporting of waiting times.

Improvements in Blind Rehabilitation

Despite the challenges, VA has taken positive steps that will help us address care enhancements to visually impaired veterans.

To maintain capacity and excellence in the care provided, the Under Secretary for Health commissioned a Blind Rehabilitation Gold Ribbon Panel. This panel identified the need to “develop and implement a continuum of care model that extends from the veteran’s home environment to the local VA care site and the regionally based inpatient training program. VA’s Visual Impairment Advisory Board (VIAB), an interdisciplinary board of providers, researchers, network representatives, and consumers who advise the Under Secretary for Health on matters related to the needs of veterans with vision impairment, was established to implement the Gold Ribbon Panel recommendations. The VIAB identified treatment of severe visual impairment as a critical need for the veteran population.

In one of its first actions, VIAB worked with the VA Office of Finance and VHA’s Allocation Resource Center to develop the means to capture appropriate workload for legal blindness and low-vision care. Universal encounter forms incorporating standard diagnosis and procedure codes for blind rehabilitation are being proposed to go into effect in FY 2005. These changes will enable the Veterans Equitable Resource Allocation system (VERA) to more appropriately reflect cost of treatment for these veterans. VIAB is also collecting data to project costs associated with treating veterans who are not legally blind, but have functional visual impairment. A proposal to create a new basic care patient classification for legally blind patients in the FY 2005 VERA Model has been recommended by both the National Leadership Board (NLB) Finance Committee and the full NLB. This proposal will be among the FY 2005 VERA recommendations to the Secretary.

The VIAB, together with VHA's Health Systems Committee and Rehabilitation Strategic Healthcare Group recently requested that VA's Rehabilitation Research & Development Service (RR&D) initiate a comprehensive internal census of existing VA eye care and vision rehabilitation infrastructure, programs, and staff. The primary focus of this effort was to conduct a gap analysis of VA's overall vision rehabilitation capacity within the continuum of care. RR&D issued its preliminary report on July 8, 2004, and the VIAB is now reviewing it. The VIAB's review is expected to be complete by mid FY 2005. The VIAB will then report its findings to the Health Systems Committee for further evaluation of the continuum of care model.

CARES and Blind Rehabilitation

The CARES planning initiative offered the opportunity to address service provision needs and additional venues for blind rehabilitation programs, thereby reducing the waiting times and waiting lists at BRCs. The CARES Commission recommended that VA optimize access to care for veterans by developing more outpatient-based blind rehabilitation opportunities. The Secretary agreed and supported the strategic emphasis on the importance of placing blind rehabilitation services closer to populations in outpatient settings. These efforts will be included in future planning guidance and will be incorporated into the FY 2005 strategic planning submission. In addition, VA will open new Blind Rehabilitation Centers in Biloxi and Long Beach.

Conclusion

VA has a long and distinguished history of funding innovative and groundbreaking projects that have benefited amputees and the vision-impaired patients throughout the world and continues to commit a major portion of its research resources to these efforts. This concludes my statement, and I will be pleased to respond to questions from the Committee.