HEARING ON OPTIMIZING CARE FOR VETERANS WITH PROSTHETICS

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BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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HEARING ON OPTIMIZING CARE FOR VETERANS WITH PROSTHETICS

WEDNESDAY, MAY 16, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The Subcommittee met, pursuant to call, at 9:59 a.m., in Room 334, Cannon House Office Building, Hon. Ann Marie Buerkle [Chairman of the Subcommittee] presiding.

Present: Representatives Buerkle, Stearns, Bilirakis Roe, Runyan, Michaud, and Reyes.

OPENING STATEMENT OF HON ANN MARIE BUERKLE, CHAIRWOMAN

Ms. BUERKLE. Good morning. The Subcommittee will now come to order.

Good morning and welcome to today's Subcommittee on Health hearing, Optimizing Care for Veterans With Prosthetics.

Our Nation's commitment to restoring the capabilities of disabled veterans struggling with devastating combat wounds resulting in the loss of limb began with the Civil War. Restoring these veterans to wholeness was a core impetus behind the creation of the Department of Veterans Affairs and then and it continues to play a vital role in the department's mission now.

Prosthetic technology and VA care have come a long way from the Civil War era wooden peg legs and simple hooks.

Following World War II, in 1945, veterans dissatisfied with the quality of prosthetic care stormed the Capitol in protest. Congress responded by providing the VA with increased flexibility for prosthetic operations and launching Federal research into the development of new mobility and assistive devices.

With these reforms, VA led the way in prosthetic care and research, guided by dedicated professionals both inside and outside the department who worked tirelessly to provide veterans with the quality care they earned and they so much deserve.

As a result, the model of VA care for today's veterans includes leading edge artificial limbs and improved services to help them regain mobility and achieve maximum independence.

Still the magnitude of the heart-breaking injuries sustained by servicemembers and veterans returning home from military service in Iraq and Afghanistan find the VA struggling to keep pace with the rising demands of younger and more active veterans with amputations.

Prosthetic care is unlike any other care provided by the department. Prosthetic devices, particularly prosthetic limbs, quite literally become a part of their owner, requiring the integration of body, mind, and machine.

The goal is not just to teach amputees to walk or use an artificial arm or hand but to provide multi-disciplinary continuing care to maintain long-term and lifetime functioning and quality of life, which is why I am troubled by the department's proposed changes to prosthetic procurement policies and procedures.

The forthcoming reforms will, among other things, take prosthetic purchasing authority from prosthetic providers and transfer them to the contracting officers. This is alarming to me. As we will hear soon, it is also alarming to many of today's witnesses.

I would like to read a quote from Captain Jonathan Pruden, a wounded warrior himself, who states in his testimony that: "we see no prospect that this planned change in prosthetics procurement holds any promise for improving services to the warrior. Instead it almost certainly threatens greater delay in VA's ability to provide severely wounded warriors' needed prosthetic devices and heightens the risk that a fiscal judgment will override a clinical one."

I think that the Members of this Committee agree, along with many of you in the audience this morning, that we cannot allow this to happen and this morning we will look to the department for assurance that it will not happen.

It is nothing short of inspiring to see how far modern technology and most importantly the spirit, courage, and resolve of our veterans themselves has come in restoring mobility, dignity, and hope to our Nation's heroes. They are our heroes and this Nation owes them this debt of gratitude to make sure our veterans have exactly what they need to survive, to thrive, and to have a high quality of life.

It is vital that we set VA prosthetic care on a course that matches the courage and bravery of the men and women who serve our Nation in uniform.

Again, I thank all of you for joining us this morning.

I now recognize our Ranking Member, Mr. Michaud, for any remarks he might have.

[THE PREPARED STATEMENT OF CHAIRWOMAN ANN MARIE BUERKLE APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD, RANKING DEMOCRATIC MEMBER

Mr. MICHAUD. Thank you very much, Madam Chair.

And I would like to thank everyone for attending this very important hearing we are having today.

The purpose of today's hearing is to look closely at VA's prosthetic and sensory aids services and to examine the, number one, demand for prosthetic services; number two, equality of care and access issues; three, the impact of ongoing procurement reforms; and, four, if current acquisition and management policies are sufficient.

As the three Office of Inspector General reports have shown, there are numerous concerns including the frequency of overpay-

ment in nearly a quarter of the transactions totaling over $2.2 million in fiscal year 2010, the absence of negotiations, price guidance, and other controls and the limited information to assess if current prosthetic limb fabrication and acquisition practices are effective.

I have said it on this Committee before, but what seems to be a case that there is little accountability in management and, once again, procurement and procedures and policies were not in place or not followed in managing nearly $2 billion worth of prosthetics and sensory aids.

The VA in the last year's budget submission claims that $355 million in savings in fiscal year 2012 and 2013 due to acquisitions improvements, but if the VA cannot follow its own policies and procedures, how much faith can we have in the claim of acquisition savings?

I hope the VA can help us understand today what accountability we should expect and to make certain that the VA does not continue to overpay for prosthetics in the future, that taxpayers and veterans receive the best value for their devices and for management to ensure that the prosthetics and sensory aids services is fully meeting veterans' needs.

Finally, it has come to my attention that VA has proposed changes in the procurement of prosthetics and that there is a high degree of concern among some of our witnesses today as to the effectiveness of these changes.

I look forward to hearing from the VA on these issues as well, and I would like to thank all of the panelists for coming today and want to thank those of our panelists who are veterans for your service for this great Nation of ours.

I am committed to working with all of you to ensure that our wounded veterans, those who have served honorably and made such great sacrifices are able to go about their lives more comfortably with these devices and with the best support and services from the VA possible.

So I want to thank you once again for coming today.

I want to thank you very much, Madam Chair, for having this very important hearing. I yield back.

[THE PREPARED STATEMENT OF HON. MICHAEL H. MICHAUD, APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you, Mr. Michaud.

I would like to now invite our first panel to the table.

Joining us this morning are John Register and Jim Mayer.

Mr. Register is a veteran of Operations Desert Shield and Desert Storm and a world-class athlete, winning nine gold medals in the army's armed services competition.

In 1994, John suffered an injury that led to the amputation of his left leg. Undaunted and with the aid of a prosthetic, John went on to win a silver medal in the 2000 Paralympic games where he set the American long jump record with a distance of 5.41 meters.

He now works with the United States Olympic Committee where he manages the Paralympic Academy Youth Outreach Program and the Paralympic Military Program.

We also have the privilege of being joined by Mr. Jim Mayer. Mr. Mayer served as an infantryman in the United States Army during

the Vietnam War. He is a combat-disabled veteran and a bilateral below the knee amputee.

After serving so honorably in combat, Mr. Mayer has devoted his life and career to assisting his fellow veterans, working for 27 years with VA and 12 with our veteran service organizations.

Perhaps most notably, he has also spent 21 years as an amputee peer visitor and mentor at VA and the Walter Reed Army Medical Center and now at the Walter Reed National Military Medical Center, where he is affectionately known as the "milkshake man".

Gentlemen, thank you both so much for your service to our Nation and for your continued service to your fellow veterans through your many worthy endeavors today. Both of you are truly inspiring to all of us and it is really an honor to have you here with us today. I very much look forward to hearing your testimony.

Mr. Register, you may proceed.

STATEMENTS OF JOHN REGISTER, VETERAN; JIM MAYER, VETERAN

STATEMENT OF JOHN REGISTER

Mr. REGISTER. Thank you very much and, Ranking Member Michaud, thank you, and Members of the Subcommittee.

And I know the milkshake man. I have to go to Walter Reed this afternoon, so that is outstanding.

Thank you for this opportunity to testify on the ability of the Department of Veterans Affairs to deliver state-of-the-art care to veterans with amputations.

And today I am testifying on behalf of myself and an organization for which I serve on the Board of Directors, that organization being the National Association of Advancement of Orthotics and Prosthetics, the NAAOP, a national association that promotes public policy and interest of orthotic and prosthetic patients and the providers who serve them.

I served, as you stated earlier, in Desert Shield, Desert Storm, and my injury actually happened May 17th, 1994. So my 18th anniversary is actually tomorrow.

I was just over at the Pentagon where a friend actually found photos of the actual accident. So I just have them in my bag, so I am kind of just stressing out a little bit right now seeing those photos again.

But it is remarkable about the prosthetic care does come afterwards and that is what I am going to talk about a little bit today.

I did go back after my injury and went to the Paralympic games in 2000, winning the silver medal in the Paralympic games.

I currently now live in Colorado Springs and I began my initial care at the amputee clinic in Denver VA hospital and referred to a local prosthetist in Colorado Springs for my primary prosthetic care.

And I sought out this process because of two reasons. They were close to my home, first of all, and, secondly, they understood the high level of activity that I am accustomed to.

This was done in no way to disparage the care that I received at the Denver VA. In fact, when I first was an amputee, I came

to Walter Reed and also the VA hospital right here in the Capitol region and had outstanding care.

In my experience, I have always been treated with dignity and respect at the three VA hospitals that I have been fortunate to work with. And finding a local prosthetist is pretty typical in the VA prosthetic care.

And just a few years ago, approximately 97 percent of prosthetic limbs were provided by private prosthetic practitioners under contract with the VA. And I understand this percentage has decreased in the past few years as the VA has invested their internal capacity to their capacity to fit and fabricate limb prostheses.

I had a close working relationship with my local prosthetist over the years and would like to continue seeing him. And the prosthetist is certified and accredited by one of two accrediting agencies the VA recognizes and requires.

My local prosthetist's office in town is seven minutes from my house. He has signed a VA contract to provide that care. And the ongoing care I receive at my contract prosthetist was high quality and very convenient, creating little disruption for my current job, my family, and my lifestyle.

I developed a need for a new prosthetic as it was coming out and I began to be interested in this new technology. And the VA hospital in Denver, when I went to go see them for the consult, said that I would have to come there in order to get this limb fitted.

And I did not realize I had a choice in the matter and believing the new technology would meet my prosthetic needs and increase my quality of life, I agreed and began the fitting process at the Denver VA, driving 70 miles each way to receive that prosthetic care. And I could have just as easily have gone down seven minutes from my home to get that care done.

And it was also later that I realized after like my fourth or fifth visit that I could be reimbursed for gas mileage. So that is something I did not know that I wanted to get out to the other vets and I began tweeting that out as well on my social network to my VA vets.

I traveled to Denver numerous times in the fitting process before I finally received my new limb which I am wearing today and I am really thankful for.

Every time I need adjustments or a servicing of the prosthetic, I must take the better part of day off of work, drive a significant amount of distance, and obtain my VA care at the Denver VA.

Again, great care there. I am not disparaging that. It is just a bit of an inconvenience. I have no complaints about the prosthetic care that I received. So I consider myself to be very fortunate where I am not vulnerable and uneducated about the process. But I worry about those veterans who are not in a position to advocate for themselves, simply accept what they are told about the prosthetic care and the options.

Veterans, I think, just need to know some of the rights that they have. They should have a choice in the prosthetic practitioner and choice of technological options and a choice to seek a second option when it is desired by a patient.

Passage of such legislation like H.R. 805, the Injured Amputee Veterans Bill of Rights, I think, is critical.

And I reviewed three reports recently issued by the Office of the Inspector General and have some general observations to just offer this Committee.

The first is of the $1.8 billion spent by VA on prosthetics in fiscal year 2010, only $54 million or three percent was spent on prosthetic limbs. And this is a relatively small portion of dollars spent by the VA on a broad category of prosthetics.

Secondly, the VA has a major investment in its internal limb prosthetics capacity in 2009 with the development of the amputee system of care, ASOC program that should be commended for its commitment and focus on this important population.

The report also notes high satisfaction of those with lower limb prosthetics but less satisfaction with upper extremity. And we agree with the OIG that the VA should improve on this care of the population and request of the VA to publish the report on upper limb research associated with the VA/DoD research conference held two years ago.

The NAAOP takes issue with the OIG's calculation of the difference in what it asserts as a cost to the VA to provide prosthesis on average to veterans and its in-house capacity and the Veterans Health Administration. The report stated that $12,000 on average for a prosthesis while the average cost of a prosthetic limb fabricated at VHA's prosthetic lab was approximately $2,900. This is highly a little suspect calculation of VA's true cost in providing prosthetic care and we just want to know what kind of the costs are associated with those that went into that report.

As the VA enhances its internal prosthetic capacity, it is important to recognize the legitimate role of private prosthetists who have provided prosthetic care to veterans for decades with the VA.

Allowing veterans to access private prosthetics in their own hometown communities preserve quality by allowing their choice in provider. The relationship between the prosthetist and patient can mean all the difference in the world, especially, you know, with myself going on to higher level competition and wanting to have a higher quality of life.

The last two points is I think it is important that the VA maintains access to local private prosthetics under the contract with the VA to conveniently service veterans. And this is why the NAAOP strongly agrees with the recommendation in the health care inspection report that VA addresses veterans' concerns with the VA approval process for fee-based and VA contract for prosthetic services to meet the needs of veterans with amputations.

So we ask the Committee to seriously consider in a subsequent legislation hearing passage of a legislation pending before this Committee that seeks to address this very issue, H.R. 805, an Injured and Amputee Veterans Bill of Rights.

So on behalf of NAAOP, I want to thank you, Madam Chairwoman, and the Subcommittee for examining this critical issue. And I also thank you for this opportunity to testify before you and I welcome your questions after my friend.

[THE PREPARED STATEMENT OF JOHN REGISTER APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much, Mr. Register.

Mr. Mayer, you may proceed.

STATEMENT OF JIM MAYER

Mr. MAYER. Chairwoman Buerkle, Ranking Member Michaud, thanks for the chance to talk to the Subcommittee today and thank you for those kind words in your introduction. I really appreciate that, ma'am.

I received, like John, I received a lot of prosthetic care. I received it from the VA, from Brooke Army Medical Center, from Walter Reed, and the private sector.

And your reference to my peer mentoring and peer visiting amputees at Walter Reed over the years, I have gotten to know current warriors and their families, their concerns. And in short, I think I understand the catastrophic injuries they have overcome through military health care and rehabilitation. I understand it from being at their bedside and I also understand from being in that hospital bed myself.

As of May 1st, there is 1,459 warriors with amputations. The care for those warriors is at the very core of the VA's mission. Yet, it is clear that VA's prosthetics today is at a crossroads. VA to me has the chance to regain its leadership role that you referred to in the excellence in this field of prosthetics provision and amputee care.

But the current direction and recent decisions involving prosthetic care suggests that the Veterans Health Administration, VHA, is about to further compromise its ability to serve these veterans.

In 2004, eight years ago, Secretary Principi testified before this Committee that VA in his opinion had lost its edge in prosthetics and it was not doing enough to ensure that VA had developed world-class prosthetic care and rehabilitation programs.

His primary solution at that time was to build a, quote, center of excellence in amputee research and rehabilitation. Secretary Principi's words of eight years ago still ring true today, but the number of warriors with amputations has since increased by over 900 percent.

In 2006, Congress revisited this issue and proposed legislation to create in VA five such centers. The leadership from the VHA opposed the bill and the legislation died.

In my humble opinion, as a result of some of that history, the VA lost its long-held leadership position in prosthetics and was eclipsed by DoD. Since 2006, DoD has not established just one but three amputee centers of excellence which are holistic in care.

The warriors there receive world-class care and when they are no longer on active duty, they are going to have to turn to the VA. In my opinion, the VA has to ensure that the expertise that is necessary to continue the level of clinical care that the warriors have become accustomed to in the military and the VA's administrative processes guarantee timely care.

I want to reference your remarks, Madam Chairwoman, about transfer of warranted prosthetic purchases within the prosthetic services in the VA to acquisition, to supply. I totally agree.

I think the potential wait times because of lack of knowledge on the supply side about prosthetics, if this were a bulk purchase

item, I probably would not be worried about it. But I know John and I know that when prosthetics are delayed, it is not a wait time. It is an inability to function in my life or to thrive in life.

I want to couple that with I understand that VA is moving towards decentralizing the funding for prosthetic purchases. This is an issue that was solved over 20 years ago by centralizing or fencing off those funds so local VA medical facility directors could not use that money for other purposes.

Twenty years ago, veterans were delayed to the next fiscal quarter or the next fiscal year because the monies were used for other purposes.

I would like to summarize by saying what I think needs to happen with VA right now. I think it is time for them to suspend their decision on VHA transfer of the prosthetic purchases to supply, also to kind of drop any discussions about decentralizing funding.

At the same time, it is time for a full-scale program evaluation led by a little more impartial body such as VA's Office of Policy and Planning and put stakeholder cohorts on that effort, and I kind of list those in my written statement, and have that effort report directly to the oversight of Secretary Shinseki.

To me, he has shown he has the ability to take tough issues and decide what is right for the veterans.

Thanks for the chance to be here.

[THE PREPARED STATEMENT OF JIM MAYER APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you both very much.

I will now yield myself five minutes for questions.

I will start with you, Mr. Register. When you received your injury, you received care from the DoD as well as from the VA.

Mr. REGISTER. I did.

Ms. BUERKLE. You mentioned that in your opening statement. Can you compare and contrast those services? How would you say one was versus the other, either positively or negatively?

Mr. REGISTER. Yes, I will. And I think that I want to clarify when I went to the Department of Defense at Walter Reed, this was before all of the new kind of bells and whistles they have over there now with the amputee care because it is extraordinary what the servicemembers have.

And so I would liken them. They were pretty much the same. They were almost on, I think, an equal basis. So I had a prosthetic limb that was made there and also over at the VA that was right here in the D.C. area and I had no issues going between either one or the other.

I think when it came time for understanding a little higher level of activity, I found both lacking in that knowledge base, so I began seeking it out as trying to become a world-class athlete again and looking at what was going on not just in the United States but around the world and what other people were walking or actually running on. That is what I started looking at. Who needs to begin to align this thing so I can actually run at my optimum time.

And that I found outside of both the DoD and the VA system. In fact, some of that was—that expertise is so critical that I went all the way to California from Virginia to find one prosthetist who

actually knew how to get me aligned right and correctly. If I did not get that person, I would not be a silver medalist today and that is just a point in fact.

I think for my ongoing care right now, again, it is more the inconvenience than it is for what I have seen. But I do see, you know, having been down to Brooke Army Medical Center, out to San Diego, California, and here at Walter Reed that the care is exquisite. And these individuals that are coming through are not—they are looking to get back into the fight. They are looking to go back with their units.

And so that is the same level of high activity that I found lacking before that they are now receiving to go back and do those things. Amputees are now back in the fight and they are going on to higher employment. They are going on to being with their families.

And that is what I see as the difference.

Ms. BUERKLE. Thank you.

Mr. Mayer, in your opening remarks, you talked about the fact that VA has lost its leadership position in prosthetics. I would like to know if you can *maybe* identify or help me to understand when and how VA lost its premier status and the military took that over.

Mr. MAYER. I will try. I had the pleasure of being the first staff Committee manager for the very first VA Prosthetics Advisory Committee in the early 1990s when Secretary Derwinski ran the VA. I did not have a vote. I just took the notes and organized the agenda.

The burning issues today are already being reconsidered by VHA. My quarrel is not with the PSAS employees and their ability. They are professionals. They do a good job.

My quarrel is at the more senior ranks of VHA management and it really does not matter who is there culturally, and I understand the motivation. Culturally they look for, because of budget reasons, they look for flexibility at the local management level at the medical facility.

Prosthetics monies and procedures are a very interesting large target. That is how I would summarize it.

Ms. BUERKLE. Thank you.

Mr. Register, in your testimony, you talk about differing needs depending on amputation—whether the amputation is an upper body or lower extremity.

Can you kind of talk about that with us and the differing needs as you see them?

Mr. REGISTER. I think with miotics and upper limb extremities, the use of getting the hand function back, I think, is one that is pretty critical. And as you look at how that has come and developed over time, it is really amazing the intricacies that the upper bodies have with getting that limb function back.

With lower extremities, it is a matter, I think, of just gait and walking and functionality of the limb. You know, it is kind of comical what is inside of the world of amputees, below the knee amputees, when I am down at Brooke Army Medical Center, for example, is below knee amputees and above knee amputees kind of have a rift going against each other where the above knee amputees always call the below knee amputees little paper cuts because they have their knee, right?

So I think it is a matter of functionality and just walking again and getting back upright with that whereas with arms, you know, we write with our arms and they are more mechanical as far as what we are doing. They are more tangible, I think, with that.

And so I think that is a difference between the upper extremity and lower extremity.

Ms. BUERKLE. Thank you both very much.

I now will yield to the Ranking Member for his questions.

Mr. MICHAUD. Thank you very much, Madam Chair.

I once again want to thank both of you for your service to this great Nation and for coming here today as well.

Mr. Mayer, you recommended that for the strategic plan that VHA can participate in it, but the operational controls should be centralized in the secretary's office.

Could you explain a little more why that should be?

Mr. MAYER. It is just an opinion based on historical experience. Like I said, VHA and PSAS have a long history of dedicated professionalism. But when it comes down to these issues, you know, I am just here to tell you John is right. This generation of warriors are athletes.

My day, we wanted to learn how to walk. Walking do not get it for these guys and gals. They run. They climb mountains. They go in the Paralympics. I mean, I got out of breath just watching them.

I am just here to tell you if you think the complaints were big 20 years ago, wait a couple months. Let these policies go in effect. And you know who is going to get the complaints. It is going to be Members of Congress and veteran service organizations.

That is why I kind of go, okay, no, not to VHA senior management, let them participate, but Secretary Shinseki has shown pretty activist style when it comes to large issues. Cool.

Mr. MICHAUD. You also mentioned the Department of Defense definitely has superiority over the VA as it relates to this issue.

Why do you think that is, the fact that it does not have to go up to the Secretary of Department of Defense? It appears that is down at the lower level. Why is that?

Mr. MAYER. Well, I think it is a question of leadership recognizing the clientele and their needs and the fact that John said a number of them want to get back in the fight.

So they have got to be trained. They have got to be conditioned and they have got to go through a board process to actually certify that they can return to duty. So it is a question of need.

Congress provides the funding. Congress still provides the funding. It is known out there as GWOT funding. It is the war funding.

My only concern about that is given the budget situation, I do not know how much longer that funding is going to let these centers operate at the level they do.

But I think the real key is what I called holistic. And I do not want to go into the details of trying to name. It is not just the surgical expertise and the clinic expertise. It is the merger right together of physical therapy, outpatient therapy, adaptive sports, challenges.

And to me, one of the best kept secrets in the military is the outpatient nurse amputee manager. For years at Walter Reed, I watched this individual, Steve Springer, quietly fix problems, keep

the track on recovery, be the advocate, and never in a way that calls attention to his role but really calls attention to the warriors.

So I think that is what makes it work. And I think collocating research with the clinical part instead of being stand alone is another big accomplishment.

Mr. MICHAUD. Great. Thank you.

Mr. Register, how long did it take you to get the new technology that permits microprocessing control of the prosthetic knee through the VA?

Mr. REGISTER. Well, I have done it twice now. And the first time I was here in the Virginia area when I first got what we call the C–Leg. And that is kind of the first microprocessing technology that actually worked pretty well.

And that process took about a month to maybe a month and a half, maybe six weeks. And the current process of going back and forth, it took about three months to get that prosthesis.

In fact, the situation was, I was going up, and I try and show by example, so I attended the National Veteran Wheelchair Games which will be in Richmond this year. And I had a wheelchair made for playing wheelchair basketball. So my chair had come in and I went back up to the VA to get it from the Denver area, traveled almost 70 miles. And I knew I had to go there to get it.

And on the way, I just kind of sent a note. And I was in the lobby area waiting for my appointment. And I saw an e-mail from my prosthetist saying you know what, your leg is here, it is in. I said great. It is all cannibalization. Let's just put it on. I can walk out of here with it.

And he said, no, we want to come back again and we have to fabricate it and make sure that everything is good to go. So I could have actually left that day with three pieces of my equipment, my wheelchair, my sports chair, and then my artificial leg and walked right out of there.

But because the VA wanted to ensure that the fabrication of my socket was done to marry that with the new X2 that I have was just—it was kind of just funny and ludicrous to me that I could not just go on in the shelf, put it on with my Allen wrench, and just walk out the door with it.

Mr. MICHAUD. Great. Thank you.

Thank you, Madam Chair.

Ms. BUERKLE. Thank you, Mr. Michaud.

I now recognize the gentleman from Tennessee, Mr. Roe, Dr. Roe.

Mr. ROE. Thank you.

And, again, both of you all, thank you for your service to our country.

And I also want to congratulate the staff that wrote this memo today for the most acronyms that I have ever seen. I counted at least a dozen. And I thought the PLO was people's, you know, whatever. But, anyway, it is a different organization here.

John, why do you think or do you think that there is, or either one of you all can grab this, a drop-off? And I have been to Walter Reed in Bethesda on multiple occasions and it is unbelievable to see the amputees up and about and the care they are getting.

Is there a drop-off when they go to the VA, when these warriors are handed off?

And you are absolutely right. There is a different expectation than in Mr. Mayer and our's generation, so there is a complete different view of the young people now.

Is there a drop-off? Do you see that?

And certainly not in your case because you are incredibly motivated, not in your case.

Mr. REGISTER. Is that to me?

Mr. ROE. Yeah.

Mr. REGISTER. I can answer. Thank you for the question.

And I think what Mr. Mayer was saying is spot on. And there is. I see a little bit of a drop that happens from DoD to the VA, but I think it is a much larger issue than just the amputees. I think there is a systematic care that has to happen, a continuum of care that goes forward.

What I am seeing now with the drop, I think it has to do, my personal opinion, is that there is a center of excellence when these young men and women are coming back to the DoD hospitals and they are coming back as units.

When we see a KIA, a killed in action, I am looking at the paper. I know that there are going to be six or seven other young men and women that are coming back and are going to hit those DoD hospitals that survived that. And so those are the ones that I am focused in on.

And when I see them come back, they are extremely motivated to get back because they do not want, as the soldier's creed is, they do not want to leave a fallen comrade. They do not want to leave their buddies on the battlefield and they feel that they have lost that ability to fight. Once they get support and those mechanisms and tools to rehabilitate, they are ready to be active again.

And I think that on the VA side, the population has always been different and that has not been—you know, the activity level has not been as high for getting back into like a war fighting situation. So I think that is the drop.

What I do see on the VA side right now is that with the new sports center that they are—the sports programs, they are really pushing out into the communities now increasing the activity level of the veteran patient.

And so those that are coming to the VA hospitals are being linked in with community-based programs across the United States. And that is at its infancy right now. So the model is being changed and I think that is going to change the dynamic for the VA.

Mr. ROE. I think part of it, too, may be generational. As you are older, your expectation may be just to ambulate. If I can ambulate well, that is a success. A 23-year-old, that is not a reasonable outcome. Your reasonable outcome is to return to the mountain climbing, snow skiing, whatever I did before, backpacking, whatever it may be.

And I totally agree with you on the upper and lower extremity. I think that is a really tough one.

We just graduated a year ago a young medical student who is now a physician and who lost his right arm with a Black Hawk helicopter crash and then came back, did his pre-med, went to medical school, graduated.

And it is tougher for him. He is going into emergency medicine, but because of the dexterity you need with your hands, he can walk, ambulate fine, but it is difficult for him to do a lot of things.

And I think that is probably the satisfaction difference that you see. If you get back to jumping, running like you are, you feel pretty good about that, whether you have a prosthesis or not.

And I think the other thing, you brought up a great point, it is very individual who you relate to. I know as a physician myself, when you have that relationship with your patient, you have great confidence in your fellow you work with or the person you worked with there in Colorado Springs. And they know you. They know your leg. They know exactly about you.

And I want to just say for myself, but I think I can speak for most of the Committee, I do not care what it costs for you to get the care you need, for a wounded warrior to get the prosthesis that they need in a timely fashion.

Mr. Mayer said it very well. It is inconvenient. It affects how you live. You take one day off or three days that you cannot do something, you cannot take care of your family, cannot go to your work, whatever, because of your prosthesis, is not acceptable.

In our budget, 1,500 and something was the last number I saw of wounded warriors who have lost one or more extremities. We cannot—as a Committee and as a country—do enough for those warriors. And those needs are going to go on.

And Mr. Mayer can tell you, Mr. Register, that you will change as you get older. Your leg changes. Things just change. And gravity has a great effect on us.

Mr. REGISTER. I am finding that out.

Mr. ROE. You are finding that out. And so we have a commitment, I think, to those wounded warriors not for this great care now but for a lifetime of great care. And I think I can speak for the entire Committee on that. I think we all feel that way.

Again, I want to make sure that the care does not drop from the time you leave DoD because I have seen that facility out there multiple times. It is phenomenal to when they get to the VA.

And I am out of time, I realize, but later if you get a chance, I want you to get on that answer about why you think the VA's prosthesis is $2,900 and you are out in the private sector, it is $12,000. I agree with your analysis. I read your testimony.

I yield back.

Ms. BUERKLE. Thank you.

I now recognize the gentleman from New Jersey, Mr. Runyan.

Mr. RUNYAN. Thank you, Madam Chair.

And, gentlemen, again, thank you both for your service to this country.

Just talking, Mr. Register, just talking about whether it is contractor or fee for based and the VA, equally satisfied with both?

Mr. REGISTER. Restate the question. I am sorry.

Mr. RUNYAN. Whether you are with, you know, with a private doctor or with the VA, the treatment equal?

Mr. REGISTER. Yes, I have no—from what I have experienced at the three VAs that I have gone to, there was one that was out in—I did a clinic in California. There was also one in Virginia as well as the one in Denver. I received great care.

Mr. RUNYAN. Because it kind of comes back to a lot of things we discuss here in this Committee, and obviously I think Mr. Mayer, you know, obviously stated that we have a 900 percent increase in the need, you know, for prosthetic treatments.

And moving forward and knowing there is a need out there, one thing we talk about here all the time is access to that care. And when we move forward from this, obviously yourself wanting to get back into the athletic mode.

When you look at the holistic approach of all this, you know, and avoiding onset of things like diabetes and stuff by staying active and not compromising your health because you do not have the access to care, you know, whether you want to make the 70-mile trip to Denver or not. There is something to be said about, you know, seven minutes away versus 70 miles away.

And I think it really becomes an issue because I see in my district all the time, you know, veterans all the time say, well, I am not going to spend my whole day traveling to go get treatment until I really need it.

And I think that is something we really have to look at because as you just said also, you do not see the—you agree that the treatment on both the private side and the VA side are equal, but if they are the same way, I do not think we—and you brought it up, you did not see you were entitled to reimbursement for travel at the end of the day also being another cost to the VA system where we could get that same cost to another veteran to help them along, you know.

And I just think I do not have a lot of questions. I just wanted to make that because there is an access to care issue here. And I think as we have increased, as Mr. Mayer said, with the 900 percent increase, it is a huge, huge issue.

And I just wanted to throw that out there. I really did not have any other questions.

So I yield back, Chairwoman.

Mr. REGISTER. Madam Chair, may I respond?

Mr. RUNYAN. Sure.

Mr. REGISTER. That is a great observation. I think what I wanted to say is what Mr. Mayer was talking about earlier and what you just said, sir, is that a lot of these veterans are finding that system of care and they are not moving away or they are moving back to where they found that quality.

So, for example, down in Brooke Army Medical Center, they may get their care. They are off and walking. They are doing what—they are going back to regular life. But they are not finding the care where they have moved to, so they wind up coming back to San Antonio because they have that system of care. They do not want to get away from it.

And it is not just about getting back into athletics, you know. That just happened to be what I did. It is getting back into school. It is getting back with your families again. It is walking your daughter down the aisle. It is taking your son fishing.

It is all those things that they had before that they want to get back to with the high level of care. And having that in a centralized location where they do not have to travel so far to do it is just—I think it is paramount for that individual.

Mr. RUNYAN. Thank you.

Yield back.

Ms. BUERKLE. Thank you very much.

If anyone else has any further questions.

[No response.]

Ms. BUERKLE. With that, we want to say thank you to both of you for giving us the opportunity to thank you in person for your service and your sacrifice to this Nation both then and now as you continue on with your work. Thank you very much. You are both dismissed. Thank you.

I would like to invite the second panel to the witness table.

Good morning and thank you all for being here this morning.

With us today is Michael Oros, Board Member for the American Orthotic & Prosthetic Association; Joy Ilem, Deputy National Legislative Director for the Disabled American Veterans, Captain Jonathan Pruden, retired, Southeast Alumni Manager for the Wounded Warrior Project; and Alethea Predeoux, Associate Director of Health Legislation for the Paralyzed Veterans of America.

Thank you all for being here. In particular, we would like to recognize Ms. Ilem and Mr. Pruden for their honorable service to our country. Thank you both very much.

Ms. Ilem is a service-connected disabled veteran who served as a combat medic in the United States Army. Captain Pruden is a veteran of the United States Army. He was severely injured when a roadside bomb struck a Humvee he was driving while serving in Iraq in 2003 and subsequently he lost his right leg.

Thank you both for your honorable service and your very important advocacy efforts on behalf of all disabled veterans.

I am eager to begin our discussion, so we will begin. Mr. Oros, if you would like to proceed with your opening statement.

STATEMENTS OF MICHAEL OROS, BOARD MEMBER, AMERICAN ORTHOTIC & PROSTHETIC ASSOCIATION; JOY ILEM, DEPUTY NATIONAL DIRECTOR, DISABLED AMERICAN VETERANS; JONATHAN PRUDEN, ALUMNI MANAGER, SOUTHEAST WOUNDED WARRIOR PROJECT; ALETHEA PREDEOUX, ASSOCIATE DIRECTOR OF HEALTH LEGISLATION, PARALYZED VETERANS OF AMERICA

STATEMENT OF MICHAEL OROS

Mr. OROS. Good morning. Thank you for holding this hearing and for your work to ensure that veterans with limb loss receive the highest quality prosthetic care.

My name is Michael Oros and I am a Board Member of the American Orthotic & Prosthetic Association. I am also a licensed prosthetist and the President of Scheck and Siress, a leading provider of orthotic and prosthetic services in Illinois.

For me, as a practicing clinician, there are really four elements to high-quality care. The first would be access. Veterans receive their care on a timely basis without having to wait weeks or traveling hundreds of miles for that care.

Second, trust. Veterans receive care from a provider they feel good about, one who listens to them and one who works with them.

Third, experience and expertise. Clinicians serving veterans design, fit, and adjust the best possible prosthetic device to address the veteran's complex challenges.

And, finally, positive outcomes. The result of high-quality prosthetic care is greater comfort, higher activity levels, more independence, and greater restoration of function to those veterans.

The potential quality of prosthetic and orthotic care for veterans has never been higher. However, veterans' experience of prosthetic care is really highly dependent on their ability to advocate for themselves.

Several barriers seem to stand in the way of providing uniform high-quality care to all veterans. These barriers can be eliminated. I would like to suggest an achievable agenda to promote quality prosthetic care. It has three elements.

The first would be to guarantee veterans meaningful access to a trusted clinician of their choice. Currently, 80 percent of all orthotic and prosthetic care is provided by community-based providers. In some places, such as New York City, the majority of veteran orthotic and prosthetic care is provided by VA employees. However, in cities like Chicago, even veterans who live close to a VA medical center may choose to receive their care from those independent contracted providers.

Those who have served and sacrificed for our country should be able to freely choose the provider who best meets their needs, especially on an issue as personal and important as prosthetic and orthotic care.

Reports from the field suggest there are real and increasing administrative barriers to veterans choosing non-VA providers. It has been suggested that the VA is moving care in-house because it is cheaper. AOPA is disturbed by the OIG's allegations that the average cost of a prosthetic limb fabricated in-house by the VA is but 25 percent of that fabricated by an outside contractor.

The costs quoted for the VA fabricated limbs almost certainly omit the cost of things like VA salaries, benefits, facility costs, and administration. We believe that a complete and accurate cost comparison would show that O&P contractors provide excellent value not only to the veterans but to our taxpayers.

The second agenda point would be to elevate the clinician expertise and experience. Over the past decade, the practice of orthotics and prosthetics has grown increasingly complex and the technology has grown increasingly sophisticated.

In response, the field has changed the entry level credential to that of a master's degree. Currently there are really only six institutions enrolling approximately eight to twelve students each in master's degree programs, with a few more in the credentialing process.

This is simply insufficient to meet the growing demand. AOPA recommends the creation of small time-limited competitive grant programs to offer grants to either create or expand O&P master's programs.

And we are grateful to Chairwoman Buerkle for your work on this issue.

And, finally, demand evidence-based practice to achieve optimum outcomes. AOPA believes that it is important to hold all O&P pro-

fessionals accountable for the quality and the cost of the care delivered. This is a challenge for the VA because, frankly, there is currently little objective, comparative outcomes research to support evidence-based practice as it pertains to orthotics and prosthetics.

For example, 20 years ago, if you had a back problem, there was no outcomes research to guide you as to whether the right decision would be surgery or physical therapy. Today objective research documents which treatment works best for which patients.

The result is better outcome, obtained more cost effectively. That is what we want for veterans who need prosthetic and orthotic care. A comparative outcomes research portfolio in the field of orthotics and prosthetics. This would increase the quality of care for veterans and others with limb loss, while protecting taxpayers by ensuring that patients receive the most appropriate care.

Madam Chairwoman, thank you for your invitation to testify and I look forward to answering any questions.

[THE PREPARED STATEMENT OF MICHAEL OROS APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much.

Mrs. Ilem, you may proceed.

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you.

Madam Chair, Ranking Member Michaud, and Members of the Subcommittee, I am pleased to present the views of DAV on the capabilities of VA to deliver state-of-the-art care to veterans with amputations.

Many DAV members have experienced limb loss due to combat trauma and are high-intensity users of VA health care and its specialized services.

VA is responsible for 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, our newest war veterans with amputations want to remain physically fit, highly active, and participate in competitive sports post injury. These expectations and interest require a team of health care specialists and lifelong care.

The VA inspector general recently issued three reports related to VA amputee care and its prosthetics and sensory aids services. The IG found that overall most veterans contacted were pleased with the quality of VA care and services they received, but some have indicated that certain processes for obtaining prosthetic limbs should be more streamlined and simplified.

In one report, the personal comments from veterans related to amputation care provide VA with good feedback and can help to reduce identified hurdles and bureaucracy for routine maintenance and repair of prosthetic limbs. We urge VA to establish a permanent mechanism to receive continuing comments from this population.

VA's extensive system for amputation care and rehabilitation collectively delivers specialized expertise across the VA health care system. In our opinion, this program is functioning very well and

we urge VA to continue to evaluate these veterans over time to better understand their complex and evolving health care needs and when necessary to readjust VA's services accordingly.

The IG also conducted an audit of VA's acquisition practices and purchasing prosthetic limbs and concluded that it had overpaid private vendors by $2.2 million in the year assessed and that VA is not getting the best value for these purchased items.

We agreed with the IG's recommendations and it appears that procurement reform and new policies to better manage prosthetic acquisition functions are underway. However, DAV is very concerned that during the transition of prosthetics, VA's services should retain appropriate staff to ensure a strong connection between veterans and clinical components of care.

While contracting will always be a dominant aspect of prosthetic supply, the determination of what type of prosthetic appliance is appropriate should remain with the physical medicine and rehabilitation specialist aided by prosthetic representatives in conjunction with direct involvement of the disabled veterans being served.

One of our commenters put it best. Without clinical precedence in ordering specialized prosthetic items and limbs, veterans could experience unnecessary delays as they would simply be invoice numbers rather than patients with unique needs.

While VA could expand its in-house prosthetic manufacturing with the IG's cost-cutting views to motivate them, cost should not be the sole factor for an expansion of in-house fabrication of limbs.

In our opinion, the most important aspect of amputee care is maintaining options for a veteran's preference of selecting a qualified prosthetist they feel most comfortable with and the convenience of those services.

Current authority provides VA the flexibility to manufacture and procure prosthetics, assistive devices to wounded war veterans without any other provision of law including cost.

However, while we believe this authority should be used to provide patient-centered care and timely delivery of prosthetic items, we do urge VA to focus on improving its business relationships with private fabricators and to work to internally improve controls, prosthetic training, certification, and inventory management as recommended by the IG.

A third IG report we reviewed evaluated the effectiveness of VA's medical centers' management of its prosthetics inventories. While DAV was very disappointed to learn of the specific findings identified in this report, we understand, however, that prosthetic services has been waiting a number of years for the development of an integrated technology solution for managing prosthetic inventories which has yet to be approved by VA's Office of Information Technology.

We urge VA to expedite development of an IT solution and take other necessary actions to resolve this issue.

In closing, while DAV agrees that prosthetic services is an expensive area of operations and that changes can and should be made to improve and leverage its purchasing power, these expenditures are well worth their cost to partially repay the sacrifices many disabled veterans have made in military service and they are an integral component of holistic health care to veterans in general.

Madam Chair, that completes my statement. I am happy to answer any questions you may have.

[THE PREPARED STATEMENT OF JOY ILEM APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much.

Mr. Pruden, you may proceed.

STATEMENT OF JONATHAN PRUDEN

Captain PRUDEN. Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, thank you for inviting Wounded Warrior Project to share its perspective on issues facing our amputees.

As Chairwoman Buerkle mentioned, I was wounded in 2003 while serving as an army infantry captain in Iraq and was one of the first IED casualties. I subsequently underwent 20 operations at seven different hospitals including the amputation of my right leg.

Over the course of the past six years with Wounded Warrior Project, I have worked closely with thousands of wounded warriors, many of them amputees, and have observed both VA and DoD care.

My friend, Jim Mayer's earlier observation that VA prosthetics is at a crossroads is perceptive and accurate. The path VA should take is clear for us here at Wounded Warrior Project. But with over 1,400 OIF/OEF amputees, many still adapting to their life-changing injuries, it seems the VA is headed down the wrong path and moving to institute changes that will set back prosthetic care rather than improve it.

We hope this hearing can alter their current course which may reverse years of progress towards appropriate and timely care for our amputees.

Currently VA uses a process under which VA physicians and prosthetists see a veteran to determine what type of prosthetic equipment is most appropriate for that individual. With this information, a prosthetics purchasing officer completes a purchase order to obtain the needed item. Those purchasing officers are specialists who handle exclusively prosthetics.

But the Veterans Health Administration intends to institute a major change on July 30th and as you have described, under the change, only a contracting officer could procure a prosthetic item costing more than $3,000. This policy would affect essential items including most limbs like mine and wheelchairs. It would require the use of a system designed for bulk procurement purchases that involves manually processing over 300, that is 300 individual steps to develop a purchase order.

This system may be great for buying cinder blocks and light bulbs, but it is certainly not appropriate for providing timely and appropriate medical care.

Equally troubling, this change offers no promise of improving service to the warrior. Instead it would mean greater delays. The change could realize modest savings, but at what cost?

A warrior needing a new leg or wheelchair should not have to wait longer than is absolutely necessary. I know warriors who have stayed home from our events, stayed home from school, from work,

cannot play ball with their kids, or live in chronic pain while they wait for a new prosthesis.

I know firsthand what it is like to not be able to put my son in the crib while I am waiting for a new prosthetic, to live in chronic pain, and to have my daughter ask my wife once again why can't daddy come and walk with us.

With VA moving ahead on changing procurement practice, wounded warriors need this Committee's help. A prosthetic limb is not a mass produced widget. Prosthetics are specialized medical equipment that should be prescribed by a clinician and promptly delivered to the veteran.

We urge this Committee to direct VA to stop implementation of this change in prosthetic procurement. Beyond this immediate concern, our warriors face other challenges. Warriors who have injuries that result in amputations are often complex and can prove difficult for later prosthetic fittings, but it is apparent that the paradigm shift promised some years ago is far from complete and more progress is needed to realize VA's vision for an amputee system of care.

As a bottom line, we have real concerns about the direction of this program which appears to have lost the kind of focused advocacy it once enjoyed and fallen victim to a bureaucratization that has lost sight of its customer, the veteran.

Today VHA seems intent on tossing out veteran-centered procurement so essential to timely and appropriate care. Tomorrow we fear centralized funding of prosthetics will be tossed out and we may wind up where, as Jim mentioned earlier, where we were 20 years ago where the fourth quarter meant that all the money for a hospital's budget had been spent and you could not get a new limb or a new wheelchair until the next fiscal quarter.

Our goal is improved prosthetics care and service. To that end, we offer the Committee with a number of recommendations in our full statement.

In closing, let me highlight just a few areas in which the Committee can make a profound difference.

First, ensure that through ongoing oversight that VA's vision of an amputee system of care is actually realized.

Second, press VA to reestablish and re-energize a robust steering Committee of experts to oversee and provide guidance on the direction and operation of VA's prosthetics and orthotics program.

And, finally, it is essential that VA reestablish itself as a leader in prosthetics research and care and maintain that position as a commitment to our wounded warriors.

That concludes my testimony. Thank you, and I welcome any questions.

[THE PREPARED STATEMENT OF JONATHAN PRUDEN APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much.

Ms. Predeoux, you may proceed.

STATEMENT OF ALETHEA PREDEOUX

Ms. PREDEOUX. Thank you.

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, thank you for allowing Paralyzed Veterans of America to testify today concerning prosthetic services of the Department of Veterans Affairs.

Ensuring that our Nation's injured veteran population is able to receive state-of-the-art prosthetic devices in a timely manner is an extremely important issue for PVA.

PVA has more than 19,000 members who all utilize VA prosthetic services on a regular basis.

In recent months, the VA Office of the Inspector General released numerous reports on VA prosthetics and sensory aids, PSAS, inventory management, acquisition of prosthetic limbs and prosthetic limb care.

PVA believes that these internal audits and investigations have identified many areas in need of improvement within PSAS and PVA generally supports the OIG recommendations.

These recommendations provide not only an opportunity to improve upon the prosthetic services for veterans with amputations but for all veterans that utilize VA prosthetic services.

The OIG's evaluations and assessments are taking place during a critical turning point for VA prosthetics. The Veterans Health Administration is currently undergoing a structural reorganization that directly impacts the delivery of prosthetic services to veterans. Today I will limit my remarks to this reorganization.

Under the current changes, VA prosthetics will no longer be solely responsible for managing the purchases of prosthetic items. Rather, the VA is currently implementing a joint purchasing structure that includes both PSAS and the Office of Procurement and Logistics making prosthetic purchases.

While the VA reports that this change will result in increased oversight and review of prosthetic orders, PVA has concern that this dual purchasing track has the potential to create delays in the delivery of items to veterans.

PVA is further concerned that this new system will lead to less VA accountability for veterans during the ordering and delivery processes.

When an order for prosthetics is placed at any point before the item is delivered, veterans or oftentimes National Service Officers on behalf of a veteran is able to contact a PSAS employee with questions regarding an ordered device or the status of delivery.

With the VA Office of Procurement and Logistics now handling prosthetic purchases, it is unclear which office will serve as a point of contact to provide veterans with timely assistance or questions or concerns that may arise.

PVA has reached out to PSAS leadership on several occasions to identify the status of the reorganization and appreciates the opportunity to provide input.

While we have been informed that the dual purchasing system was piloted in three veteran integrated service networks beginning in January 2012 and will be further implemented in additional areas in July of 2012, we are not aware of how VA intends to make sure that veterans are aware of these changes.

Therefore, PVA encourages VA leadership to consult with veterans and their families as well as stakeholders who regularly

work with VA prosthetic offices to provide input as they further develop the process for prosthetic purchases through the Office of Procurement and Logistics.

PVA further recommends that the VA regularly update this Committee with the findings that are compiled as a result of the pilots that were implemented in January 2012 as well as future findings as plans move forward.

Lastly, the Office of Procurement and Logistics is governed by VA policies of VA acquisition. Such policies are meant to address the purchasing of various items from many different offices within VA. As such, PVA would like to make certain that the change to the Office of Procurement and Logistics managing the purchases of high-cost prosthetics does not lead to the standardization of items, particularly highly specialized prosthetics such as artificial limbs, specialized wheelchairs, and surgical implants.

PVA strongly urges the VA to continue to abide by VA policy that adheres to Title 38, United States Code Section 8123, a statute that enables VA to meet the unique prosthetic needs of veterans in a timely manner without the limitations of cost-saving measures such as standardization of items or contract bulk purchasing.

Veterans must have access to prosthetics that best fit their individual needs. For many years, PSAS has done a good job of ensuring that the number one consideration when ordering prosthetics is quality, the ability to meet the medical and personal needs of veterans.

The VA must make certain that the issuance and delivery of prosthetics continues to be provided based on the uniqueness of veterans and to help maximize their quality of life.

Again, PVA thanks this Committee for their attention to this important issue and encourages continued oversight. I am happy to take any questions from the Committee.

[THE PREPARED STATEMENT OF ALETHEA PREDEOUX APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you all very much.

I will now yield myself five minutes for questions.

Mr. Oros, in your opening statement, you mentioned the four very important tenets of access, trust, experience, and positive outcomes.

As you look at the VA prosthetic care, do you think that VA encompasses those four tenets that you laid out for us this morning?

Mr. OROS. I think it can, but, once again, it is somewhat dependent on the veterans' ability to advocate for themselves.

I think the outcomes piece, frankly, is missing almost across the board, both inside and outside the system.

Ms. BUERKLE. Can you give us some insights? How do we change that? How do we make those outcomes more positive? How do we make sure of these tenets are included?

Mr. OROS. Well, I think specifically with outcomes, there are validated instruments, tests that can be undertaken when prosthetic limbs are prescribed so that, are we truly getting, I am going to use the words the most bang for your buck when it comes to prescribing a particular prosthetic foot or a particular prosthetic need.

And, you know, there simply are no research dollars allocated to studying comparative effectiveness when it comes to orthotics and prosthetics. And in the absence of that, we will continue to use our experience and our best judgment as to what we think are the best particular components for a veteran, without any necessarily evidence to support that.

Ms. BUERKLE. Do you have any information or knowledge as to why there has not been that kind of research done and, say, compiled regarding outcomes?

Mr. OROS. My suspicion is we are really just too small of a profession. And so if it is not industry-driven, then it, frankly, has to come from the Federal government. And I cannot explain beyond that.

Ms. BUERKLE. Thank you.

Mr. Pruden, in your testimony, you say that VA prosthetics research has lagged in recent years.

Now, Mr. Oros talked about outcomes, but I think you are talking more generally in terms of the research.

What impact has that had on veterans and the services that they need?

Captain PRUDEN. The VA has stepped up in a number of capacities in the past few years. But as Mr. Mayer pointed out earlier, DoD has taken the lead on the, you know, development of the DEKA arm and all these advanced technology things.

In years past, VA has been—one of its key roles and one of the reasons it exists is to provide specialized medical equipment for our combat wounded, for our veterans. And VA really needs to have the capacity and the focus on research for their own medical equipment.

When DoD and Global War on Terror dollars go away, and this also ties into the discussion about centers of excellence at Walter Reed, Brooke Army Medical Center, and so forth, when these dollars go away, those DoD facilities will certainly scale back their capacity both for rehabilitation and for research.

And what we are calling for is for VA through the amputee system of care and enhancements in research to be prepared to meet the needs as DoD scales back.

Ms. BUERKLE. Thank you.

Ms. Predeoux, I am extremely concerned with regard to your comments about the filing system being outdated and the backlog that that creates.

Could you comment on that for us?

Ms. PREDEOUX. Yes. In my written statement with the filing system, it refers to medical records within one VA medical center and if, for instance, a veteran were to relocate, for example, our director actually of benefits relocated to this area from San Diego, and it took quite a bit of time for the medical records to be transferred from San Diego to D.C. simply because there is not one central system in which all the medical centers are able to locate and actually view the medical records of a veteran.

And as the panel before us testified, it is not just a wait time. It is a matter of being able to be comfortable and actually be mobile.

Ms. BUERKLE. That was going to be my follow-up question. So when those records are not able to be transferred expeditiously that means the veteran then does not have——

Ms. PREDEOUX. The records are not being able to be transferred for the medical provider to see them and they are not able to get what is needed. It could be a chair. It could be a repair, those type of items.

Ms. BUERKLE. Thank you all very much.

I will now yield five minutes to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair.

I will start with Mr. Oros. Mr. Mayer from the first panel actually recommended that the Committee ask the VA to freeze the pending reorganization until a full-scale program to evaluate a new strategic plan can be achieved. And I know it sounded like the Wounded Warrior Project agrees with that assessment.

Do you agree with that as well, and each of the panelists can answer that question, and why?

Mr. OROS. I guess I am not entirely familiar with the differentiation between what Mr. Mayer is asking to be done and the current system.

Mr. MICHAUD. Do you think we should ask the VA to freeze the reorganization, bringing everything in-house?

Mr. OROS. Absolutely. Absolutely.

Ms. PREDEOUX. I am happy to provide a comment on that.

With regard to the reorganization, all of our concerns are provided in our written statement. But until I think that we can answer that, it would be great to be able to know the results and how things worked in the pilots that were implemented in January.

It is my understanding that within those pilots, the re-org was implemented in different ways in different VISNs. So it would be interesting to see how veterans were affected and the delivery of items, the timeliness, those issues, and access.

Mr. MICHAUD. The different pilot programs, are they diverse the way they implemented? Is the diversity great or is it minor?

Ms. PREDEOUX. Oh, I think it is minor. It is administration of certain policies and how they handed off items that needed to be handed off to PL&O versus PSAS. That is my understanding.

Mr. MICHAUD. Why should the VA undertake research in comparative prosthetics outcomes? Why couldn't this be done by other agencies such as the Department of Defense or the National Institute of Health? Start with, okay, anyone who wishes to answer that.

Captain PRUDEN. I would say that the DoD's mission is to rehabilitate troops to their maximum potential for rehabilitation and either return them to the line or send them on for further care.

VA's job is for the long-standing lifelong care once they leave the service. Those are different goals. So the DoD's focus is on acute care and acute rehabilitation. VA's should be on long-term outcomes and long-term care for our warriors.

And certainly, if possible, it should be done in partnership with NIH and DoD, but VA should be taking the point on long-term care for our amputees.

Mr. MICHAUD. All the panelists agree with that?

Ms. ILEM. Yes. I would concur with that. I think that is absolutely essential for VA just because of the paradigm shift that did occur within DoD, maintaining veterans, disabled veterans for so much longer, and providing this up-front amputee care.

But as they transition into VA, that is certainly the lifelong care. And they are focused on effective care and good outcomes, so that would certainly be within their portfolio.

Mr. MICHAUD. I guess this would be for Mr. Oros or anyone else who might want to answer it.

There has been some discussion about the cost in the private sector versus the VA. Has anyone done an analysis of what the cost is within the Department of Defense?

Ms. ILEM. We have not, but I think the comments that Mr. Oros made were really pertinent.

The first thing we thought when we saw the IG report and the difference between the two cost comparisons was, you know, not factoring in a number of other things. You know, maybe that was just material. So we would certainly like to see a better analysis of that.

Captain PRUDEN. And may I say that $2.2 million, while it seems like a lot of money, for us to allow our most severely injured, the ones who will utilize devices that cost more than $3,000, our blind, our wheelchair bound, our prosthetic using or to bear the burden of cost savings at $2 million even assuming that all those savings could be realized, I think, is unconscionable. And that is where I stand on that.

Mr. MICHAUD. A point well taken and I agree with your point. We will be asking the IG and the VA as far as how did they come up with those cost comparisons because sometimes they are not comparing apples to apples which will give you that deviation, but as well as DoD.

It would seem to me that the cost should be similar to the VA as far as, you know, if the VA and DoD costs are the same, then probably their methodology is correct. If it is not, then I would be interested in seeing that as well.

So I see I have run out of time, so I yield back. Thank you, Madam Chair.

Ms. BUERKLE. Thank you.

I now yield to the gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Madam Chair. I appreciate it very much.

I thank the entire panel for their testimony today.

My first question is for Mr. Pruden. First of all, thank you for your service to our country.

You mentioned in your testimony, again, the same subject, you mentioned in your testimony your concerns about the VA's planned changes in the prosthetics acquisition process.

Will you elaborate on the real-world implications that this will have on our veterans? Specifically from the time a prosthetic is ordered, how long does it typically take to arrive under the VA's current process and what timeframe would you anticipate under the new proposed acquisition process? And then what are the quality of life and health issues that could arise from these delays?

Captain PRUDEN. Thank you for the question, sir.

Under the current system, there are safeguards in place to ensure that VA is being fiscally responsible. And it can take a month, two months. Some of this is predicated on the clinical needs of the patient and availability of the product in their area which is appropriate.

Our real concerns is that with the new system, it would be supposition, but it may take months and months longer to get purchase orders for needed equipment. And the veterans should not have to wait and the clinicians' hands should not be tied. If they feel that a device is appropriate and going to provide the best care for a warrior, they should be able to prescribe that device.

I have had the opportunity to speak with over a dozen VA clinicians and prosthetists who are currently serving and several former chiefs of prosthetics and every single one of them said they share our concerns about the ability to remain timely and potential delays in veterans receiving needed prosthetic devices under this new system.

Dr. Beck will come up in a few minutes and she will say that one of the things that we are going to consider is if a device is generally available and interchangeable, then it will fall under the Federal acquisition regulations.

Who is determining what is generally available and interchangeable? It is going to be somebody in acquisition, not a physician, not a clinician who has the patient's best interest at heart. And that is our real concern.

The VA was given wide discretion by Congress to provide prosthetic and assistive devices without consideration of applicable Federal acquisition regulations years ago because Congress recognized this very special and unique role in prosthetics for providing care for our warriors.

And, unfortunately, this seems to be a step in the opposite direction.

Mr. BILIRAKIS. Thank you.

Again, maybe for the entire panel, let's address this specifically. What are the quality of life and health issues that could arise from these delays? If anybody would like to testify on that.

Captain PRUDEN. Well, I will say it again that I have personally experienced this through the natural and appropriate delays that occur from the time, say, I break a prosthetic foot to the time I need a new one, but my quality of life is hindered. My ability to go on walks with my kids, my ability to do some aspects of my job are directly hindered.

And I could tell you story after story about warriors that I have worked with who have been stuck in wheelchairs, who have gained weight, and had subsequent health issues due to an inability to get up on their prosthetic limbs.

A buddy of mine, Katlin Mixon, is a bilateral above the knee amputee who lost both his legs in Iraq and a clinician that worked with him was able to use some discretion, some latitude to get him the appropriate devices in a timely manner recently.

And that same physician told me I am really concerned that if this goes through, I would not have been able to do that for Katlin. Katlin would still be in his wheelchair today because he would not

have been able to stretch and go outside to take care this veteran. And that is the last thing we want to see happen.

The mantra in hearings from the past several years within PSAS has been take care of the veteran first and foremost. That is our end goal, ensure they receive the devices they need. And it is concerning to see us stepping back from that.

Mr. BILIRAKIS. Yes. What about maybe mental health issues as a result of these delays? Anyone want to comment on that?

Ms. ILEM. Yeah. I think from DAV's perspective, certainly we, you know, we have a number of members and people that we work with and our staff, you know, in Washington, D.C. and the local area that are prosthetic users that have been long-time users, and certainly when something goes wrong, whether they have to have a revision of their stump, whether, you know, there is a broken foot or some sort of issue with their prosthetic appliance, it is absolutely critical, and you can see it in them how frustrated they are not to be able to ambulate, to be able to do the things they are used to doing, if there is a delay in getting those items fixed and getting to their prosthetist of their choosing, oftentimes the person that has worked with them over years and years, so I think that it definitely can impact on their mental health. And, you know, they want to be functioning, you know, all that they can.

Mr. BILIRAKIS. Thank you.

Anyone else?

Ms. PREDEOUX. My colleagues have discussed quality of life and mental health. Quality of care is also an issue. Oftentimes when there are delays, there are sometimes quick fixes and other times they could be larger issues, but veterans are able to step in, figure out what the issues are, and kind of interrupt that process that could extend the delay.

When it comes to acquisitions, as it stands, it is not an office that generally sees many veterans or that veterans can call and see what is going on or their representative can call.

So with regard to the reform and moving over to acquisitions, systems must be put in place that will allow veterans to know the exact process in which the order will be going so that when there is a delay, they can call and say there has been a delay, what is the problem, and then hopefully the problem can be fixed.

Mr. BILIRAKIS. Very good. Thank you, Madam Chair. I appreciate it. I yield back.

Ms. BUERKLE. Thank you.

I now recognize the gentleman from Florida, Mr. Stearns.

Mr. STEARNS. Thank you, Madam Chair.

Let me welcome the panel.

And, Mr. Pruden, I understand you went to University of Florida?

Captain PRUDEN. Yes, sir.

Mr. STEARNS. That is good.

Captain PRUDEN. Go getters.

Mr. STEARNS. Go getters. It is my honor to represent the University of Florida in Congress and so I am delighted that I could come over here in time. I have two other Committees at the same time, but I wanted to especially be here to welcome you personally and to thank you for your service. And I just admire your ability and

leadership here in testifying and presenting to the American people some of the problems for the wounded warriors.

I think what I am asking is sort of an overview. I understand you were one of the first improvised explosive devices, IED casualties of Operation Iraqi Freedom. Is that perhaps true?

Captain PRUDEN. Yes, sir.

Mr. STEARNS. Yeah. You also testified before the Oversight Subcommittee on seamless transition issues in 2010.

Captain PRUDEN. Yes, sir.

Mr. STEARNS. Have you discussed any of your concerns raised in your testimony with the VA clinicians or other VA officials?

Captain PRUDEN. I certainly have, sir. I had the opportunity to speak with numerous current VA physicians and prosthetic chiefs, several candid off-record discussions. And all of them had real concerns about this process and about us moving forward in changing our procurement requirements and potentially tying the hands of our clinicians and hampering the delivery time for our veterans.

Mr. STEARNS. I guess particularly the Members here on the VA Subcommittee which I have served for 24 years, I guess with the growing population of wounded veterans, do you feel confident that the transition that we are making will not encounter greater delays perhaps in our veterans receiving the care they need and the prosthetics they need?

Captain PRUDEN. Sir, I certainly feel that that is a real danger. And that is why we are asking the Committee to stop the implementation of this until we either are assured that there are safeguards in place that will not cause this to happen or just find another way to find savings.

The IG report that was cited several times here today in no means and nowhere in the report does it call for the use of Federal acquisition personnel in procuring these assistive devices. It asks for stricter cost controls and certain control measures. And certainly we are all for fiscal responsibility and for, you know, saving taxpayer money, but not on the backs of our most severely injured.

Mr. STEARNS. I am looking at some of the statistics my staff provided and it says as of March, there were 1,288 servicemembers who experienced major limb loss and of that number, 359 lost more than one limb. And that is just this past month.

The Walter Reed National Naval Medical Center received two quadruple amputees. This is sort of mind boggling to think that there is that many.

Do you think that with that number, should we organize all these people together in an en masse type of grouping to work with them in a focused way rather than sort of in a broad way? I mean, is there something—since we can identify these people and we know the problems they are going to have and the enormous challenges they have, shouldn't we try to single out these folks and try to have a very special program?

Captain PRUDEN. Sir, I think that would be appropriate. And what you are hitting on is that it is a real challenge. And actually the number I got this morning is, I think, 1,458 new amputees from Iraq and Afghanistan.

And it is a challenge. I had the honor of being on a 27 member expert panel that made some recommendations about the amputee

system of care. And VA to their credit has implemented that amputee system of care in large measure. But it is not there yet. It has not met all its stated objectives.

And certainly we want to encourage the Committee to provide oversight and support as needed for prosthetic and sensory aids services, to continue that program of enhancing care for our warriors.

Dr. Beck, Dr. Miller, as Jim said, these are professionals. They are doing a good job, but certainly there is need for oversight and we certainly do not want to see, you know, penny pinching curtail all of the advances that have been made in the past 20 years.

Mr. STEARNS. Madam Chair, I would think that the Committee might just think about this. Since we can define who these people are, we should give advantage in the job market for these people either through tax credits or tell the employer if you hire one of these people, you are going to get advanced depreciation on your capital assets or you are possibly going to get write-offs or incentives for them to hire these people so that all of these people get a job because in the end, the challenge that they have mentally and physically is so enormous. It can be overcome if they have a job that they feel they have strong self-esteem and they are self-sufficient and independent. And they need this job more than anything else.

Would you agree with that?

Captain PRUDEN. I think that is an excellent idea. And in principle, I certainly agree with that, yes, sir.

Mr. STEARNS. Yeah. Yeah. And, in fact, those employers that hire these people should be singled out with merit and recognized somehow in their corporation with a designation that they are hiring these roughly, you know, 13, 14 hundred people. So across America, everywhere you go, a person could look and say that is a company that is doing a great service for our veterans and for this Nation.

So, Captain, I want to thank you for your service, for your sacrifice. It is truly a pleasure for me to represent you and the folks in Gainesville. Thank you.

Mr. ROE. [Presiding] Captain Pruden, I was going to cut you some slack until I found out you went to the University of Florida, so you and I are probably going to have to go head to head. All kidding aside, after this is over, I want to talk to you about something I want to do privately with wounded warriors.

Captain PRUDEN. Yes, sir.

Mr. ROE. I think what I have heard from certainly with the prosthesis and with limb loss and so on are the very individual care that veterans need and that relationship they have with their provider is very important and may go on a lifetime as that person—either in private practice or with the VA.

I can understand saving taxpayers money, but, Captain, I could not agree more. We are not going to balance this budget on the backs of people who have lost limbs in service to this country. Whether it is going to a private prosthetist or to the VA or wherever they may go, they need to get the best care wherever it is.

And I think we need to see if we are measuring apples to apples, too, because I do not think $3,000 probably looks at the cost of the

light bill, the water bill. If you really dig down into it, my bet is it is the cost of them and just the actual cost of the prosthesis, the materials and putting it together which that is not anywhere near the total cost. If you have ever run a business you understand, all the things that go into just running a business.

And I think what I heard you say about how we could set this back if we do what the VA is going to do and delay and what was said by Mr. Mayer right before you about it is not just an inconvenience. It is like you said, you cannot go out and walk your daughter or whatever it may be, whatever function you may have.

The other thing I would argue a little bit, I would not argue, but just to comment with Congressman Stearns, is that what I see with a lot of these wounded warriors, they want to go back to just a regular life. And they use this prosthesis not to have any advantages, but just to be able to do what they could do before they went in the military.

Am I wrong on that or not?

Ms. ILEM. I think, too, and the employment issue is obviously important for many veterans, but it all comes down to again their ability to be able to do what they want to do, to regain their function, to live, you know, to have a quality of life. And that comes down to the care that they are going to get, the lifelong care that they are going to get at VA and maintaining their prosthetic items and getting them in a timely manner.

Mr. ROE. Just a brief example. I had been here probably six months in Congress. This is only my second term, and had been to Walter Reed and was walking down the steps with Spanky. You remember him who worked here. He is a major who lost his—I did not know he was an amputee until I saw him go down the steps.

He had returned to duty and was carrying on exactly like he always had. And when I saw him, and then we sat down and had a little talk about that, but that was amazing to me that he was able to do that. And for months I saw him walking out of here and did not even know he was an amputee.

I think that is the kind of return to duty that people want. And when they have lost an extremity, and some obviously are more horrific than others, but I believe that is the goal of every wounded warrior is to be able to go back to what they did and assume the life they had before they signed on and took the pledge.

I appreciate you all's testimony and certainly every one of your service to our Nation. And I will now call our next panel. Thank you all.

Now, joining us on our third panel is Linda Halliday, Assistant Inspector General for Audits and Evaluations for the Office of Inspector General, IG for the U.S. Department of Veterans Affairs.

Ms. Halliday is accompanied by Nicholas Dahl, Director of the Bedford Office of Audits and Evaluations for the IG; Kent Wrathall, Director of the Atlanta Office for Audits and Evaluations for IG.

And we are also joined by Dr. John Daigh, the Assistant Inspector General for Health Inspections for the IG. Dr. Daigh is accompanied by Dr. Yang, a physician for the Office of Healthcare Inspections for the IG.

Thank you all for being here today and to share your expertise.

Ms. Halliday, we will begin with you.

STATEMENTS OF LINDA A. HALLIDAY, ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY NICHOLAS DAHL, DIRECTOR OF THE BEDFORD OFFICE OF AUDITS AND EVALUATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; KENT WRATHALL, DIRECTOR OF THE ATLANTA OFFICE OF AUDITS AND EVALUATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND JOHN D. DAIGH, JR., ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY ROBERT YANG, PHYSICIAN, OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF LINDA A. HALLIDAY

Ms. HALLIDAY. Representative Roe, Ranking Member Michaud, and Members of the Subcommittee, thank you for the opportunity to discuss the results of our two recent reports on VHA's management and acquisition of prosthetic limbs and the management of prosthetic supply inventories.

We conducted our work at the request of the House Veterans' Affairs Committee.

Today I will discuss our efforts to evaluate VA's capabilities to deliver state-of-the-art prosthetic limb care and manage prosthetic supply inventories at its medical centers.

In our first report, we examined the procurement practices and the cost paid for prosthetic limbs. We identified opportunities for VHA to improve payment controls to avoid overpaying for prosthetic limbs and to improve contract negotiations to obtain the best value for prosthetic limbs purchased from contract vendors.

With regard to the cost comparisons in our report addressing VA fabricating the prosthetic limbs or purchasing these limbs via contract, our report concluded VA lacked information to make the decisions it needs to know whether it should continue with the use of the labs or to rely on contractors to provide these limbs.

In no way did we address cutting the quality of the requirements to purchase a limb. The focus was on contract administration. And the contract administration piece occurs when VA enters into contracts with vendors to provide limbs at certain prices.

What we looked at was the invoices coming into VA. We found they lacked an adequate review process prior to certification for payment which resulted in overpayments. This is a contract administration issue and I want to be very clear, did not say cut the quality of a prosthetic limb for any of these veterans.

But clearly VA has an opportunity to fix controls, so they can then reprogram the funds saved to provide more prosthetics care for veterans.

The overpayments for prosthetic limbs were a systemic issue in 21 Veteran Integrated Service Networks and we identified overpayments in 23 percent of all the transactions paid in 2010.

The overpayments generally occurred because invoices received from vendors lacked adequate review. As a result, the vendor invoices were just processed with charges in excess of the prices in the vendor contracts.

We reported VHA would continue to overpay prosthetic limbs for about $8.6 million over the next four years if it did not take action to strengthen these controls.

We also found that VISN contracting officers were not always negotiating to obtain a better discount rate with vendors. Without negotiations for the best discount rates obtainable, VHA cannot be assured it receives the best value for the funds it spends to buy prosthetic limbs.

We noted that taking action to ensure contracting officers consistently negotiate better discount rates in no way compromises the quality of the prosthetic limbs VA buys.

We also found and made a clear point in our report that the VHA guidance states the prosthetic service should periodically conduct evaluations to ensure prosthetic labs are operating effectively and economically as possible. We found that the VA officials suspended their review of labs in January 2011 after reviewing only nine of the 21 VISNs nationwide.

Because reviews of all VISNs were not conducted, prosthetic service was unaware of its in-house fabrication capabilities or cost. VHA lacked the information to know if its labs are operating effectively or efficiently.

We were never trying to draw a cost comparison between the numbers in the report. Those were the only numbers available at the time and we clearly recognize it was not an apples to apples comparison. We footnoted differences in the report to talk of the costs that are not involved in the VA's cost such as profit and overhead of a contract vendor.

In our second report, we addressed VA's prosthetic supply inventory management and offered a comprehensive perspective of the suitability of VHA's prosthetic management, supplies, and procedures. We also recommended VHA replace its current inventory systems with a modern inventory system.

We reported that strengthening VA's management of prosthetic supplies inventories in VA medical centers will reduce costs and minimize the risks of supply expiration and disruption to patient care due to supply shortages.

For almost 60 percent of the inventory of prosthetic items, VAMCs did not maintain optimal inventory levels. For almost 93,000 inventory items, we estimated VA inventories either exceeded current needs for approximately 43,000 items or the inventories on had were too low for 10,000 items.

Further, we saw that documentation for an annual required wall-to-wall physical inventory had not been performed. This occurred because VAMCs did not consistently apply basic inventory practices or techniques.

For example, VAMCs did not set normal reorder or emergency stock levels in their automated inventory system for over 90 percent of the prosthetic items.

Weak and often ineffective inventory practices led to VAMCs spending about $35 million to purchase prosthetic supplies in ex-

cess of their needs and that clearly increased the risk of supply expiration, theft, and shortages. In fact, if controls are so weak, the losses associated with any diversion could go undetected.

Improvements in inventory practices and accountability over prosthetic inventory is still needed. VHA must improve its inventory management systems and remain committed to replacing its existing inventory systems by 2015.

We are pleased to see that VA is adopting practices to achieve greater savings along with providing more attention to ensuring the fiscal stewardship and contract administration of the funding needed for prosthetic care in response to the issues we reported on.

We will be happy to take any questions.

[THE PREPARED STATEMENT OF LINDA A. HALLIDAY APPEARS IN THE APPENDIX]

Mr. ROE. Thank you, Ms. Halliday.

Dr. Daigh.

STATEMENT OF JOHN D. DAIGH

Dr. DAIGH. Dr. Roe, Mr. Michaud, Members of the Subcommittee, it is an honor to be here to speak with you on our report on prosthetic limb care in the VA.

We have done a series of reports on what I would call transition to care and in those reports, we have allied ourselves with the DoD, IG, specifically Elias Nimmer who has helped us gain access to DoD data.

And also we have used Dr. Clegg in my office who is a biostatistician to get the metrics right and who is quite an expert on population health.

We have reported on moderate TBI, access to mental health in Montana, combat stress, women veterans, this report on prosthetics and one we just published on homelessness in this population.

So this issue of transition to care is important to us, and again we thank you and your staffs' support for this work.

We looked at two populations in this report. One is a population of about 500,000 veterans who left DoD and became veterans in the 2005, 2006 timeframe. And we were then able to follow those veterans as they transitioned through VA and then received several years of VA care.

And there were a couple of outcomes from that data that I think are worth noting. One was surprising to me, maybe not to those who work with this population all the time, it was not just the limb that was affected in these patients. Every organ system you looked at by diagnostic category had significantly elevated disability or medical disease burden in this population.

So whether it is the blast injury they suffer at the time that they are injured or the other circumstances of trauma and recovery on the battlefield are unclear, but this is a population that has quite a significant disease burden beyond those that you would think of.

The second feature that stood out from that analysis was the problem of pain management and substance use disorders, I mean, in addition to the normal mental health issues that this population would be expected to have.

Again, I cannot speak out enough the difficulty that this population has with these disorders and the difficulty that VA currently has and society has in dealing with these issues.

The second population that we looked at we got with the help of Dr. Paul Pisquina at Walter Reed, both the old Walter Reed and the new Bethesda campus, who is a physiatrist there, and Mr. Charles Scoville who works with TMA, was in charge of the prosthetic program, I believe.

And they provided us their data set of combat-injured veterans from the recent wars who had major amputation. At the time that we got our data, there were 1,506 major amputations. Of that number, 180 were not traumatic. They were related to some other feature. Thirty-eight of those individuals were dead which left us with 1,288 individuals with combat-related major amputations.

Of that number, about 450 remained on active duty, some of whom were employed and some of whom it appears to us were severely medically ill and DoD seemed to be keeping them to make sure that they were in a better condition when discharged from DoD. That left us with about 838, again, traumatic major amputations of the upper and lower extremities that we tried to assess.

If you take that number and divide it by 150 medical centers, and we did plot out addresses for these folks, you find out that this population, they are everywhere in the United States. So there is a simple problem of having ten or less on average without knowing specifically patients who have these problems across the VA just as a point of reference.

Whereas, when you look at the elder population the VA normally takes care of where it looks to us they have several thousand amputations a year, major amputations a year, that is mostly older gentlemen who have diabetes or other vascular disease. So there is a significant difference there.

We also went out and telephone surveyed and visited in person these returnees from the war trying to get a feeling of whether what we were seeing on TV and in the press was an accurate reflection of how well these gentlemen and women were doing. In other words, the same ten people we were seeing playing softball all the time or in general these folks doing very well.

And I would say that we are very, very impressed that this population which entered the military with a can-do and follow-me attitude has really maintained that and I do not believe that what we see on TV is an aberration. I believe that in general this population is doing extremely well.

There is one caveat to that. The folks at Walter Reed were very concerned about the 33 veterans at the time that I give you the number 1,500 who had three and four limb amputations. And that population, we were unable to see enough of to get a clear feeling of how they are doing. But I do believe that they are significantly more impacted in a total body sense from those who have one or two amputations, enough to be really, I think, a different category of disease.

I think that we also heard in our interviews and in our discussions with these veterans essentially the same comments that you have heard from the previous two panels. And I will not go through those except to say that people wanted to know why they could not

take a picture of their broken prosthesis and send it in by e-mail and, you know, try to expedite the paperwork involved in trying to get the billing process and the bureaucracy of things done.

We have had conversations with Dr. Beck and her staff. They are well aware of these issues and I am confident that they are thinking about how to best deal with these issues. And they will be on the next panel to discuss the changes that they would propose. But they have been very cooperative, I think, in trying to come up with what the right answer is.

We made three recommendations. One was we asked VA to consider this data set which I think has really previously not been available in the detail that we have published it and I think VA has done that in trying to tailor their care.

We do believe that the upper extremity veterans both in the surveys that we have done, have for a variety of reasons, a great deal more difficulty than those with lower extremity and we do urge that research be done and that the appropriate level of effort be made to get those upper extremity prosthetics up to speed.

And, thirdly, we asked VA to deal with the bureaucracy, that is the fee basis or contract complaints in a way that would sort of lessen the aggravation that veterans who have these difficulties have in trying to make their way through the system.

With that, I will end my testimony and be glad to answer any questions that you have. Thank you.

Mr. ROE. I thank the panel.

And I just have a couple of observations and, of course, we appreciate you being here and testifying today.

Ms. Halliday, it does not look like a huge issue, but just with the simple changes in contracting, and I certainly understood what you were saying, this does not change the quality of the prosthesis——

Ms. HALLIDAY. Right.

Mr. ROE. —at all. It may be the same one if you just negotiate a lower price for the same. Am I correct on that? Is that what you were saying?

Ms. HALLIDAY. You are correct. What we were concerned about was if we have an existing contract with a vendor and it says that you are going to charge $10.00 for an item and the invoices start to come in, if they are not reviewed and you are really charged $15.00 or $20.00, that is the point we wanted to see the correct prices paid. That money could be reprogrammed to prosthetics care.

Mr. ROE. And that should not be a big issue. I mean, moneywise, it is a significant amount of money that could be spent because as either Captain Pruden or whoever said a minute ago there is $54 million in the VA budget. That is not a lot of money that is spent on prosthetics.

So I guess the savings there would be fairly significant. And prosthesis, I think, in the VA terminology is—we would think of as a limb. It could be a hearing aid or a wheelchair or a crutch. Am I correct on that?

Ms. HALLIDAY. Yes. But this report that we issued looked at the limbs.

Mr. ROE. Okay. Just at the limbs?

Ms. HALLIDAY. Yes.

Mr. ROE. Okay. And you also agree that this was not an apples to apples when you were looking at it? You are not really sure what that $2,900 figure——

Ms. HALLIDAY. We absolutely agree with that. It was the only cost information available. We put it in the report and clearly said it was not apples to apples in our footnote there.

The fact was VA did not have good information to make decisions on whether it should have labs, whether the labs could provide these items at a more economical cost and the same quality. They just did not have that type of information available when my audit team went out.

Mr. ROE. Dr. Daigh, that was fascinating data that you had that you presented. And did I hear right that there were 33 that had three amputations, more than two?

Dr. DAIGH. Yes, sir. I believe the number we had in the report was 33 individuals who had three or four limb amputations who were alive at the time we did this report.

Mr. ROE. Well, I think the challenge is now, and I will just be very brief here, but Mr. Michaud and I went to Afghanistan together three years and then I went again in October of this past year, and just from a physician's viewpoint, the treatment of trauma care has changed dramatically from the time I was in the service.

And you can see the results. The results are a lot of people are surviving horrific injuries. And if you do not die of your injury on the battlefield, you have about a 95 percent chance now of surviving that injury as opposed to when Mr. Reyes was in Vietnam which was a lot less than that, I can tell you.

So we are going to have to deal with these issues going forward and we should.

And I guess the question I have for you is, do you agree with what Captain Pruden said a moment ago about if the VA changes its procurement and so forth, this will be detrimental? In other words, should we just keep doing what we are doing and then tighten up on what Ms. Halliday said?

And inventory, I mean, Walmart can tell you when a tube of tooth paste went out the door, they can replace it. So we should be able to do that.

And the VA it sounds like by 2015, that should be implemented. Do you agree with what the captain said?

Dr. DAIGH. Well, sir, I did not look at the business practices by which these prosthetics are determined which is appropriate and procured. We simply in this report looked at the populations that existed and tried to understand who they were and what was going on with them.

Similarly to the gentleman on the second panel, we did not look at the effectiveness of one prosthetic over another or the cost effectiveness of different measures. We simply did a population health study.

So I do not have a comment on that, sir.

Mr. ROE. And I think the other thing you said just to make sure that we all understand it is that the cohorts in this study had multiple comorbidities. It was not just I lost my leg below the knee and

that is the only thing that is wrong with me. There are multiple. Am I correct there?

Dr. DAIGH. It was very impressive to me that the total body injury that these men and women had sustained which to the outward appearance would mostly be looked at as a prosthetic arm or leg.

Mr. ROE. I yield now to Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

My question is on one of your recommendations, and I will quote, and I quote, consider veterans' concerns with the approval process of fee based and VA contract care for prosthetic service to meet the needs of veterans with amputations, end of quote.

Would you expound a little bit more on that recommendation in detail? Is the reason why you came up with that is because you were finding that veterans are being denied care or unduly delayed in receiving care?

Dr. DAIGH. What we found in interviews with veterans were complaints similar to what the first panel expressed and that was these men and women are active. They are going to school. They have families. They have lives.

If their prosthetic breaks, they want it fixed immediately. They do not want to have to get in the car and drive some place to have an examination done or to get the paperwork accomplished appropriately.

Our work did not analyze the business practices of making that happen. So I did not feel I was in a position to offer advice to VHA as to how to fix that problem, but we did sit down and have discussions with Dr. Beck and others to lay out what we thought the problem was.

Dr. Yang and others gave comments directly as to what we heard and then we asked VHA to consider how they are doing their work and see if they can't improve that.

At this point in time, I am not knowledgeable enough unfortunately to give you advice on exactly what I think they should do different. I wish I could, but I do not have that information.

Mr. MICHAUD. There has been some discussion and was clarified as far as the cost and the savings comparing apples to apples and the management of the inventory.

Have you or your sister agency ever done a report within the Department of Defense to find out what the cost comparing DoD to VA? Is the cost equal, number one?

And, secondly, you talked about the inventory management. Is your recommendation consistent with what actually the Department of Defense is doing or do they have the same problems that VA has in regards to cost and inventory management?

Dr. DAIGH. With respect to the provision of care and the way VA and DoD are different, I think, is that DoD has, I believe, focused the care of patients who are badly injured from war at several discrete centers and by then getting a large enough group of patients continuously there, they are able to put the resources in those select several places, D.C., maybe San Diego, San Antonio, maybe one or two others and then provide cost-effective state-of-the-art care.

VA is a much more dispersed organization and veterans live throughout the country. They have already been through the acute trauma. They are up and about. So it is a little bit of a different problem.

As to the second question, we have done no work on the cost of DoD compared to VA on providing the same level of care.

Mr. MICHAUD. When you talk about the wounded warrior utilizing the DoD versus VA, the numbers are higher in DoD. Do you know how many veterans, the newer generation veterans are still utilizing the Department of Defense versus going into the VA because they feel, you know, that they are getting better service at DoD and how many veterans are using DoD versus the VA?

Dr. DAIGH. We have found in looking at transition to care that there is a flow back and forth between DoD and VA for veterans. Some veterans have DoD disability that allows them to go to a DoD facility or they are retired and, therefore, they are able to use DoD facilities.

In our report, we show that the veterans with prosthetic issues transferred to VA fairly quickly and in much larger numbers than the average veteran who left DoD did.

Actually when we started this study, I was concerned that DoD might hold on to or that those veterans might reside around the cities where these areas of—the DoD areas of expertise have highlighted. But I think we found that really they have not stuck there. They have transitioned very quickly to VA which was somewhat of a surprise to me.

And I could get back with specific numbers at specific times, but there is a nice chart that shows over four or five years, they are almost all in the VA.

Mr. MICHAUD. Great. Thank you very much.

Mr. ROE. Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman. I apologize for being late. As you know, we have competing hearings taking place.

In Fort Bliss, we have the wounded warrior transition center. And one of the questions that I get asked is, the research and development that is going on in the area of prosthetics.

Can any of you comment on what kind of R&D is going on because I know just seeing the kinds of prosthetics that are being used today from my viewpoint, it is phenomenal? But I am not sure that I understand where that R&D is taking place for prosthetics.

Dr. DAIGH. Sir, I apologize. I do not know the answer to that in detail that you need. I could get it for you. And, again, Dr. Beck may be able to in the next panel explain what VHA is actually funding and how they are dealing with that. I cannot give you a good view of that, sir.

Mr. REYES. Okay. And the other question I have, there have been many concerns expressed about the proposed changes to the procurement. I am not sure I understood the issue and the concern from veterans that there might be a further delay in getting their service for the prosthetics.

Can you comment on whether or not that is a valid concern on the part of veterans using the VA?

Ms. HALLIDAY. To some extent, I can offer some comments on that.

The VA is changing its procurement practice bringing more involvement to contracting officers which I think will help with strengthening the contract administration process that we found problems with.

My concern is that it really requires communications between the prosthetic assistants and the contracting people so that the veterans' needs are truly met.

In the past, VA has had some communication issues between these offices. I think the new leadership is working very hard to fix those.

And I cannot comment to whether the veterans will experience delays. VA has just put a pilot in place to look at this new model, but they have not shared that information with us nor have I had an opportunity to see it in practice to really measure its effectiveness.

I think the question should also go to VA.

Mr. REYES. Okay. So can you comment on whether or not there is either going to be or there is a process of providing feedback?

Ms. HALLIDAY. I cannot comment on that. I think that is a question for VA.

Mr. REYES. Okay. Thank you, Madam Chair.

Ms. BUERKLE. [Presiding] Thank you.

With that, if there are no more questions from the Committee, we thank you very much for your testimony this morning.

And we will now invite the fourth and final panel to come to the witness table.

Joining us this morning in our fourth panel is Dr. Lucille Beck. Dr. Beck is the Acting Chief Consultant for the Prosthetics and Sensory Aids Service for the Veterans Health Administration for the United States Department of Veterans Affairs.

Dr. Beck is accompanied by Dr. Joe Webster, National Director for the Amputation System of Care; Dr. Joe Miller, National Program Director for the Orthotic and Prosthetic Services; and Norbert Doyle, Chief Procurement and Logistics Officer, all of which are with the VA Administration or the Department of Veterans Affairs.

Thank you all very much for being here this morning or I guess it is afternoon now.

And, Dr. Beck, if you would proceed. Thank you.

STATEMENT OF DR. LUCILLE BECK, ACTING CHIEF CONSULTANT, PROSTHETICS AND SENSORY AIDS SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JOE WEBSTER, NATIONAL DIRECTOR FOR THE AMPUTATION SYSTEM OF CARE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; JOE MILLER, NATIONAL PROGRAM DIRECTOR FOR ORTHOTIC AND PROSTHETIC SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; NORBERT DOYLE, CHIEF PROCUREMENT AND LOGISTICS OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF DR. LUCILLE BECK

Ms. BECK. Thank you.

Good morning, Chairman Buerkle, Ranking Member Michaud, and Members of the Subcommittee. Thank you for the opportunity to speak about the Department of Veterans Affairs' ability to deliver state-of-the-art care to veterans with amputations.

I am accompanied today by Dr. Webster, our Director of the Amputation System of Care; Dr. Miller, our National Program Director for Orthotic and Prosthetic Services; and Mr. Norbert Doyle who is VHA's Chief Procurement and Logistics Officer.

VA's Prosthetics and Sensory Aids Service is the largest and most comprehensive provider of prosthetic devices and sensory aids in the world, offering a full range of equipment and services. All enrolled veterans may receive any prosthetic item prescribed by a VA clinician without regard to service-connection when it is determined to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

I will briefly summarize the major initiatives underway to improve the quality and availability of amputation care. These fall under five general headings: Staffing and community partnerships; accreditation of VA laboratories; improved training for VA staff; greater research into amputation and clinical issues; and collaborations with the Department of Defense.

First, VA's Prosthetics and Sensory Aids Service has a robust clinical staff of orthotists and prosthetists at more than 75 locations and also partners with the private sector to provide custom fabrication and fitting of state-of-the-art orthotic and prosthetic devices.

VA maintains local contracts with more than 600 accredited O&P providers to help deliver care closer to home. Commercial partners help fabricate and fit prosthetic limbs for veterans across the country.

Since its creation in 2009, VA's Amputation System of Care has expanded to deliver more acceptable, high-quality amputation care and rehabilitation to veterans across the country.

This system of care utilizes an integrated system of VA physicians, therapists, and prosthetists working together to provide the best devices and state-of-the-art care.

Second, VA promotes the highest standards of professional expertise for its workforce of more than 300 certified prosthetists, orthotists, and fitters. Each VA lab that is eligible for accreditation is accredited by the American Board for Certification in orthotics, prosthetics, and pedorthics, and also the Board of Certification Accreditation International or both. This accreditation process ensures quality care and services are provided by trained and educated practitioners.

Third, to support the continued delivery of high-quality care, VA has developed a robust staff training program. We offer clinical education, technical evaluation, and business process and policy education in addition to specialty product training to help our staff provide better services to veterans.

Further, VA has one of the largest orthotics and prosthetics residency education programs in the Nation with 18 paid residency positions at 11 locations across the country.

Fourth, VA's Office of Research and Development is investing heavily in prosthetics and amputation health care research. It is issuing a request for applications for studies to investigate a variety of upper limb amputation technologies and applications.

VA also works with the Department of Defense to support joint research initiatives, determine the efficacy and incorporation of new technological advances.

Finally, the partnership between VA and DoD extends further to provide a combined collaborative approach to amputation care by developing a shared amputation rehabilitation clinical practice guideline for care following a lower limb amputation.

VA is also supporting the Department of Defense by collaborating on the establishment of the extremity trauma and amputation center of excellence. The mission of this center is clinical care including outreach and clinical informatics, education and research, and is designed to be a lead organization for direction and oversight in each of these areas. The center is currently being implemented and will obtain initial operating capacity by the end of this fiscal year.

In summary, VA supports high-quality amputation and prosthetics care by supporting groundbreaking research into new technologies, training a highly qualified cadre of staff, and pursuing accreditation of all eligible prosthetic laboratories in VA's Amputation System of Care.

We are improving our oversight and management of prosthetics purchasing and inventory management to better utilize resources we have been appropriated by Congress and to serve America's veterans.

We appreciate the opportunity to appear before you today to discuss this important program. My colleagues and I are prepared to answer your questions. Thank you.

[THE PREPARED STATEMENT OF DR. LUCILLE BECK APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you, Dr. Beck, for your testimony and for being here today.

I have a number of questions. A lot of it is based on what we heard from the three previous panels, especially the veterans and

the veteran service organizations. I think they provide for us a reliable source of information and they identify needs for us.

My first question is, what was the impetus behind the change? You heard the concern from the previous panels. What was the impetus behind the change in the procurement policy and did you consult with the veteran service organizations and/or veterans? Who did you talk to to make this change?

Ms. BECK. The impetus for the change is an impetus from the department to assure compliance with Federal acquisition regulations.

I have with me Mr. Norbert Doyle who is VHA's Chief Procurement and Logistics Officer today. We were anticipating some of these questions and he is available to provide more information about the change and what is happening.

Ms. BUERKLE. And just if you would before you start, does that mean heretofore the VA was not compliant? I mean, if that is the basis for this change. Maybe you could make that clear to us.

Mr. DOYLE. Yes, ma'am. Thank you.

Thank you, Dr. Beck.

Ma'am, yes, the impetus was to bring the VA contracting to include VHA and all the other VA contracting organizations in better alignment with the Federal acquisition regulations.

It is my understanding the department recognized several years ago actually that they were weak in certain areas in contract administration and awarding of contracts. And this was also to bring it in-house to ensure proper stewardship of the government dollars.

In reference to your question, did we talk with veteran service organizations, actually last—I do not believe we did before we started the process. However, last week—and I am happy to meet with any organization to discuss what we are doing. I heard the complaints of the veteran service organizations that they feel out of the loop.

I met last week with Dr. Beck with the Secretary's Advisory Committee on Prosthetics and Special Disabilities. We spent a great deal of time with them, and I think that group has representatives from many veteran service organizations, to address their concerns that they may have.

Again, I make that offer that I will be happy to meet with any group to discuss these.

Ms. BUERKLE. Thank you.

I think it would be in the best interest as we go forward to do what is best for veterans and to hear from the veteran service organizations and from the veterans themselves and from those who have gone through this process and who understand intimately as did the first two panelists. It would seem very basic to talk with them and to have them identify needs and concerns.

You heard Wounded Warriors say we are asking you, Congress, to please freeze this change until, and the other point I wanted to bring up was the pilot.

You heard Paralyzed Veterans, their organization asked or mentioned a pilot. Have you done a pilot? If so, what were the findings? You know, is that the justification for this change?

Mr. DOYLE. Yes, ma'am. I actually have a number of issues to address along those lines.

First, to put it in context, and, granted, we are talking about the more expensive items that we are talking about today, the transfer of the contracting authority from prosthetics to contracting only impacts those procurements above $3,000 which is the mandated Federal acquisition or Federal micro-purchase threshold.

So only three percent of orders that we estimate fall in the realm. So 97 percent of prosthetic orders will stay with prosthetics.

As I said, we are doing this to bring us more in line with Federal acquisition regulations and also to address many of the issues that the IG has mentioned, although those were identified, I think, previously.

Now, I want to assure everybody that if a clinician specifies a specific product for a veteran, contracting will get that product for that individual.

I do not as the chief contracting person in the Veterans Health Administration, I do not want my contracting officers making a decision as to what goes in the veteran's body or gets appended to it. That is clearly a clinician decision.

And how are we going to get that product that the clinician specifies for the veteran, and we are going to do it under the auspices of the Federal acquisition regulations. We are going to cite the authorities of 8123 which is—one individual mentioned that the broad latitude given by Congress to the Veterans Administration.

We are going to do that by properly preparing justification and approvals for sole source, citing in paragraph four the authorities granted under 8123.

And there are seven exceptions in part six of the FAR to full and open competition. Exception five is the one that is authorized by statute and that is what we will use.

We have gone through great pains to ensure success in this transfer. And a little bit of history. Even starting last summer when we started this process under the direction of the department, Dr. Beck's and my folks, we formed a team and that team included field personnel, both prosthetics and contracting, which we thought was critical.

They developed a plan for the transfer. It was a very detailed plan. The plan actually as we got into it got more detailed as we identified other issues.

We then worked with our union partners to ensure that they did not have issues and that we could proceed successfully.

There were pilots as part of the plan which is probably the best part other than bringing field people into the planning process. The pilots was a great aspect.

We did the pilot in three VISNs, in VISNs 6, 11, and 20, and that is the Virginia, North Carolina area, the Michigan area, and the Pacific Northwest.

We piloted beginning in January for about 60 days. Those pilots concluded in March. We did learn from those pilots and we are implementing changes to ensure that care is not impacted.

Some of the things we learned is that our staffing models were incorrect and the number of procurements that we could do in a day and the contracting officer we are hiring, we received approval to hire additional people to ensure we can keep up.

We are streamlining the process by, I mentioned, justification approvals by templating that process, so it becomes more fill in the blank with the clinician's prescription. Those are the type processes.

We are slowly now implementing in the rest of the Veterans Health Administration. I think four more VISNs are starting that process now and the rest of the VISNs will be coming on in June and July. The goal is to have all this done by the end of July.

There is a contingency plan that we have discussed. We still have the legacy procurement system if something does not go right or something unexpected happens that we can fall back on. But we do not expect that to happen.

Ms. BECK. And I would like to add that this has been a very strong collaboration and partnership. Prosthetics and Sensory Aids Service is very concerned that we can continue to provide the services to the veterans that they deserve and that we have always been able to do.

And so our prosthetics organizations at our local medical centers and at the VISN level remain the eyes and the ears. So all orders still come through prosthetics. Prosthetics is managing them and working with contracting officers to achieve the placement of the order as is required to be meeting all of our acquisition requirements.

And we are, as Mr. Doyle has said, very aware of the ability to use 8123 and have spent a significant amount of time developing justifications and approvals that allow us to use that and really reflect the needs of our—the individualized rehab needs of our veterans.

We are very much aware that we customize these products and services, that they are selected based on an individual veteran's needs. And that has been our goal as we have managed this transition.

We are coming into a critical time as we move the transition forward and extend it to other VISNs and we have very well-developed and exact procedures in place to monitor this as we go.

And we are prepared, I think, Mr. Doyle and I as a team to, and our office as teams, to review this very carefully and make recommendations as the way forward based on how this process affects veterans.

Mr. DOYLE. And I am sorry, ma'am.

Ms. BUERKLE. Go ahead.

Mr. DOYLE. May I add that when I met with the Advisory Committee on Prosthetics and Special Disabilities last week, they had many of these very same concerns. I think after spending some degree of time with them, they at least understood what we were doing. They are still very interested in ensuring we do achieve success. But I will let Dr. Beck comment.

I do not think we left there with a burning issue, at least I did not, that we needed to address.

Also, as a veteran myself who made several trips to Iraq and Afghanistan both in a military and a civilian capacity, you know, I am very sympathetic to the needs of the veteran population. And I can assure you I will do nothing that hurts the veterans because,

you know, there but for the grace of God go I, actually and that is the way I look at it.

Ms. BUERKLE. Thank you.

My time has way run over. However, if my colleagues will indulge me, I just have a couple follow-up questions and I will allow you to have as much time as you need.

My first concern is that you said with procurement, it only pertains to those over $3,000 and you stated only three percent of the orders are over $3,000.

How many requests do you have?

Mr. DOYLE. That is still not an insignificant number. Based on our planning estimate or our planning figures for fiscal year 2010 in which we planned the transfer over, three percent of the orders equals roughly 97,000 orders.

Ms. BUERKLE. So I would suggest that because we are talking about 1,500 warriors with amputations that probably are in need of prosthetics that that is going to be a small percentage of what you are doing. However, all of those are going to exceed that $3,000 threshold.

We heard earlier about a $12,000 limb and if it is $25,000, that does not matter because the veterans need prosthetics and they need state-of-the-art prosthetics. That concerns me, that piece right there.

The other thing that concerns me is you mentioned that you talked with your union partners. It would seem to me more appropriate to talk to your veteran partners and to the veterans who have gone through this and be more concerned with their thoughts about this being a program that works versus talking just to the union partners.

And, lastly, if I could respectfully request that you would provide us with the results of those pilots. I think you said you did three, in 6, 11, and 20 VISNs. If you could provide us with the findings from those pilot programs, I would appreciate it.

Mr. DOYLE. Yes, ma'am.

Ms. BUERKLE. Thank you.

And I now yield to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair.

I just want to follow-up, Mr. Doyle, on your comment that you made where you mentioned that contracting officers do not change what the clinicians prescribe, but actually in testimony we heard earlier from PVA, that is not the case, that their testimony states that contracting officers when they do receive the orders, the request for the devices is modified and even denied in cases because of the cost.

So that is a huge concern. There seemed to be a disconnect from what you are hearing versus what the VSOs are hearing because that is not the case. The cost is a factor. It is not the veterans of health care.

So do you want to comment on that?

Mr. DOYLE. Yes, sir.

Mr. MICHAUD. Yeah.

Mr. DOYLE. First of all, all contracting officers do have a mandate under Federal acquisition regulations to ensure that there is

a price reasonableness aspect to the cost we are providing. So I do not know if that is a concern or not.

I cannot really speak to what may have happened before, but I have put out to the contracting community that under 8123, if the contracting officer receives a physician's consult for a specific product, we will do due diligence to ensure we pay a fair and reasonable price for that product, but we are going to get that product for that individual.

So I do not know if it is a concern. Again, I will take full blame for not bringing the veteran service organizations into the loop and to this discussion and we can fix that. But I do not know if that is part of the issue there, that's why that concern was being raised.

Mr. MICHAUD. Well, it is very clear from the VSOs, some of their statements, that it is not uncommon for clinicians to prescribe something and it is being modified by contracting officers and primarily because of cost. And that is a big concern that I would have.

My other question is, Mr. Oros talked about older veterans at his practice complaining that there appears to be a new administrative hurdle to prevent their continuing to receive care at Scheck and Siress.

The VA has assured veterans that they may choose their own prosthetist and, yet, veterans who wish to use community-based providers report widespread administrative hurdles and other pressures to choose in-house VA care.

How would you explain the perception among the veterans and the community-based providers because there seems to be a disconnect here as well as far as what you have told us versus what is actually happening out there?

Ms. BECK. Yes, sir. I will start. And we do have contracts with 600 providers, approximately 600 providers. We do offer choice to our veterans. And in our amputee clinics, when we initiate the process for the multi-disciplinary care that we provide, we have our physicians and our clinicians and our prosthetists there.

We also have our vendors, our contracted community partners, our contracted prosthetic vendors from the community are there as well. The veterans do have that choice. That is part of our policy. And as we become aware of, we will reaffirm that policy with the field based on what we have heard from our veterans today. And we are improving the processes.

I think the Inspector General report pointed out that there are some contract administration initiatives that we need to undertake including streamlining the way we do our quote reviews so that they happen in a more timely fashion and that they really clarify the prescriptive elements for fabrication of the leg and we are doing that, or fabrication of the limb and we are doing that.

The second thing that we are doing is we are making sure that our contracting officers and their technical representatives who have as part of their responsibility to review those quotes and certify that they are doing that regularly and in a timely fashion.

There is guidance that is being prepared even now to re-instruct the field and educate them on that.

And the third thing we are doing is we are taking a contracted, what we call contracted templates where we are developing policy and guidance that can actually go into our contracts so that it is

clearly specified for the contracted provider and the VA exactly what the requirements are and the timeline.

So we have taken the report that we have from the Inspector General about the need to improve contract administration to support our veterans seriously and we are making those corrections and have been doing that over the last several months.

Mr. MICHAUD. And do you feel that with the new changes that you are providing, gets back to my original question, that the clinicians will have final say in what a veteran receives versus a contracting officer who has to look at contracts and saving costs which I believe that we have to do?

But the bottom line for me is to make sure that the veterans get the adequate prosthetics that they need. And if it costs a little bit more, then they should be able to get it if it fits them more appropriately.

And the concern that I have is, yes, you have got to look at saving cost, but not at the cost of providing what our veterans need. And I do have a concern with contracting officers injecting more cost versus the clinician looking at the veterans' needs.

Ms. BECK. Yes, sir. I have a concern with that too. I am a clinician myself working in another area who provides rehab technologies to veterans. And it is critically important that what the clinician requests, and that, of course, is done in collaboration and in partnership with the veterans, these are choices and decisions about technologies that our veterans make with our clinicians.

And we are absolutely. Rehabilitation is not effective unless we are able to provide the products and services that our veterans need. And our role in prosthetics and in rehabilitation is to assure that any contracts and the way we procure items enhances and—well, not only enhances, but provides high-quality individualized care.

We have done that successfully for a long time and we believe that we are able to do that as we move forward. And as Mr. Doyle has cited, we can certainly work within the framework of contracting requirements and the added authority that Congress gave us many years ago for 8123, I think, is the other piece of sole source procurement that we can do when we need to provide and when we are providing highly individualized products and services.

Mr. MICHAUD. Thank you.

Thank you, Madam Chair.

Ms. BUERKLE. Thank you.

I now recognize the gentleman from Texas, Mr. Reyes.

Mr. REYES. Thank you, Madam Chair.

Dr. Beck, you mentioned the center of excellence. Where is that located and how much of the work being done there is medical research as it pertains to prosthetics?

Ms. BECK. The center of excellence that I spoke about is a joint VA/DoD center of excellence for extremity care. That actually will be a virtual center or it is a virtual center. It will have locations in San Antonio, Texas and in Washington, D.C.

Staff will be distributed across our system so that some of our staff will be in various centers, both VA and DoD centers around the country so that we are collaborating, coordinating our efforts.

And I think you mentioned research earlier, sir.

Mr. REYES. Right.

Ms. BECK. And one of the things that we talked about that we will be able to do by leveraging the capability with DoD and VA is that we will be able to do clinical trial type of evaluations at a number of different centers at the same time.

And that is one of the missions of this joint VA/DoD center of excellence is research coordination and studying and reporting on new technologies and developing better outcomes for care.

Mr. REYES. And how will you ensure that at least the medical research that is going on is somehow tied back with the feedback being given back by the veterans, you know, their experiences with the different types of prosthetics, the challenges that they have, and also pain management? Is that all part of that?

Ms. BECK. It is. I will comment and then I will ask Dr. Webster to comment.

The participants in these studies will be our veterans and active-duty servicemembers. So they will be able to report to us firsthand what their experiences are. So that is how we will tie in the feedback.

We also listen carefully to our veterans as we look at their outcomes of care and their successful use of prosthetic limbs and technologies to gain information about where the research needs are.

I am going to ask Dr. Webster to comment just for a minute on what we are doing with pain management.

Mr. WEBSTER. Thank you. I really appreciate the opportunity to be here today and provide this testimony.

And I would agree that, you know, it is extremely important that we get feedback and information from the veterans and servicemembers with amputations on, you know, what is important in research.

You know, we can do research looking at various things, but if it is not important to the veteran or servicemember, it is not going to do us much good. So that is critically important. And that is done on a routine basis.

Captain Pruden provided his testimony earlier, kind of this expert panel that was put together previously that was looking at the amputation care as well as the prosthetic care. And that will continue to occur as we move forward with our research efforts.

Again, with the center of excellence, several of the physicians, the more administrative headquarters will be in San Antonio and the National Capitol region, but many of the research staff are actually located within our treatment facilities, so they are located within Walter Reed, they are located within the Center for the Intrepid. So they are completely integrated with the clinical staff and with the soldiers and veterans who are being treated in those facilities.

Mr. REYES. And I am curious how the process works. Is there like a case worker that will have a caseload of the particular veterans to make sure that feedback is coming to the case worker and that feedback goes into the R&D component? How does the process work?

Mr. WEBSTER. I think it can occur both directly from the servicemember or veteran, you know, to the researchers. Again,

they are going to be collocated in the clinical area, so that feedback can come directly.

But, you know, there is also opportunities for the feedback to the people who are doing the research to come from the case managers, to come from the other providers, whether it be a physical therapist or a physician. Any of those providers who are providing care for people with amputations can also provide that input into what is important for research and research initiatives.

Mr. REYES. And when will this process be implemented? Is it already going on and, if so, are there examples or an example of how that is working to make sure that the feedback of the veteran is taken into account?

Ms. BECK. Well, the center that we spoke about is standing up now and we expect it to be operational by the end of this year.

I want to talk about, I think, a couple of research projects which are good examples of the work that we are doing. And I think that one of them is what is known as the DARPA arm which is the probably most advanced research activity that is going on. And that is the Defense Agency project for the development of a prosthetic and upper extremity prosthetic arm.

And the way that is working and VA's participation, that, of course, has been funded by the Defense Department——

Mr. REYES. That is the one that Medal of Honor winner——

Ms. BECK. Yes.

Mr. REYES. —Dr. Petri has, right, the one that the hand comes off?

Ms. BECK. Does he have that arm? Oh, we are going to find out that for you. We are not exactly sure, but——

Mr. REYES. I think that is right because I visited with him in my office and he actually took the hand off and put it back on. And I am not a hundred percent sure, but I think either he or somebody with him referred to it as the DARPA arm.

Ms. BECK. Oh, did they? Okay. We will check on that for you and find out.

But one of the things, and this is a good example of veteran feedback, in the first study that was done to evaluate the DEKA arm, our veterans participated in that study and actually came to VA facilities and participated in the study.

We anticipate the second part of the study which will now be a take-home study where veterans will actually be able to take the arm home and use it in their everyday activities and so they will then be providing feedback on the arm and how it works and what is required next.

And we do that frequently with technologies. I think the Genium knee, the iWalk foot are two examples of technologies that VA and DoD have worked on together and had our veterans and active-duty servicemembers participate in those evaluations.

Mr. REYES. So each veteran, again so I can understand, is a case onto him or herself and the responsibility will be with the equivalent of a VA case worker to make sure that all of these things take place?

Ms. BECK. Okay. So the VA has in place a type of case manager for amputees or amputation care and that person is known as an amputation rehabilitation coordinator. And at all of our major am-

putation care sites that we talked about, our seven regional centers, our additional 15 network sites spread throughout the country, we have in place this special kind of case manager who is case managing our amputees and providing those services and seeing that their needs are met.

So it is a case management kind of function similar to the other types of case manager, but it specialized to address the needs of our amputees. And many of those case managers are therapists, either physical therapists or occupational therapists.

Mr. REYES. Very good. Thank you for your indulgence and the time.

I think this may be an area we as a Subcommittee can follow-up on because——

Ms. BUERKLE. I was actually going to ask if you all would like a second round of questions or we can certainly have follow-up.

So with that, I think we will start a second round of questions if you have the time and you would indulge us for a few more questions——

Ms. BECK. Of course.

Ms. BUERKLE. —this afternoon. In the panel with Mr. Pruden, Captain Pruden, I should say, he talked about this new system that you are going to go to, the electronic contract management system, and talked to us about the fact that it requires 300 steps to get the request in.

Can you comment on that?

Ms. BECK. I am going to ask Mr. Doyle who is our expert in this area to comment on that electronic contract management system.

Mr. DOYLE. ECMS, it is new and that we will be putting in place as part of the system, the advanced planning model, which is the part where the requiring people, in this case prosthetics, can put in their requirements and that is how it is transferred over to the contracting office.

We have had the electronic contract management system actually in VA for several years and that is our contract writing tool in effect. And that is what we will use to write the contracts for the prosthetics that come across to us.

As for the 300 steps, I will say that I know it is not probably the easiest system to use and it can be laborious. I would have to sit with the individual to say how they came up with the 300 steps. That is a new figure on me, however.

Ms. BUERKLE. My concern is when we are talking about light bulbs or tissues or any sort of items that we need to purchase and contract out within the VA, that is one thing. But we are talking about in the whole scheme of things a very small quantity, a very specialized product.

And this morning in the testimony, I heard the word intimate. It becomes a part of the veteran's body. It is not like some isolated product that we use. It is specific to that person.

And to take that request or that contract and to dump it into a system like this, it seems to me that the opportunity for a lack of timeliness, a lack of personalization, you name it, I mean, this thing is rife with the possibilities that the veterans, and you heard their testimony, it means I cannot walk my daughter down the aisle, it means I cannot put my baby in the crib.

Those are intimately personal that we, the VA or whatever the system, we may run the risk of not allowing our veterans to do that. And every day that goes by without a wheelchair or without a prosthetic, shame on us, shame on this country because we ought to be—if we are ever on our game, we ought to be on the game when we are providing for our veterans and our military.

And so my concern with this is as soon as you take away the personal piece of this, we run the risk of government bureaucracy and making sure that veteran has exactly what they need as soon as they need it and it is state-of-the-art so that they can get back to the life that they had as best they can and that we maximize that for them. That is my concern.

Our responsibility is to maximize a quality of life for these veterans and when I hear this, I just think to myself you all know what it is like to deal with the government. You all know how impersonal even in a hospital, in a smaller setting, you know, with prescriptions or anything else, but this goes right directly to the veteran's quality of life.

My concern is that this was arbitrary. I will be anxious to see the results of the pilot studies, that not enough thought was given to this, not enough consultation was had with the veterans and the VSOs, not enough work was done before this change was being made.

We are not talking about 25 or 30 thousand prosthetics. We are talking about a much smaller group and I think the very least this government can do is make sure we are doing it right for these veterans.

And with that, I will yield to the Ranking Member if he has additional questions.

Mr. MICHAUD. Thank you very much.

Just two additional questions. My first is, does the VA have an objective measure to evaluate the prosthetic outcome for a veteran?

Mr. DOYLE. May I, Dr. Beck?

Yes, sir, we do. Our workload staffing when we first entered into this project, we took the number of orders that were expected to come over into acquisition and we had a workload factor model and we anticipated or assumed a number of people that would be required in procurement to staff that.

It turns out through the three pilots that our staffing model was wrong and we are hiring additional people. Unfortunately for Dr. Beck, many of the people we are hiring in procurement are her purchasing agents who are coming across from the purchasing agent career field to the contracting career field and will be now working procurement which is probably good for them because there is much more career opportunity as what we say an 1102 versus a purchasing agent, 1105.

We are staffing at the level of, I believe, two to three complete orders per day. That is the metric. And we will be tracking those metrics to ensure we do not fall behind on those metrics.

And as I mentioned earlier, if we do start falling behind, if the unexpected does happen because we are approaching the fourth quarter as well which is traditionally the busiest time of the year for contracting folks, we have the legacy system and those purchasing agents in prosthetics that could fall back upon.

Mr. MICHAUD. What about the individual veteran themselves as far as are they really satisfied? If they do not come back, do you ever contact them to see why they have not come back with the services they received from the VA?

Mr. DOYLE. Yes, sir. At all times, the face to the veteran is going to remain prosthetics, the prosthetics office. They should have no interaction with the contracting folks whatsoever.

And as the IG mentioned, it does come down to communication between the offices or actually in many cases setting up prosthetic cells where the joint contracting and the prosthetics people working together to make sure we meet the needs of the veteran again.

But the prosthetics people will be the up-front face to the veteran identifying what they need. The requirement will come to contracting. We will get under 8123, if it is a specific product, we will get that product for them and then the product will come back to the prosthetics people for the follow-up aspect with the veteran.

And I am sure that there will be, if there are delays, that the prosthetics folks will let us know and ensure that there is an issue.

Mr. MICHAUD. You are talking about delays in getting the limb. My question is, the veteran themselves, have you done an evaluation? Is the customer, the veteran satisfied with the service and, if not, why not, or if they have not come back, have you ever followed up with the veteran themselves to find out whether everything is satisfactory?

Mr. DOYLE. Well, I know in procurement, we have not because we are just getting into this ball game, but I do not know if we do customer satisfaction surveys.

Ms. BECK. In prosthetics, we have done a number of surveys over the years, some extensive ones where we have looked at using our VA SHEP type surveys, our overall customer service and veteran satisfaction with care as we do for our medical centers. We have done two of those specialized surveys over the years.

We also did a Gallop poll survey in 2009 which looked at evaluating what our amputees thought at that time.

The IG has actually, Inspector General in this most recent report also provides us with veteran satisfaction data.

We realized we needed to do more in that area and are now looking at a couple of options that we have. One is a standardized survey that related to patient satisfaction that the Committee on Accreditation of Rehab Facilities uses. We intend to use that. And for our Amputation System of Care, we will be able to use that better in satisfaction surveys in all of our amputation care clinics.

And we are also looking at other ways that we can assess veteran satisfaction.

Mr. MICHAUD. Could you provide the Committee with your latest survey for the——

Ms. BECK. Yes.

Mr. MICHAUD. —veterans and their satisfaction? My last question is, do you find it difficult since this is a special field to find and hire, you know, qualified clinical personnel?

Ms. BECK. We have done a lot of hiring in the field of rehabilitation and for orthotists and prosthetists over the last several years and I think we have added a lot of new providers, providers who are highly experienced and very capable.

For this profession as we have with physical therapy and occupational therapy and some of the high rehab professions, the jobs are extremely competitive.

We have done a couple of things in our system. One is our orthotists and prosthetists are Title 38, so we are able to recognize them for their clinical capabilities and advance them based on that performance and pay scale.

So while it is a challenge, we have been able to attract high-quality providers and fill our positions.

I am going to ask Dr. Miller who is our lead prosthetist to also give you some comment.

Mr. MILLER. Thank you very much for allowing me to testify today.

I am an Iraqi vet and I have had the honor of serving both at Walter Reed Army Medical Center as the Chief of prosthetics there before coming over and serving here in the VA.

With regards to our workforce, the VA is very competitive in that. We are able to attract and retain quite a few of the private sector orthotists and prosthetists. One reason is because we offer them the ability to treat and care for veterans. And that is a mission that they enjoy and are wanting to do.

We also offer training and education. We offer the accessibility to the technology that the veteran receives and many times that technology is only available within the VA or DoD. And that is enticive to those prosthetists and orthotists that like to practice and do clinical care.

Ms. BUERKLE. Mr. Reyes, do you have any additional questions?

Mr. REYES. Just, I think, a couple of brief points.

Of the 600 vendors that you mentioned, the contact with our veterans, are they independent of the VA or are they through the VA? Is it like sometimes happens that a patient will be contacted outside of the system and be convinced that maybe this product is something they ought to try? How do those 600 vendors have contact with our wounded warriors?

Ms. BECK. You want to take that?

Mr. MILLER. Sure.

Yes, sir. The 600 contracted vendors are our community partners and so they are active within our own VA facilities. They attend clinics and they help in the prescription rationale of that item for that veteran. And so they are involved extensively with us in the care.

Mr. REYES. So they would not have independent contact with the veterans themselves?

Mr. MILLER. Yes, sir, they would. If the vendor was selected to provide that limb, the veteran then would typically go to their private facility and have that prosthesis fabricated and designed for them independent of what is going on at the VA medical center.

Mr. REYES. Okay. And those vendors, are they just doing these prosthetics based to VA specs or do they do them independent?

Mr. MILLER. So whenever a prescription is written for that, it is done to what we refer to as the industry standards. So we contact with those providers that have accreditation and certification just like the VA providers do.

Mr. REYES. For a specific product?

Mr. MILLER. That is correct.

Mr. REYES. Okay. The other thing is, on the surveys, part of what I think does not reflect the sentiments of the veteran base, and I say this from experience that we have had there in El Paso, the veterans that are not getting either access to health care or are upset about something, they are really good about taking these surveys and sending them back in.

It has been my experience, and I say this because I have had even some of the members of my family that have gotten those surveys and because they are satisfied, they do not even return them. They just chuck them.

So is there a way or a process that you factor that into that? In other words, if you send out 20,000 surveys and you only get back 1,000, is there some way to factor in those veterans that do not send it in because they are satisfied?

These surveys are multiple pages and they do not want to take the time to or can take the time to answer all those questions. And I think that that really skews the results for the VA facility.

So is there some way that can be done or is that being done? Is that taken into consideration?

Ms. BECK. That is a very challenging question and I could answer that a couple of ways.

I think when any of us use surveys or when we publish surveys or when we read about surveys, we will very often see a statement about the response rate because if the response rate is very low, if you send out 20,000 questionnaires and only 1,000 people respond, then your questionnaire does not have a lot of validity because the number of people that you sampled, and I think that is a challenge in our Gallop polls and every way we do surveys, so that would be the first thing that we do.

And I think our survey folks try to design surveys that will be easy so that people return them. And I think we, you know, need to do better with that. I think as we are developing outcome measures and satisfaction measures, we are very focused on making them short and easy for the clinicians and for the veterans to fill out.

And I think that is what we are trying to do as we address patient satisfaction, veteran satisfaction, and even outcome measures.

Mr. REYES. Because I think if you just include a postcard that——

Ms. BECK. Yes.

Mr. REYES. —basically says, hey, I am satisfied, I cannot or do not want to go through the whole survey, count me as satisfied or somehow like that because——

Ms. BECK. Okay.

Mr. REYES. —because I believe that the results are being skewed——

Ms. BECK. Okay.

Mr. REYES. —because veterans do not want to go through those multiple pages. Whoever is designing those to be short is failing. I have gotten them myself and let me tell you——

Ms. BECK. Thank you.

Mr. REYES. —16 pages is not short.

Ms. BECK. Yes. No, I do not want to fill those out either, so thank you.

Mr. REYES. Thank you.

And thank you, Madam Chair.

Ms. BUERKLE. Thank you, Mr. Reyes.

Before we adjourn this afternoon's hearing, I would just respectfully request that you would provide us—earlier, Dr. Beck, you mentioned there is shared clinical practice guidelines. So much of the testimony was saying that DoD has taken the lead in prosthetics and you are assuring us that there is some collaboration between DoD and VA.

Ms. BECK. Yes.

Ms. BUERKLE. If you could provide for the Committee or for the Subcommittee, I should say, all of the initiatives that are going to ensure that the VA at least is working with and trying to emulate and catch up to DoD's prosthetic programs, I think that would be helpful for us.

Ms. BECK. Thank you. Yes, we will do that.

Ms. BUERKLE. If there are not any further questions, I just want to thank this fourth panel for your endurance, this was a long hearing, and for your willingness to be here. Thank you and thank the both of you, Dr. Miller and Mr. Doyle, for your service to this country.

And before we adjourn the meeting, this is always a good opportunity for this Subcommittee to say thank you to all of the veterans, and to our veteran service organizations for your service and for your sacrifice to this country.

The United States is the greatest country in the history of the world and it is because of the service and the sacrifice of the men and women who serve this country and who have served this country. So thank you very much.

With that, I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include any extraneous materials. Without objection, so ordered.

Thank you again to all of our witnesses, to all the participants in today's hearing, and our audience members for joining in today's conversation.

The hearing is now adjourned.

[Whereupon, at 12:58 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Ann Marie Buerkle, Chairwoman

Good morning and welcome to today's Subcommittee on Health Hearing, "Optimizing Care for Veterans with Prosthetics."

Our Nation's commitment to restoring the capabilities of disabled veterans struggling with devastating combat wounds resulting in loss of limb began with the Civil War.

Restoring these veterans to wholeness was a core impetus behind the creation of the Department of Veterans Affairs then and it continues to play a vital role in the Department's mission now.

Prosthetic technology and VA care have come a long way from the Civil War era wooden peg legs and simple hooks. Following World War II, in 1945, veterans dissatisfied with the quality of VA prosthetic care stormed the Capitol in protest. Congress responded by providing VA with increased flexibility for prosthetic operations and launching Federal research into the development of new mobility and assistive devices.

With these reforms, VA led the way in prosthetic care and research, guided by dedicated professionals both inside and outside the Department who worked tirelessly to provide veterans with the quality care they earned and deserved.

As a result, the model of VA care for today's veteran amputees include leading edge artificial limbs and improved services to help them regain mobility and achieve maximum independence.

Still, the magnitude of the heartbreaking injuries sustained by servicemembers and veterans returning home from military service in Iraq and Afghanistan find VA struggling to keep pace with the rising demands of younger and more active veterans with amputations.

Prosthetic care is unlike any other care provided by the Department.

Prosthetic devices, particularly prosthetic limbs, quite literally become a part of their owner, requiring the integration of body, mind, and machine.

The goal is not just to teach amputees to walk or use an artificial arm and hand, but to provide multi-disciplinary continuing care to maintain long-term and life-time functioning and quality of life.

Which is why I am troubled by the Department's proposed changes to prosthetic procurement policies and procedures. The forthcoming reforms will, among other things, take prosthetics purchasing authority from prosthetic providers and transfer them to contracting officers.

This is alarming to me and - as we will hear soon – it is also alarming to many of today's witnesses. I would like to read a quote from Capt. Jonathan Pruden, a wounded warrior himself, who states in his testimony that:

"We see no prospect that this planned change in prosthetics procurement holds any promise for improving service to the warrior. Instead, it almost certainly threatens greater delay in VA's ability to provide severely wounded warriors needed prosthetics devices . . . .[and] . . . heightens the risk that a fiscal judgment will override a clinical one . . . "

We cannot allow that to happen and this morning we look to the Department for assurance it won't happen.

It is nothing short of inspiring to see how far modern technology and – most importantly - the spirit, courage, and resolve of our veterans themselves has come in restoring mobility, dignity, and hope to our Nation's heroes.

It is vital that we set VA prosthetic care on a course that matches the courage and bravery of the men and women who serve our Nation in uniform.

Again, I thank you all for joining us this afternoon. I now recognize our Ranking Member, Mr. Michaud [ME–SHOW] for any remarks he may have.

Prepared Statement of Hon. Michael H. Michaud, Ranking Democratic Member

Good morning. I would like to thank everyone for attending this important hearing today.

The purpose of today's hearing is to look closely at VA's Prosthetic and Sensory Aids Service and to examine the:

1. Demand for prosthetic services;
2. Any quality of care and access issues;
3. The impact of ongoing procurement reform; and
4. If current acquisition and management policies are sufficient.

As the three Office of Inspector General reports have shown, there are numerous concerns, including:

1. The frequency of overpayments – in nearly a quarter of transactions, totaling over $2.2 million in FY2010;
2. The absence of negotiations, pricing guidance, and other controls; and
3. Limited information to assess if current prosthetic limb fabrication and acquisition practices are effective.

I have said it on this Committee before—What seems to be the case is that there is little accountability in management and once again procedures and policies were not in place or not followed in managing nearly $2 billion worth of prosthetics and sensory aids.

The VA, in last year's budget submission, claims $355 million in savings in 2012 and 2013 due to "acquisition improvements." But if the VA cannot follow its own policies and procedures, how much faith can we have in claims of acquisition savings?

I hope that VA can help us understand today what accountability we should expect - to make certain that:

1. VA does not continue to overpay for prosthetics in the future;
2. That taxpayers and veterans receive the best value for these devices; and
3. For management to ensure that the Prosthetic and Sensory Aids Service is fully meeting veterans' needs.

Finally, it has come to my attention that VA has proposed changes in the procurement of prosthetics and that there is a high degree of concern among some of our witnesses today as to the effectiveness of these changes. I look forward to hearing from VA on that issue as well.

I thank our panelists for appearing today.

I am committed to working with all of you to ensure that our wounded veterans, those who have served honorably and made such great sacrifices, are able to go about their lives more comfortably with these devices and with the best support and services from the VA.

Madam Chair, I yield back.

Prepared Statement of John Register

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee:

Thank you for this opportunity to testify on the ability of the Department of Veterans Affairs (VA) to deliver state of the art care to veterans with amputations. I testify today on behalf of myself and an organization for which I serve on the Board of Directors, the National Association for the Advancement of Orthotics and Prosthetics (NAAOP). NAAOP is a non-profit trade association dedicated to educating the public and promoting public policy that is in the interest of orthotic and prosthetic ("O&P") patients and the providers who serve them. My service on NAAOP's board has exposed me to the field of limb prosthetics from a policy perspective and that perspective is further informed by my own experience with amputation and prosthetic limb use.

The issues to be addressed in this hearing are critical to the ability of veterans with amputations and other injuries and conditions to live active, fulfilling lives, to live as independently as possible, to participate in community activities, to raise families, and to work. I served in the U.S. Army through Operations Desert Storm and Desert Shield over a period of six years. I speak today from personal experience

as an amputee veteran who has worn a prosthesis since 1994 when I lost my leg at the knee joint due to a severe injury sustained during an athletic competition. I currently work for the United States Olympic Committee (USOC) and direct the Paralympic Ambassador Program and the Paralympic Experience Youth Outreach Program, as well as the USOC's Paralympic Military Program, a program for service-members who return from conflict with physical disabilities.

Office of Inspector General Reports on Prosthetics: I have reviewed the three reports recently issued by the Office of Inspector General and have some general observations to offer on the two reports that were issued on March 8th entitled, "Veterans Health Administration: Audit of the Management and Acquisition of Prosthetic Limbs," Report No. 11–02254–102, and "Healthcare Inspection: Prosthetic Limb Care in VA Facilities," Report No. 11–02138–116. The third report issued by the OIG on March 30, 2012 (Report No. 11–00312–127) and entitled, "Audit of Prosthetics Supply Inventory Management" addresses the broader VA prosthetics benefit and goes well beyond limb prosthetics. I, therefore, will not address this report in my comments.

- The term "Prosthetics" is used by the VA to describe a wide variety of devices that have nothing to do with limb prosthetics or artificial limbs. In fact, the data establish that of the $1.8 billion spent by the VA on "prosthetics" in FY 2010, only $54 million (or 3 percent) was spent on prosthetic limbs. This is a relatively small portion of dollars spent by the VA on the broader category of prosthetics.
- The VA's nomenclature (i.e., defining "prosthetics" as virtually any device that assists a veteran, including internally-implanted devices) does not easily mesh with the field of limb prosthetics, which is closely aligned with the field of orthotics (commonly referred to as custom braces for the back, neck, legs, and arms).
- The VA has made a major investment in its internal limb prosthetics capacity since 2009 with the development of the Amputee Systems of Care (ASoC) program, a series of prosthetic centers with differing levels of prosthetic expertise and capacity. The VA has emphasized accreditation of these programs and certification of the professionals in these programs as a measure on quality. The new investments in amputee care are designed to integrate care for veterans and treat the whole patient, not just the prosthetic needs of the amputee. Maintaining internal VA capacity and expertise to treat amputees in an integrated manner is important and the VA should be commended for its commitment and focus on this important population.
- At the same time, especially with respect to its practices with private prosthetists who have contracts with the VA, the VA appears to treat limb prosthetics in much the same way they procure other prosthetic commodities such as wheelchairs and hearing aids, without fully recognizing that prosthetic care is highly clinical and service oriented. The component parts of a prosthesis are but one aspect of quality prosthetic care that results in an amputee walking or functioning consistently well without significant pain.
- The Healthcare Inspection Report (11–02138–116) details relatively high satisfaction levels with lower limb prosthetics, most of which are provided by contract prosthetists, but less satisfaction with upper extremity prosthetics. This is a small but important veteran population and we support the recommendations to improve care for these veterans. Notably, the Department of Defense and the VA have made significant investments in technology in the area of upper limb prostheses and even held a joint research conference in Baltimore, Maryland two years ago. However, we understand that a written report of this conference has not yet been published. We encourage the VA to publish this report and to make additional improvements to its upper limb prosthetic program to improve access to appropriate technology and good quality care.
- We note that despite some internal payment controls that need improvement, the Healthcare Inspection Report (11–02138–116) concludes that the vast majority of veteran amputees have high satisfaction rates with their prosthetic care which are primarily provided by private practitioners under contract with the VA.
- NAAOP questions several conclusions in the VA OIG Report entitled, "Veterans Health Administration: Audit of the Management and Acquisition of Prosthetic Limbs" (11–02254–102).
- NAAOP takes strong issue with the OIG's calculation of the difference in what it asserts it costs the VA to provide a prosthesis, on average, to a veteran through its in-house capability at the Veterans Health Administration (VHA) versus what it costs the VA to purchase an average prosthesis under contract

from a private prosthetist. The OIG asserts that VA spent $12,000 on average for a prosthesis while the average cost of a prosthetic limb fabricated in the VHA's prosthetic labs was approximately $2,900. This is a highly suspect calculation of VA's true costs of providing prosthetic care to veteran amputees and sends the erroneous signal that the VA is vastly overpaying for contract prosthetic care. This is simply not the case. It is not clear which costs the OIG factored into its analysis because the report offers no detail on its calculations, but it is highly likely that OIG failed to include the critical costs of labor (salaries for certified prosthetists and technicians), overhead (the costs of maintaining clinical facilities, laboratory machinery, information processing, etc.), and myriad other costs that go into the fabrication and fitting of prosthetic limbs. In fact, if the OIG were to factor into the calculation the recent investments the VA has made on its Amputee Systems of Care initiative, the cost of providing prostheses to veterans through its internal capacity would be significantly higher than calculated.

- As the VA enhances its internal capacity to meet the needs of veteran amputees, it is important to recognize the legitimate role of private prosthetists who have provided prosthetic care to veterans for decades under contract with the VA. Allowing veterans to access private prosthetists in their own communities preserves quality by allowing choice of provider. The relationship between a prosthetist and a patient can mean all the difference in successful prosthetic rehabilitation. Proximity to care is also very important for veterans. It is important that the VA maintains access to local private prosthetists under contract with the VA to conveniently serve veterans—within the overall plan of care designed by the VA clinical team. Finally, choice of prosthetic technology is critical in order to allow veterans to access the most effective prosthetic alternatives that address their medical and functional needs.
- NAAOP agrees with and strongly supports the recommendation in the Healthcare Inspection Report (11–02138–116) that VA's Under Secretary for Health consider veterans' concerns with the VA approval processes for fee-basis and VA contract care for prosthetic services to meet the needs of veterans with amputations. This is a key area that addresses the satisfaction of prosthetic care among amputee veterans. In fact, there is legislation pending before this Committee that seeks to address this very issue, H.R. 805, the Injured and Amputee Veterans Bill of Rights.

My Experience with VA Prosthetic Care: I currently live and work in Colorado Springs, Colorado. I began my initial care at the amputee clinic in the Denver VA Hospital and was referred to a local prosthetist in Colorado Springs for my primary prosthetic care. This is typical of VA prosthetic care. I sought this prosthetist out because a) they were close to my home and b) they understood the high level of activity to which I was accustomed. This was done in no way to disparage the care I received at the Denver VA. In my experience, I have always been treated with dignity and respect at the three VA hospitals I have been fortunate to work with. Finding a local prosthetist is typical of VA prosthetic care. Just a few years ago, approximately 97% of prosthetic limbs were provided by private prosthetic practitioners under contract with the VA.[1] (I understand this percentage has decreased in the past few years as the VA has invested in their internal capacity to fit and fabricate limb prostheses.) I developed a close working relationship with my local prosthetist over the years and would like to continue seeing him. This prosthetist is certified and accredited by one of the two accrediting organizations that VA recognizes and requires. My local prosthetist's office in my town is seven minutes from my house by car. He has signed a VA contract to provide prosthetic services to veterans and he is, in fact, a fine prosthetist.

Working in concert with the VA amputee care system, which brings together a comprehensive team to assess my prosthetic and other health care needs, my local prosthetist's services have kept me a very active and energetic amputee, walking well, engaging in strenuous exercise, and functioning fully. The ongoing care I received from my contract prosthetist was very convenient, creating little disruption with my USOC job, my family, and my lifestyle.

Unfortunately, my prosthetic needs changed recently and I became interested in a new technology that permits microprocessor control of the prosthetic knee. This new technology is an incredible advance in prosthetic care in that it prevents my knee from "buckling" which causes instability and could cause a fall. Using micro-

[1] Congressional Testimony of Frederick Downs, House Small Business Committee, Subcommittee on Contracting and Technology, Hearing on Ensuring Continuity of Care for Veteran Amputees; The Role of Small Prosthetic Practices, Serial No. 110–105 (July 16, 2008).

processor technology, the prosthetic knee anticipates your movements and adapts instantaneously in order to function as close to a natural leg as possible. The VA Hospital in Denver told me that the only way to be fit for this new technology would be to have my new limb fit, fabricated, and serviced at the Denver VA Hospital's amputee program.

I did not realize I had a choice in the matter and believing the new technology would meet my prosthetic needs, I agreed and began the fitting process at the Denver VA, driving 70 miles each way to receive the prosthetic care I could have accessed just seven minutes down the road from my home. I also did not realize that I could have been reimbursed for my travel expenses until my fourth visit.

I traveled to Denver numerous times during the fitting process before I finally received my new limb. Every time I need adjustments or servicing of the prosthesis, I must take the better part of a day off from work, drive a significant distance, and obtain my care at the Denver VA. Again, I have no complaints with the amputee/prosthetic care they provide at this hospital. They are professional and knowledgeable, but the wasted time and energy is a major imposition in my life and a disruption to my job and family responsibilities. In addition, I have had times when a quick visit to my local prosthetist could have resulted in quick adjustments to maintain the fit and function of my prosthesis. Instead, I have found myself delaying care until something significant happens or the need for prosthetic care intensifies. This is not an efficient, convenient, or patient-friendly system.

I consider myself very fortunate that I am not in a position where I am vulnerable or uneducated about my prosthetic options. But I worry about those veterans who are not in the position to advocate for themselves and simply accept what they are told about their prosthetic care options. And such options appear to be very inconsistent across the Veteran Integrated Service Networks (VISNs). The VA needs to ensure that all veterans with amputations consistently receive the high quality prosthetic care they need and deserve. One of the primary ways to ensure this is to make sure that veterans know that they have rights and responsibilities. They should have a choice of prosthetic practitioner, a choice of technological options, and a choice to seek a second opinion when desired by the patient. This is completely consistent with the OIG's recommendation that the VA improve its approval processes for fee-basis and VA contract care for prosthetic services to meet the needs of veterans with amputations.

In fact, this recommendation, and the agreement by the Under Secretary of Health to this recommendation, seems at odds with the VA manual provisions that suggest that each VISN maintain between three and five contracts with private prosthetists, an exceedingly low number that does not square with the notion of veteran choice of practitioner. This is perhaps why some regions examined in the OIG reports maintain far more contracts with private practitioners than three to five. We would hope the VA revises this guidance in the future to more accurately reflect the needs of veteran amputees.

Support for H.R. 805, the Injured and Amputee Veterans Bill of Rights: H.R. 805, the Injured and Amputee Veterans Bill of Rights, has been introduced in the past three Congresses by Ranking Member Bob Filner. In fact, this bill—its predecessor, H.R. 5730—passed the House in December 2012 but the Senate did not have time to act before the 111th Congress adjourned. This legislation proposes the establishment and posting of a "Bill of Rights" for recipients of VA healthcare who require O&P services. This Bill of Rights will help ensure that all veterans across our country have consistent access to the highest quality of care, timely service, and the most effective and technologically advanced treatments available, all in concert with the enhanced internal capacity of the VA in the prosthetic field. NAAOP believes that adoption of this "Bill of Rights" will establish a consistent set of standards that will form the basis of expectations of all veterans who have incurred an amputation or injury requiring orthotic or prosthetic care.

The bill proposes a straightforward mechanism for "enforcement" of this "Bill of Rights," with an explicit requirement that every O&P clinic and rehabilitation department in every VA facility throughout the country be required to prominently display the list of rights. In addition, the VA's websites would also post this Bill of Rights for the interest of injured and amputee veterans. In this manner, veterans across the country would be able to read and understand what they can expect from the VA healthcare system in terms of their orthotic and prosthetic care. And if a veteran is not having their orthotic or prosthetic needs met, they will be able to avail themselves of their rights and become their own best advocate. But above all, no veteran will be in the position of resigning him or herself to the fact that they are not functioning well with their O&P care for lack of information about their rights.

This bill would simply condense to writing the O&P rules and procedures that the VA has used for years. An analysis of Congressional testimony delivered in 2008 by the Chief of the VA Prosthetic and Sensory Aids Service before the House Small Business Committee confirms that none of the rights listed in H.R. 805 (and its predecessor, H.R. 5730) would expand the rights the VA has granted veterans for years, including in the area of practitioner choice and choice of prosthetic technology.[2] But the bill would, in fact, put these rights in writing and post them for veterans to see, understand, and employ to help ensure they receive the quality O&P care they need and deserve. This bill would also provide Congress with easy access to the level of compliance with this "Bill of Rights" across the country and could identify particular regions of the country where problems persist.

I understand the Congressional Budget Office gave the bill a nominal "score" in terms of what this would cost the VA. This is because none of the rights in the bill expand the rules and procedures the VA has acknowledged it uses for veterans in need of O&P care. Thirty-five veterans' organizations, rehabilitation associations, and consumer and disability groups support passage of H.R. 805. While passage of H.R. 805 will not solve all the problems and shortcomings with the current VA prosthetics program, I believe it will have a material effect on the ability of the VA to deliver consistent, state of the art care to all veterans with amputations.

NAAOP and a number of national O&P associations recently met with senior VA officials in charge of the Prosthetic and Sensory Aids Service. While the VA does not appear to support passage of the legislation, they do appear to recognize the problems that I have personally experienced as representative of some veterans' experiences with the VA limb prosthetics program. We have agreed to continue discussions to see if there are ways to address issues raised by H.R. 805. But passage of legislation would establish, in law, a baseline of expectations for injured and amputee veterans that would not subject the contents of the "Bill of Rights" to the discretion of future VA administrations.

Conclusion: On behalf of NAAOP, I want to thank you, Madam Chairwoman, and this Subcommittee for examining this critical issue. The OIG's Healthcare Inspection Report provides valuable information on this subpopulation of veterans that will guide advancements in O&P care in the future. On the other hand, NAAOP questions significant aspects of the data presented in the Audit of the Management and Acquisition of Prosthetic Limbs Report. My organization, NAAOP, and I hope to continue working with this Subcommittee and the VA to help ensure that veterans with amputations and other injuries receive the highest quality orthotic and prosthetic benefit possible. Finally, we call on this Subcommittee to seriously consider passage of H.R. 805, the Injured and Amputee Veterans Bill of Rights, in subsequent legislative hearings as soon as possible, and to ultimately enact this legislation this year.

I thank you for this opportunity to testify before the Subcommittee and welcome your questions.

Prepared Statement of Jim Mayer

Chairwoman Buerkle, Ranking Member Michaud, thank you for the opportunity to appear before you and the Subcommittee concerning the capabilities of the Department of Veterans Affairs (VA) to deliver state-of-the-art care to veterans with amputations. I commend your Subcommittee for its continued work to ensure that veterans receive the best possible VA health care.

I am a combat disabled, former US Army infantryman, Vietnam veteran and a bilateral below the knee amputee for over 43 years. I am a retired VA employee with 27 years of service and 12 additional years of experience working for veterans service organizations. I have received prosthetic care from VA, Walter Reed Army Medical Center (WRAMC) and the Walter Reed National Military Medical Center (WRNMMC).

I also have been an amputee peer visitor and mentor for over 21 years primarily at WRAMC but also at the National Naval Medical Center and now at WRNNMC. I have made thousands of visits with wounded warriors and have witnessed firsthand the catastrophic injuries they and their families overcome through quality and comprehensive military health care and rehabilitation. I am a certified trainer for

[2] Congressional Testimony of Frederick Downs, House Small Business Committee, Subcommittee on Contracting and Technology, Hearing on Ensuring Continuity of Care for Veteran Amputees; The Role of Small Prosthetic Practices, Serial No. 110–105 (July 16, 2008).

the Amputee Coalition for the Peer Amputee Visitor and the Wounded Warrior Project Peer Mentor programs.

I would summarize my observations about VA's prosthetics and its Amputation System of Care by noting that while I understand VA has recently initiated internal efforts to design improvements—it's clear to me that America's military prosthetic care for warriors with amputations has far surpassed VA's previous long standing leadership position. In my opinion, VA is going to have to work hard and creatively to regain that leadership.

Now is an opportune time for a full scale program evaluation and development of a new short and long term strategic plan for VA Prosthetics & Sensory Aids Service (PSAS) and the Amputation System of Care. VA's Amputation System of Care includes—the Regional Amputation Centers (RAC), Polytrauma Amputation Network Sites (PANS), Amputation Care Teams (ACT), and the Amputation Points of Contact (APOC).

The VA Prosthetics program has been under acting leadership for about 9 months after the retirement of its leader of some 30 years. I understand that the Veterans Health Administration (VHA) is working on a prosthetics reorganization that will include VA acquisition staff taking over the purchasing of prosthetic items over $3,000. From what I have heard of the VA supply function taking over prosthetics purchases – I am very concerned by this change and how it will impact veterans. Prosthetics are a truly individualized extension of one person's body and mobility, not your typical bulk supply purchases. I don't believe VA supply staff has the expertise in prosthetics to pull this transfer through without introducing major obstacles for veterans with amputations. Taking prosthetic purchase warranting authority out of PSAS to VA acquisition could dramatically increase complaints from veterans. I also understand VHA is poised to relax its long standing "centralized funding" rules which prohibit VA medical facility managers from diverting prosthetics monies for other uses – a major problem which was originally corrected by "centralized funding" in VHA years ago and has since served veterans with amputations well.

I recommend that this Committee ask VA to freeze its pending reorganization until a full scale program evaluation and new strategic plan can be achieved. I suggest that this effort include representation to include—

- Veterans with amputations from various eras, particularly those wounded in Afghanistan or Iraq who received prosthetic care from VA and a DOD center of excellence
- VA's Prosthetics & Sensory Aids Advisory Committee
- VA, military and private industry clinicians with stellar amputation and prosthetics experience
- Prosthetists/Orthotists
- Therapists experienced with amputee rehabilitation
- Private sector prosthetics and orthotics manufacturers
- Veterans service organizations

It's my sincere belief that majority of the program staff of VA's PSAS and the Amputation System of Care are dedicated professionals. Given my previous experience as a VA staffer and as a member of a past blue ribbon task force on VA prosthetics development and management, I would recommend that this evaluation and strategic plan include VHA participation but operational control of the effort be centralized to the Secretary of Veterans Affairs. I believe Secretary Shinseki has shown in the past a propensity for deciding to do what's right for veterans.

From my perspective, certain events of past years epitomize a culture of reluctance on these issues within the senior management ranks of the VHA which appears to me from these past 9 months to be alive and well.

On February 2, 2004, then Secretary Principi told the House Committee on Veterans Affairs—

> . . . I will tell you that one area that I really think that the VA needs to spend more of its resources, and I think the current war highlights it, is building a center of excellence in amputee research and rehabilitation. Again, I go back to our core mission, to care for people who have been wounded and disabled in combat or in training . . . And we need to do everything in our power to develop the most modern prostheses available for them and to have a rehabilitation program that's second to none in this country. And I think we've lost the edge ... We're not doing enough . . . [1]

[1] Source: *http://democrats.veterans.house.gov/hearings/schedule108/feb04/2–4-04/2–4f-04.pdf*

Secretary Principi's words of 8 years ago would accurately apply to VA if said again today. The day before Secretary Principi's testimony he had tasked VHA with implementing the VA Amputee Center of Excellence. I attended that meeting. Four months later VA's PSAS had identified 14 potential Prosthetics and Orthotics Labs as potentially eligible for upgrade to Amputee Center of Excellence status and indicated a Request for Proposals was imminent. VHA's work then slowed down in the preparatory stages.

In 2006, in light of no definitive VA progress, S. 2736 was introduced to create five such VA centers. The then Deputy Under Secretary for Health, one VHA leader originally tasked by Secretary Principi in 2004 to implement such a center, testified before the Senate Committee on Veterans Affairs on May 11, 2006 opposing that legislation. [2]

Since that 2006 VA opposition, military medicine has filled the void. DoD has opened two state-of-the-art, multi-million dollar amputee centers of excellence at WRAMC (and recreated anew at WRNMMC) and the Center for Intrepid at Brooke Army Medical Center. The Navy also established the C5 (Comprehensive Combat and Complex Casualty Care) at the National Medical Center San Diego. I have received care from the DC based military centers and have visited both the CFI and the Navy's C5. To me, VA's efforts pale in comparison. It's like day and night, with VA being the night.

Those comprehensive military facilities are primarily for active duty wounded warriors and offer limited access to warriors discharged from the military. According to staff from whom I receive prosthetic care, the real enabler for these military programs and staffing is known as "GWOT Funding" within DoD. My concern is how long will DoD have the funding available to continue these centers? Even if continued at today's levels for the foreseeable future – these fine military centers do not serve a large number of those no longer in military service.

When today's warriors are referred to VA and seek the newer, cutting-edge, technologically superior prosthetics they have been accustomed to—will VA be able to meet that demand? DoD centers of excellence provide state of the art and often newly evaluative prosthetics that have allowed the warriors to thrive incredibly, not just in the walking ability—but also run competitively, compete in the Paralympics, rock climb, play a myriad of sports and other athletic endeavors. Most warriors receive multiple, special purpose prosthetics prior to discharge. VA must develop the clinical expertise necessary to continue that level of clinical care and must have administrative processes in place to ensure warriors receive prosthetics in a timely manner – including increasing the number of prosthetic devices VA currently allows an individual veteran.

Quality and speed are not the only superior aspects of DoD provision of prosthetics – it's the holistic merging of excellent clinical, physical and occupational therapy, adaptive sports and recreation events and alternative medicine strategies that produces such excellent results. The key question is—can VA Amputations System of Care meet the needs and expectations of this new generation of warriors and yet maintain its prevalent focus on care for the thousands of amputations performed annually by VA which are usually involve more senior age veterans with post-vascular complications?

Please accept my compliments to you for holding this hearing and for your continued leadership in ensuring state-of-the-art care in VA for veterans with amputations. I would be pleased to answer any questions or provide any additional information you may require.

Prepared Statement of Michael Oros

Good morning Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee. Thank you for the opportunity to provide testimony today. The American Orthotic and Prosthetic Association (AOPA) is grateful for your work to ensure that Veterans with limb loss receive state of the art prosthetic care. We applaud you for convening this hearing, Madam Chairwoman, and deeply appreciate the invitation to shed some light on current issues facing the fields of prosthetics and orthotics when it comes to quality care for our Veterans.

My name is Michael Oros, and I am a member of the AOPA Board of Directors. The American Orthotic & Prosthetic Association (AOPA), founded in 1917, is the country's largest national orthotic and prosthetic trade association. Our membership draws from all segments of the field of artificial limbs and customized bracing for

[2] Source: *https://www.va.gov/OCA/testimony/svac/060511MK.asp*

the benefit of patients who have experienced limb loss, or limb impairment resulting from a chronic disease or health condition. AOPA members include patient care facilities, manufacturers and distributors of prostheses (artificial limbs), orthoses (orthopedic braces such as those used by TBI and stroke patients) and related products, and educational and research institutions.

In my day job, I am a licensed prosthetist and President of Scheck and Siress, Inc., a leading provider of O&P services based in Illinois. Like many other community-based providers, Scheck and Siress is committed to serving Veterans, and does so through contracts with the VA. Scheck and Siress is also proud to employ Melissa Stockwell, the first American service woman to lose a limb in Iraq. After sustaining the injury that resulted in her limb loss, Ms. Stockwell went on to become a Paralympic athlete, and had the honor of carrying the American flag at the closing ceremonies of the Paralympic Games in Beijing. Melissa is now a certified prosthetist, and a member of the staff at Scheck and Siress.

It seems to me that, before we can have a conversation about the quality of prosthetic and orthotic care provided to our Veterans, we need to agree on what "quality" prosthetic and orthotic care is. I'm not certain that I've ever seen an official VA definition of "quality" care, so at the risk of being pushy, I'd like to suggest my own for the purposes of our discussion today. For me, as a practicing clinician who has been taking care of Veterans with limb loss for 26 years, four major elements comprise quality prosthetic care:

1) Access. Veterans must be able to receive care on a timely basis, without waiting for weeks or having to travel hundreds of miles for their prostheses to be checked, adjusted, repaired or replaced.

2) Trust. Veterans must know about and be able to exercise their right to receive care from a provider they trust, who listens to them and works with them to achieve the most functional prosthesis possible. Fitting a good prosthesis is as much art as it is science, and a positive, ongoing working relationship between the Veteran and the prosthetist is an important element of getting it right.

3) Expertise and experience. Clinicians serving Veterans must have the training and clinical know-how to select, custom-build, fit and adjust the best possible prosthetic device to address the complex challenges Veterans with limb loss face every day.

4) Outcomes. The result of high quality prosthetic care is greater comfort, higher activity levels, more independence and greater restoration of function for Veterans with limb loss, so that they can live their everyday lives successfully and continue to do the things they want to do despite the absence of one or more limbs.

Overall, the quality of prosthetic and orthotic care for Veterans has never been better. New technology has restored previously unachievable levels of function for servicemembers returning from Iraq and Afghanistan with Traumatic Brain Injury or having lost limbs. However, in my experience, there is really two types of prosthetic care being provided to our nations' Veterans. Some Veterans are very well informed, technology-savvy, very aggressive and successful advocates for themselves and their care. These are the Veterans that we are most likely to see at a practice like Scheck and Siress, and for them, the Veterans' Administration creates relatively few administrative and other barriers to care.

However, there is also another group of Veterans, typically older, typically non-service connected new amputees. These Veterans are less likely to advocate aggressively for their own care. It is difficult for me to say whether they are aware of their right to see a prosthetist of their own choice, but they are certainly less likely to request an appointment at a practice like Scheck and Siress. Veterans in this category who have been patients with Scheck and Siress for some time have begun to complain to us about new administrative hurdles to care. We are hearing more about administrative pushback, increased paperwork, and new requirements to be seen at a VA clinic prior to approval to receive care from Scheck and Siress.

So several barriers persist that stand in the way of providing even higher quality O&P care to Veterans, Veterans who are returning from overseas and Veterans of other conflicts who may be losing limbs to diabetes and cardiovascular disease. Each of these barriers is directly related to the elements of quality care I outlined at the beginning of my testimony. All of these barriers can be eliminated, if they receive enough intentional focus by this Committee and by the Veterans' Administration. If I may be so bold, I would like to outline a concise, achievable agenda for this Committee to promote quality prosthetic care for Veterans. It has three elements:

1) Guarantee Veterans meaningful access to trusted clinicians.

2) Elevate clinician expertise and experience.
3) Move towards evidence-based practice to achieve optimum outcomes

I will briefly discuss the elements of these recommendations now, and would ask that my written testimony, which contains a more detailed overview of these issues, be included in the record.

1) Guarantee Veterans Meaningful Access to Trusted Clinicians.

As you are aware, between 10 and 20 percent of O&P care provided to Veterans nationally is delivered by direct employees of the Veterans' Administration. 80 to 90 percent of Veteran O&P care is provided by community-based providers, often small businesses, that contract with the VA. This system of contracting with a large network of community-based providers helps to ensure that all Veterans, regardless of geographic location, have access to quality O&P care without having to travel hundreds of miles to reach a VA facility. In some regions of the country, such as New York City, the majority of Veteran O&P care is provided by VA employees. In other cases, such as Chicago, even Veterans who live close by a large VA Medical Center prefer to receive their care from independent providers such as those at Scheck and Siress.

Unfortunately, despite their legal right to choose an O&P provider, in many cases Veterans are under significant pressure to receive their O&P care from VA centers rather than community-based providers. Veterans frequently are unaware that they have the right to receive O&P care from their preferred provider, be it VA or community-based. AOPA strongly supports the right of all veterans to receive O&P services from the provider who they feel best meets their needs. It is imperative that those who have served and sacrificed for our country be aware of their rights, especially on an issue as personal and important as orthotic and prosthetic care. AOPA has supported Ranking Member Filner's legislation to require the VA and its facilities to take proactive steps to educate Veterans about their right to choose the O&P provider who best fits their needs. However, it is regrettable that this legislation has been made necessary; this is a problem the VA could and should solve administratively.

AOPA believes that the vast majority of community-based providers working under contract with the VA provide high quality care to Veterans at highly competitive rates – rates, in fact, that represent an average discount of 10% below the published Medicare fee schedule. This has been challenged recently by a VA Inspector General's audit that we are concerned may have been poorly researched and is, if not completely inaccurate, at least extremely misleading. AOPA is disturbed by allegations put forth in the IG's Audit of the Management and Acquisition of Prosthetic Limbs issued on March 9, 2012, claiming that the average cost of a prosthetic limb fabricated by the VA in house is $2,900, while the average cost of a limb fabricated by a third party contractor was $12,000. We have been unable to determine precisely which costs were taken into account by the IG when making these calculations, and we are disappointed that this analysis was not challenged by the VA Prosthetics and Sensory Aids staff before the report was published. Nevertheless, this is not an apples to apples comparison, and it offers you and the VA leadership no useful information. It is not unusual for Veterans with extremely complicated devices to choose community-based providers rather than VA staff, which would skew the cost of devices provided in-house downwards. Further, the costs quoted for the VA-fabricated limbs almost certainly only take into account only the cost of components, without accounting for VA staff salaries, benefits, facilities costs, administration and taxes. We believe that, with few exceptions, a complete and accurate cost comparison would show that community-based O&P contractors provide excellent value to Veterans and taxpayers.

2) Elevate Clinician Expertise and Experience.

There is another challenge looming that will affect the quality of care for Veterans across the entire O&P field, at VAMCs and independent providers alike. Over the past decade, the practice of orthotics and prosthetics has grown increasingly complex. This is true both in terms of the types of medical challenges presented by Veterans, as well as the technologies used to treat these problems.

Whether they treat young Veterans returning home from the wars in Iraq and Afghanistan who have lost limbs on active duty, or older Veterans who have had limbs amputated as a result of other health problems like diabetes and cardiovascular disease, O&P clinicians are faced with more and more complicated issues in caring for our Veterans, active duty servicemembers, and the civilian population with limb loss. For example, most traumatic amputations from the current conflicts in Iraq and Afghanistan are suffered the result of IEDs, causing additional com-

plications never before seen. The concussive force of the blasts can result in microfracturing in the otherwise undamaged portion of the limb. These fractures lead to the formation over time of bone spurs, which greatly complicate the fitting and use of a prosthesis. On the other end of the spectrum, increasing numbers of aging Veterans undergo amputations due to diabetes, cardiovascular disease, and other health conditions. As Veterans age, their skin becomes more fragile and their circulation deteriorates. This can cause significant challenges in attaching a prosthesis to the residual limb and greater issues in avoiding skin breakdown, ulcers, and infection.

In recognition of the increasing complexity of O&P care, the field recently changed the entry-level credential for orthotists and prosthetists to a master's degree. Clinicians simply need more time in academic, as well as clinical, settings to emerge prepared to provide high quality orthotic and prosthetic care to Veterans, and the limb loss population at large.

As we sit here today, there are only six institutions of higher learning in the United States that are accredited and enrolling students in master's degree programs in O&P. Several received federal support in the form of Congressional earmarks to garner the start-up funding required to get their programs off the ground. Graduating classes are very small – in many cases, well under a dozen students. There are an additional six programs at various stages of accreditation that hope to start offering O&P master's degrees in the coming years. This is an insufficient number of programs to meet the growing demand for highly skilled orthotics and prosthetics professionals and offer Veterans the highly technical, high quality care they deserve. The existing programs simply cannot graduate enough students to meet the need.

If we are to provide the best possible prosthetic and orthotic care to our Veterans—and to the rest of the country – we must quickly and significantly increase the number of accredited master's degree programs in O&P, as well as expand existing graduate programs. The VA has funding sources s that help to support education for doctors and nurses. The DoD and HHS support graduate medical education in various ways, (mostly through grants of financial resources to students to attend graduate programs, rather than to institutions to create them). But there is currently no legislation that authorizes any federal agency to support the creation or expansion of accredited graduate education programs in prosthetics and orthotics.

Part of the VA's mission is to support high quality medical education for clinicians who will work in various parts of the health system—VA and non-VA facilities—caring for Veterans and the broader population. The advanced education of the next generation of prosthetists and orthotists is critical to restoring the maximum possible function for our Veterans, and to doing so in an efficient and cost-effective manner.

AOPA recommends the creation of a small, time-limited competitive grant program that could offer federal grants of up to one million dollars each to approximately fifteen universities to create or expand accredited master's degree programs in prosthetics and orthotics. Only institutions with a demonstrated ability to create or expand accredited programs to grant master's degrees and/or doctoral degrees in prosthetics and orthotics should be eligible to apply, and one-time grants should be made available to universities that have not previously received competitive awards through this funding source. We recommend that these grants should support curriculum development; accreditation costs; purchase of needed training equipment; development, recruitment and retention of qualified faculty members; and limited expansion or renovation of space to house programs. Use of these grants to support major construction should be prohibited.

As part of the condition of receiving such a VA grant to expand advanced O&P training, O&P programs should be required to work with VA Medical Centers and/or private O&P practices that serve significant numbers of Veterans. One of the reasons the field has moved to the master's degree requirement is to make sure that O&P professionals have more clinical experience when they secure their credential. By caring for Veterans as part of their clinical training, the next generation of highly qualified prosthetists will be more familiar with the needs of Veterans with limb loss and better able to meet their needs.

We are grateful to Chairwoman Buerkle for your examination of this issue, and look forward to continuing to work with you to create a small, time-limited competitive grant program to enable colleges and universities to create or expand accredited master's programs in O&P.

3) Move Towards Evidence-Based Practice to Achieve Optimum Outcomes

While AOPA is firm in our belief that the vast majority of private sector clinicians are providing care to Veterans that is as good or better than that they could receive

at the VA, we also believe that it is important to hold O&P professionals accountable for the quality of care and the cost of that care. This poses something of a challenge for the VA, due to the fact that there is currently no body of objective, comparative outcomes research to support evidence-based practice in O&P. Currently, the only mechanism available to evaluate the quality of prosthetic and orthotic services offered by any provider – inside or outside the VA – is the patient satisfaction survey. While community-based providers typically score very highly on such surveys, we know that more could and should be done to evaluate O&P outcomes for Veterans.

This leads me to my final point. Unlike other health professions, there is no body of comparative outcomes research to guide O&P professionals. Their judgments about which prosthetic device, service or support is most appropriate for which patient is based largely on personal experience and expertise developed over years in the field. However, there is almost no objective research on outcomes to validate or inform that experience.

In this regard, O&P is stuck where many other health care professions were twenty years ago. Twenty years ago, if you had a back problem, there was no outcomes based research to guide your primary care doctor in advising you on what kind of care to seek out. If she sent you to physical therapy, the PT would tell you the best way to treat your back was PT. If she sent you to a back surgeon, the surgeon would tell you that you could only be cured with surgery. There was no objective research to suggest who was right, and under which circumstances.

Today, if you went to the doctor with severe back pain, your doctor would have the benefit of extensive research that compares the outcomes of physical therapy and surgery in different circumstances, and informs your caregivers' recommendations. Now that doctors and patients have an objective picture of what treatment works best for which patients, today more patients with back pain have better outcomes, obtained more cost-effectively.

That's what we want for Veterans who need prosthetic and orthotic care. Our field has important, unanswered questions with significant cost implications for DoD, the VA,

Medicare and health care more generally. Significant research questions remain, including:

- What interventions can prevent amputation or subsequent surgeries?
- At what point in the in the course of patient treatment is orthotic and prosthetic intervention most effective?
- Which patients benefit most from which technologies?
- What O&P practices facilitate successful aging, and how does the aging process affect the use of prosthetics, including increased skin breakdown, loss of balance, falls and other issues, such as promoting return to work?
- What conclusions could longitudinal data relating to amputees and their treatment provide that would improve quality and cost effectiveness of their care?
- What is the optimal timing of O&P intervention to prevent lost of activity, mobility and ability to work and carry out activities of daily living?

Such elements of a coherent O&P research agenda are vitally important

to ensuring that Veterans receive appropriate, necessary care as well as to eliminating unnecessary future health care costs. These and other key questions being asked by the field remain unanswered. An outcomes-based research portfolio, and the resulting body of evidence, in the field of O&P would increase the quality of care for Veterans and others with limb loss while protecting taxpayers by ensuring that patients receive the most appropriate care, and that quality and cost effectiveness objectives are attained in a data-driven manner that generates the best possible outcomes, from the beginning.

AOPA applauds the VA for working toward this end by joining with the Department of Defense in March of 2010 to hold the joint State of the Art Conference on Orthotics and Prosthetics. This conference generated much discussion related to the creation and execution of an outcomes-based research portfolio in the field of O&P. While the discussion was encouraging, we have been disappointed to see that no progress toward the implementation of the recommendations has been made. No report on the conference has ever been made publicly available, and so far as we can tell, no steps have been taken by the VA or DoD to implement any of the conference recommendations.

Despite the government-wide focus on health care outcomes, there is currently no federal research agenda on prosthetic and orthotic outcomes. Not at the VA. Not at the DoD. Not at the NIH, the CDC, or NIDRR. AOPA strongly encourages the VA, DoD and NIH to help improve the care for Veterans, servicemembers, and seniors by implementing a robust comparative outcomes research agenda that addresses the

questions in the field and helps to inform effective, efficient delivery of O&P care. We believe this will also yield dividends in assuring that the major technological advances precipitated by research commitments from VA and DoD for Veterans and active duty military are actually pulled through to have a practical impact on care provided to our nation's seniors and other members of the general public..

Madam Chairwoman, Members of the Committee, thank you very much for the invitation to testify, and for your commitment to providing the highest quality prosthetic and orthotic care to our nation's Veterans. I look forward to answering any questions that you might have.

Prepared Statement of Joy J. Ilem

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 mores 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 docu-

menting 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 multipart 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 ac-

tivities 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.

Prepared Statement of Capt. Jonathan Pruden, U.S. Army, Retired, Wounded Warrior Project

Chairman Buerkle, Ranking Member Michaud, and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project to share its perspective on issues facing our amputees.

My name is Jonathan Pruden and in 2003 while serving as an Army Infantry Captain I became one of the first IED casualties of Operation Iraqi Freedom and subsequently underwent 20 operations at 7 different hospitals including amputation of my right leg. I was medically retired from the Army and found a new mission working with my fellow wounded warriors. In my role as an Alumni Manager for the Wounded Warrior Project (WWP) I've had the honor of personally interacting with thousands of warriors over the past six years, often working hand in hand with VA and DoD to ensure our warriors and their families receive the care they deserve.

Over the past decade DoD and VA have made significant strides in prosthetic care, particularly in comparison to the Vietnam war era when some 6000 veterans with amputations returned to a woefully unprepared system.[1] Today, improvements in protective gear, rapid medical evacuation, and innovations in military trauma medicine help account for a nearly 90 percent survival rate among those injured in Iraq and Afghanistan, compared to a 75 percent survival rate among those injured in Vietnam.[2, 3] While the survival rate has increased, many warriors are returning

[1] Sigford BJ, "Paradigm Shift for VA Amputation Care," *J Rehabil Res Dev;* 47(4): (2010) xv-xx.

[2] Dougherty PJ, "Wartime Amputations," Mil Med, 1993 158(12): 755–63.

[3] Peake JB, "Beyond the Purple Heart – Continuity of Care for the Wounded in Iraq," *N Engl J Med;* 352(3): (2005) 219–22.

home with injuries, including major limb loss, which require extensive rehabilitation and present long term care needs. As of March, 1,288 servicemembers experienced major limb loss as a result of combat in OEF/OIF/OND; of that number, 359 lost more than one limb.[4] Just this past month, WRNNMC has seen the arrival of two quadruple amputees. The long road to recovery and rehabilitation has both physical and psychological dimensions and for those warriors who have suffered an amputation, excellent prosthetic care is critical to ensuring the opportunity for an active, fulfilling life.

Short term Challenge:

Just as our warriors are adapting to wrenching, life-changing injuries, the health care system whose mission is to care for and rehabilitate them—the VA—is moving to institute changes that, in our view, will set back prosthetic care rather than advance it.

It is disappointing that we have come to this point given the long, proud history of steady leadership within VA's prosthetics program and Congress' strong support for that program. Congress has long recognized that VA's prosthetics program is critical to meeting the specialized rehabilitative needs of disabled veterans. This Committee, in particular, has played a key role in sustaining that vital mission. For example, a proposed Veterans Health Administration (VHA) reorganization in 1995 led this subcommittee, and ultimately Congress, to enact legislation directing the Secretary "to maintain [VA's] capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with amputations) in a manner that affords those veterans reasonable access to care and services for those specialized needs.[5] Congress further directed the Secretary to carry out that requirement in consultation with the Advisory Committee on Prosthetics and Special Disabilities.[6] Congress certainly recognized that prosthetics is not just another service, but a fundamental component of VA health care.

While there are areas of VA prosthetics service that need improvement, as we will discuss, WWP is deeply concerned about proposed changes in VA prosthetics' procurement that could reverse decades of progress, and substantively erode both the quality of care and quality of life of our nation's most severely wounded. As discussed below, planned changes to VA's prosthetic acquisition and procurement policies may greatly impair clinician's ability to provide the most appropriate prosthetics and at the same time create substantial delays in a system that is already too slow for the amputee who is unable to walk while waiting for a new "leg".

Under current practice, VA physicians and prosthetists are able to see a veteran, make a determination regarding the most appropriate type of prosthetic equipment for a veteran, and relay that information to a Prosthetics Service purchasing officer to complete a purchase-order to obtain the needed item. Those purchasing officers exclusively handle prosthetics' purchases, and are specialists in ordering medical equipment specified by health care providers. A major change that the Veterans Health Administration intends to institute on July 30th, would require that any prosthetic item whose cost exceeds $3000—to include such essential items as limbs, wheelchairs and limb-repair components – must be procured by a contracting officer. This is not simply a matter of substituting a generalist for a specialist. Under the proposed change, these contracting officers would use a labor-intensive system (the Electronic Contract Management System (eCMS)) designed to achieve cost savings. That system, designed for high-dollar bulk-procurement purchases that benefit from using the Government's purchasing power, requires over 300 individual steps to manually process a purchasing order. While well-suited for buying widgets, the system was neither designed for nor well-suited to procuring highly specific, individualized medical equipment. Ill-suited to prosthetics, this new process would also require increased coordination between clinicians and off-site contracting officers who would be responsible for purchasing everything from light bulbs to now highly specific prosthetic legs.

This is not a small change. Moreover, it not only increases the margin for error but also the potential for prolonged, delaying "back-and-forth," with the likelihood of clinicians having to justify why a more expensive wheelchair is clinically necessary when a seemingly-similar less- costly model exists. We see no prospect that this planned change in prosthetics procurement holds any promise for improving

[4] VA Office of Inspector General. "Health Care Inspection: Prosthetic Limb Care in VA Facilities" Report No. 11–02138–116, 8 March 2012. Accessed at: *http://www.va.gov/oig/pubs/VAOIG-11-02138-116.pdf*

[5] 38 U.S.C. sec. 1706(b)(1).

[6] *Ibid.*

service to the warrior. Instead, it almost certainly threatens greater delay in VA's ability to provide severely wounded warriors needed prosthetic devices.

WWP is aware of concerns raised in a recent IG report that called for separating the duties of Prosthetic Purchasing Agents (PPAs) to ensure that each prosthetics' order is reviewed and that VA receives the greatest possible discount on prosthetics.[7] The IG recommended strengthening controls for the review process and issuing improved guidance to Certified Prosthetists. But VHA's response was vastly disproportionate to the IG's modest recommendation. Rather than simply concur with IG's recommendation, VHA cited its plan to remove purchasing authority for items over $3,000 from PPAs altogether. WWP believes VA's plan goes many steps too far. While we agree that VA must be a smart buyer, its overriding responsibility is to the veteran and to its service mission – and its plan appears to compromise both those responsibilities.

Instead, its planned change in processing procurements will, at a minimum, inject greater delay – lengthening the time between when the clinician and prosthetist see and evaluate a veteran for a new device and when he actually receives it. Even more problematic, the change heightens the risk that a fiscal judgment will override a clinical one – that is, the risk that a contracting officer's judgment will override the clinical judgment of clinicians and prosthetists who are attempting to provide flexible, timely, and appropriate care for our veteran amputees.

In conversations with several highly placed current and former VA officials in this arena about the decision to use federal acquisition agents, all expressed concerns about creating additional delays for purchase orders and decreasing discretion to do the "right thing" for our amputees. These potential additional delays are especially troubling because VA outsources the vast majority of prosthetic fabrication. VA currently contracts with over 600 independent labs, accounting for about 97% of the limbs provided to veterans.[8] Currently, most contract prosthetic labs will start fabrication on a limb before a VA purchase order is received to ensure the veteran receives the prosthetic as soon as possible. However, as a former VISN Prosthetics Director warned, chronic "delays in providing purchase orders and subsequent payments will mean that many contracted prosthetists will not make a limb if they do not have a purchase order in hand."

This plan may hold potential for modest savings, but at what cost? When a warrior needs a new leg or wheelchair, they have to wait. Every day they wait their lives are tangibly impaired. I personally know warriors who stay home from our events, stay home from school and from work, don't play ball with their kids, or live in chronic pain while they wait for a new prosthesis. I have personal experience waiting for prosthetics and know firsthand what it is like to live in pain while waiting for a new limb and the frustration I felt when my daughter asked my wife, "Why can't daddy come on a walk with us?"

Wounded warriors need this Committee's help to ensure that they are not forced to put their lives on hold any longer while federal acquisition personnel process purchase orders. While we acknowledge that prosthetic procurement in its current form is imperfect, VA's prosthetics' procurement plan seems to take a meat cleaver to a situation best addressed with a scalpel. Prosthetics are not light bulbs or hammers. They are specialized medical equipment that should be prescribed by a clinician and promptly delivered to the veteran. Congress has long recognized the unique importance of prosthetics by exempting them from burdensome federal purchasing requirements.[9]

Given these concerns, *we urge this Committee to direct VA to suspend implementation of this major change in prosthetics procurement.* A change of this magnitude in a critical area of service-delivery to wounded warriors – and particularly one that offers no promise of any service-improvement—should not even be considered in the absence of a detailed implementation plan. Minimally, such a plan should include both (1) credible evidence that veterans would not encounter greater resultant delay in receiving needed prosthetics and (2) meaningful safeguards to protect clinical discretion. Should VHA wish to go forward with this process, we urge the Committee to require it to develop such a plan and to defer implementation until the Veterans

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[7] VA Office of Inspector General. "Veterans' Health Administration: Audit of the Management and Acquisition of Prosthetic Limbs." Report No. 11–02254–102, 8 March 2012. Accessed at: *http://www.va.gov/oig/pubs/VAOIG-11-02254-102.pdf*

[8] *Ibid.*

[9] "The Secretary may procure prosthetic appliances and necessary services required in the fitting, supplying, and training and use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as the Secretary may determine to be proper, without regard to any provision of law." 38 USC sec. 8123. Given this specific authority, there is no obvious rationale for changing current prosthetics-service procurement practice.

Affairs Committees have had sufficient time to review it thoroughly (we would recommend a period of not less than 90 days).

Long term Challenges

While the proposed change in prosthetics procurement constitutes a matter of immediate, acute concern, we see longer-term challenges as well. War zone injuries that result in amputations are often complex and can prove difficult for later prosthetic fitting because of length, scarring, and additional related injuries such as burns.[10] To its credit, VA has instituted an amputation system of care and initiated the development of amputee centers of excellence which can become important components of needed change. But WWP's experience is that much more progress is needed to realize the underlying vision. We are pleased to hear that approval was recently given for the creation of a VA Amputation System of Care registry/ repository. But we remain concerned that VA prosthetics research – among VA's strengths in the past and so important to serving wounded warriors tomorrow – has lagged, even as the numbers of new veteran-amputees climb steadily. In that regard, I had the honor of serving on a 27-member expert panel that is to date the most comprehensive review of the status of prosthetics-device issues facing wounded warriors, but that study is now three years old and many of those recommendations have yet to be implemented. VA must re-establish itself as a leader in prosthetic research and commit to implementing the finds of such research so that veterans can realize its benefits.

Looking ahead, it is important to recognize that the Department of Defense has far surpassed VA in providing state of the art rehabilitation for this generation of combat injured amputee service members and veterans. With OEF/OIF veterans being seen at VA medical facilities across the country, any one particular medical center may provide prosthetics care to only a few young veterans. The average age of an OEF/OIF warrior at the time of injury leading to an amputation is 25.[11] These veterans are young, computer-literate and inquisitive about technology and the options available. Their active lifestyle frequently requires specialized equipment with which VA staff at some facilities – unable to keep uniform pace with technological advances – often lacks familiarity. Today, some 39% of the OEF/OIF amputee population returns to DoD to receive prosthetic care. While DoD is currently able to shoulder that demand, WWP is concerned that as the current conflicts draw down DoD facilities will ultimately scale back their services and associated funding with the decline in combat injuries. VA must be ready to meet this need; but it's not yet there. There are pockets of excellence within VA's prosthetic system such as the VISN 3 Manhattan prosthetic department, but that level of expertise is not consistently available to veterans across the VA system.

Wounded warriors advise WWP that the paradigm shift in amputee care has yet to become evident at most VA medical centers. In fact, an amputee being seen at a primary care clinic is seldom, if ever, asked how the individual's prosthetic is working, and whether it is causing pain. Prostheses should be prescribed on the basis of careful evaluation, and joint patient-clinician decisionmaking that takes account of best medical evidence and practice.[12] But, as warriors attest, VA clinicians themselves too often base decisions about orthotic and prosthetic equipment on past practice and word of mouth, rather than informed medical judgment, with the result that the choice of equipment may or may not be appropriate.[13] With wide variability in providers' knowledge and expertise with new prosthetic technologies, warriors report significant disparities from facility to facility in the quality of care and the approval of specific durable medical equipment.[14] We are concerned, in that regard, that such disparities may worsen over time, particularly if VA prosthetics service funding is decentralized, as some have discussed.

Centralized funding of prosthetics service has been vital to ensuring that VA can meet wounded warriors' needs. While we are not aware that any change in policy to decentralize prosthetics' funding is imminent, we are not alone in holding deep concerns regarding such a possibility. Candidly, the concern is closely related to a VHA reorganization that occurred last year, which diminished the standing of VA's Prosthetics and Sensory Aids Service relative to sister services—and which, along with the planned change in prosthetics' procurement raises red-flags of concern re-

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[10] *Ibid.*

[11] VA Office of Inspector General. "Health Care Inspection: Prosthetic Limb Care in VA Facilities" Report No. 11–02138–116, 8 March 2012. Accessed at: *http://www.va.gov/oig/pubs/VAOIG-11-02138-116.pdf*

[12] *Ibid.*

[13] Arrendondo, et al., "Wounded Warriors' Perspectives; Helping Others to Heal," *J Rehabil Res Dev,* 47(4): (2010) xxi-xxviii.

[14] *Ibid,* xxvi.

garding the priority in which VA currently holds prosthetics. Centralized funding is a means of insuring that provision of prosthetic and orthotic equipment for wounded warriors continues to be a national priority and that that priority will not be compromised at the VISN level, such that there develop 22 different levels of priority. Centralized funding of prosthetics must be preserved.

As a bottom line, we have a real concern about the direction of this program, which appears to have lost the kind of focused leadership it once enjoyed, and has fallen victim to a bureaucratization that has lost sight of its customer, the veteran.

Recommendations:

Let me re-emphasize the dangers inherent in VHA's proposed changes in procuring prosthetics, and urge this Committee's intervention, as discussed above. At the same time we are mindful that there are steps VA can and should take to improve prosthetics care and service. In that regard, WWP has long urged the need to improve system-wide coordination and consistency, and – in the constructive spirit—offers the Committee the following recommendations toward continued improvement of the prosthetics program:

- Ensure through ongoing oversight that the vision of the Amputee System of Care is realized;
- Press VA to establish a steering committee of experts composed of academicians, clinicians, and researchers to oversee and provide guidance to the Department on the direction and operation of its prosthetics and orthotics program;
- Direct VA to develop guidance to assist clinicians in more appropriately prescribing durable medical equipment (in particular, expanding clinical practice recommendations through the use of algorithms such as are commonly employed in other fields of medical practice);
- Encourage VA to serve warriors more effectively through such means as (1) creating an equipment-loan center or centers through which warriors could borrow and test equipment before final issuance; (2) providing veterans—in addition to any primary assistive device needed for mobility or to perform ADL's—with functional spare equipment; and (3) expanding efforts to develop informative materials for veterans and caregivers on available devices; and
- Urge VA to assign additional VA prosthetics and sensory aids staff at military amputee centers of excellence.

Continued congressional oversight to ensure both preservation of the prosthetics' system strengths and progress in improving the quality of VA's prosthetics and orthotics care (at least in part through VA adoption of the above recommendations) would go a great distance toward improving the lives of those who have lost limbs in our ongoing war, and improving the care of veteran-amputees of all generations. After more than eleven years of war and thousands of combat related amputations, it is essential that VA re-establish itself as a leader in prosthetic research and care and maintain that position as a commitment to our severely wounded.

That concludes my testimony; I would be happy to answer any questions you may have.

Prepared Statement of Alethea Predeoux

Chairwoman Buerkle, Ranking Member Michaud, and members of the Subcommittee, thank you for allowing Paralyzed Veterans of America (PVA) to testify today concerning prosthetic services of the Department of Veterans Affairs (VA). Ensuring that our nation's injured veteran population is able to receive state of the art prosthetic devices in a timely manner is an extremely important issue for PVA. PVA has more than 19,000 members who all utilize the services of PSAS on a regular basis. Our National Service Officers work very closely with VA to ensure timely delivery of quality prosthetic items needed by veterans.

In recent months, the VA Office of Inspector General (OIG) and the OIG's Office of Audits and Evaluations have released numerous reports on PSAS inventory management, the management of PSAS acquisition of prosthetic limbs, and prosthetic limb care. PVA believes that these internal audits and investigations have identified many areas in need of improvement within PSAS, and PVA generally supports the spirit of the recommendations provided by the OIG. The recommendations provide not only an opportunity to improve upon the prosthetic services for veterans with amputations, but for all veterans that utilize VA prosthetic services.

The OIG's evaluations and assessments are taking place during a critical turning point for PSAS. The Veterans Health Administration (VHA) Office of Procurement and Logistics (P&LO) is currently undergoing a structural reorganization.[1] These changes include a joint purchasing structure for prosthetic items that includes both PSAS and P&LO making prosthetic purchases. Specifically, the division of purchases will be based on the cost of items, the "micro-purchase threshold."[2] Essentially, when an item costs a specific amount or higher, it will be purchased by P&LO. While the VA reports that this change will result in increased oversight and review of prosthetic purchase orders, PVA is concerned that this dual purchasing track that involves both PSAS and P&LO has the potential to create delays in the delivery of items to veterans.

PVA is further concerned that this new system will also lead to less VA accountability for veterans during the ordering and delivery processes. When an order for prosthetics is placed, at any point before the item is delivered, veterans, or often times a National Service Officer on behalf of a veteran, is able to contact a PSAS employee with questions regarding the device or the status of delivery. With P&LO now handling prosthetic purchases, it is unclear which office will serve as a point of contact to provide veterans with timely assistance when questions or concerns arise before the prosthetic item is delivered.

To ensure that the newly divided purchasing authority for prosthetics does not lead to increased delays in delivery of items and services, PVA recommends that PSAS leadership use a tracking system to provide veterans, clinicians, and VSOs with timely updates, as well as reasons for delays, when necessary. The VA has developed the *eCMS* planning module to manage prosthetic orders. This system will serve as a single point of entry for P&LO prosthetic purchases. PVA encourages VA to notify veterans and their health care providers electronically through the *eCMS* system to address issues that arise with prosthetic orders such as delays in delivery. PVA also recommends the VA develop guidelines that establish the length of time in which an order should be completed.

PVA has reached out to PSAS leadership on several occasions to identify the status of the reorganization and appreciates the opportunity to provide our input. While we have been informed that the dual purchasing system was piloted in three Veteran Integrated Service Networks (VISNs) beginning in January 2012, and will be further implemented in additional areas in July 2012, we are not aware of how VA intends to make sure that veterans are aware of these changes. Therefore, PVA encourages VA leadership to consult with veterans and their families, as well as stakeholders who regularly work with PSAS to provide input as they further develop the process for prosthetic purchases through P&LO. Many veteran service organizations and veterans have been working with PSAS for many years and could provide valuable input that will help VA ensure that this change does not negatively impact veterans. PVA would also encourage the VA to provide Congress and veteran service organizations with updates and any findings that are compiled as a result of the pilots that were implemented in January 2012, and future findings as the plans move forward.

As it relates to the impact of this procurement reform, dividing the purchasing of prosthetics between PSAS and P&LO, PVA has concerns regarding potential differences between the two departments' internal policies, and how such differences may negatively impact the quality of care and services provided to veterans. The P&LO office is governed by policies of VA acquisition. Such policies are meant to address the purchasing of various items for many different offices within the VA. As such, PVA would like to make certain that the change to P&LO managing the purchases of high cost prosthetics does not lead to the standardization of prosthetics or increased limitations on ordering devices. PVA strongly urges the VA to continue to abide by VA policy that adheres to title 38, United States Code, Section 8123, which states that:

The Secretary may procure the prosthetic appliances and necessary services required in the fitting, supplying, and training and use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as the Secretary may determine to be proper, with regard to any other provision of law.[3]

This statute enables VA to meet the unique prosthetic needs of veterans in a timely manner without the limitations of cost saving measures such as standardiza-

[1] The Department of Veterans Affairs, Office of Inspector General: Office of Audits and Evaluations; "Veterans Health Administration: Audit of the Management and Acquisition of Prosthetic Limbs," March 8, 2012; 11–02254–102; *http://www.va.gov/oig/pubs/VAOIG-11-02254-102.pdf*

[2] *Ibid,* pg. 17

[3] Title 38, United State Code, Section 8123; March 31, 2011.

tion of items or contract bulk purchasing. Veterans must have access to the prosthetics that best fit their individual needs. For many years, PSAS has done a good job of ensuring that the number one consideration when ordering prosthetics is quality—the ability to meet the medical and personal needs of veterans. The VA must make certain that the issuance and delivery of prosthetics continues to be provided based on the unique needs of veterans, and to help them maximize their quality of life. As VA undergoes this procurement reform, and the reorganization of the Veterans Health Administration, leadership must ensure that prosthetics do not become subject to issuance restrictions based solely on cost or internal pressures to control spending.

While PSAS has done a good job of providing veterans with the prosthetics that they need, no health care system is perfect, and gaps continue to exist in VA's delivery of prosthetics. As stated previously, delays in delivery of prosthetics continue to exist. Often these delays are due to inconsistent administration of prosthetic policies between VISNs that ostensibly operate under the same guidance. For instance, when a prescription for a prosthetic device is issued, purchasing agents and administrators in one VISN often use an approval process that may vastly differ from those used in the neighboring VISNs. This becomes particularly problematic when a facility in one VISN places an order for a veteran through its subsidiary facility, in another VISN, and each uses different approval processes. When this occurs, orders go back and forth between networks before they can be authorized, placed, manufactured, and delivered to the veteran.

With established guidelines required for all staff handling prosthetic orders, the back and forth during the approval process would be eliminated. Ultimately, such inconsistencies in the administration of PSAS policies lead to prolonged delivery of prosthetic items to veterans. PSAS must require all VISNs to adopt consistent operational standards in accordance with national prosthetics policies that provide veterans with the best possible customer service.

Delays are also caused by an outdated filing system for veterans' medical records. When veterans travel across the country or relocate, should they need to seek services at a VA medical center for the first time, they often have to wait for medical records to be emailed, mailed, or even faxed. Urgent prosthetic care is delayed because there is no system in place that allows veterans' records to be instantly viewed by more than one medical center when necessary. This gap in care must be addressed to make certain that veterans do not go without their much needed prosthetic items.

Another example of administrative inconsistencies involves the prosthetic purchasing agents and the clinicians that prescribe the prosthetic. PVA has found that it is not uncommon for clinicians to prescribe a prosthetic based on their medical expertise and the medical needs of veterans, however, when the contracting officers receive the order, the request for the device is modified or even denied due cost, or the VA not having an established contract with the manufacturer of the device. PVA understands that in the current fiscal environment the VA must ensure that its employees are making smart and efficient spending decisions. However, PVA believes that smart, efficient decision making includes providing veterans with a quality prosthetic device that meets their needs and provides them with quality of life and independence.

Additionally, the quality of prosthetic devices is extremely important to providing veterans with quality of life. When veterans are issued prosthetics, it is VA policy to ensure that they have an alternative device that is able to be used in the event that the primary prosthetic is not available. The second prosthetic is commonly referred to as the "back-up" device. While the VA issues back-up devices to veterans with prosthetics, often the back-up prosthetic and the primary prosthetic are not of equal quality. This poses significant problems for veterans when their primary prosthetic is undergoing repairs, or simply not available to them.

PSAS should work to provide veterans with quality prosthetic devices as back-up options for veterans. Ordering quality prosthetics for veterans has many benefits. While better quality items may not always be the cheapest option, in the long-run it is cost efficient for the VA. Providing veterans with quality prosthetics leads to longer periods of use and less spending on replacement items, and also prevents potential health hazards that may result from veterans using equipment that is not durable or meant to meet their unique physical needs.

There is a direct correlation between quality care and quality of life. Prosthetics is one of the most important elements of providing disabled veterans quality of life. VA prosthetics should give veterans the opportunity to live with a disability without the concerns of physical limitations that prevent them from being active, productive individuals. Although PSAS could improve upon the management and acquisition of prosthetic items such as limbs, for the past several years PSAS has provided thou-

sands of veterans with specialized, state of the art, quality prosthetic devices. PVA believes that the only way to continue this performance is to streamline the administrative practices of the VA, and make certain that veterans are provided with quality prosthetic devices that meet their needs in a timely manner.

Again, PVA thanks the Committee for their attention to this important issue and encourages continued oversight of VA prosthetic services. I am happy to answer any questions from the Committee.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2012

No federal grants or contracts received.

Fiscal Year 2011

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program— $262,787.

Fiscal Year 2010

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program— $287,992.

Prepared Statement of Linda Halliday

Madam Chairwoman, Ranking Member Michaud, and Members of the Subcommittee, thank you for the opportunity to discuss the results of recent Office of Inspector General (OIG) reports on prosthetic issues dealing with the delivery of care, and contracting and supply issues [1]. Based on the Committee's interest in VA's capabilities to deliver state-of-the-art prosthetic limb care, we conducted one review of VA's delivery of prosthetic limb care in its facilities and two audits related to contracting and supply issues. The OIG is represented by Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations; Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections; Dr. Robert Yang, Physician, Office of Healthcare Inspections, OIG; Mr. Nicholas Dahl, Director of the OIG's Bedford Office of Audits and Evaluations; and Mr. Kent Wrathall, Director of the OIG's Atlanta Office of Audits and Evaluations. The population analysis of veterans with prosthetic limbs was performed under the direction of Limin Clegg, PhD.

BACKGROUND

Prosthetics include limbs, sensory aids, durable medical equipment, and orthotic appliances, parts or accessories required to replace, support, or substitute an anatomical portion of the body. In addition to artificial limbs, VA considers scooters, wheelchairs, telehealth equipment, braces, watches, and implantable devices such as heart valves and stents as prosthetics. From fiscal year (FY) 2007 through FY 2011, the Veterans Health Administration's (VHA) prosthetic costs increased from $1.0 billion to $1.8 billion. VA maintains an inventory for most prosthetics items. For some prosthetic items, such as artificial limbs, VA Medical Centers (VAMC) do not maintain inventories and instead order these items as needed for individual patients.

VA uses two automated inventory systems to manage prosthetic inventories. Prosthetic and Sensory Aids Services (PSAS) uses the Prosthetic Inventory Package (PIP) to manage the majority of prosthetic inventories. Supply Processing and Distribution (SPD) Services uses the Generic Inventory Package (GIP) to manage prosthetic supplies stored in Surgery Service and medical supply inventories.

Three VA Central Office organizations have responsibilities related to prosthetic inventory management. VHA's PSAS develops policies and procedures for providing

[1] *Healthcare Inspection—Prosthetic Limb Care in VA Facilities,* March 8, 2012; *Veterans Health Administration—Audit of the Management and Acquisition of Prosthetic Limbs,* March 8, 2012; Veterans Health Administration—*Audit of Prosthetics Supply Inventory Management,* March 30, 2012.

prosthetics to veterans. VHA's Procurement and Logistics Office (P&LO) provides VAMCs logistics support and monitors compliance with inventory management policies and procedures. VA's Office of Acquisition, Logistics, and Construction supports VAMCs in acquiring and managing supplies and offers training to VA's acquisition professionals.

HEALTHCARE INSPECTION – PROSTHETIC LIMB CARE IN VA FACILITIES

While the majority of the amputations performed by VA are for older patients with diabetes and poor circulation, we focused on those veterans who had one or more major amputations as a result of injuries sustained during Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND). This group of veterans is a growing and considerably younger group that poses a different set of challenges to VA with regards to prosthetic services.

In order to assess VA's capacity to deliver prosthetic care, we reviewed VA credentialing requirements for prosthetists and orthotists; the demand for health care services; and psychosocial adjustments and activity limitations of OEF/OIF/OND veterans with amputations and their satisfaction with VA prosthetics services. We found that VA prosthetics staff were appropriately certified; that veterans with amputations are a complex population who are significant users of VA health care services including non-prosthetic services; and that veterans adjusted to life with their artificial limbs as well as those in the civilian population.

Demand for Health Care Services

Veterans with a major amputation differ significantly from their peers. To identify how they differ, we examined the records of almost 500,000 veterans who separated from the military from July 1, 2005, to September 30, 2006, for their experience transitioning to VA and using VA health care and compensation benefits through September 30, 2011. We compared frequency of diagnosis for veterans with traumatic major amputations with their non-amputated counterparts in this veteran population. In our analysis, we found that veterans with amputations used significantly more health care services and that this difference held true in every major disease category we examined, not just for prosthetic-related services, traumatic brain injury, or post- traumatic stress disorder (PTSD) issues. This group also had a higher frequency of service-connected disability and higher service-connected disability ratings. Veterans with amputations are more likely to receive medical care at a VA facility than their counterparts.

Assessment of Veterans with a Major Amputation

With the assistance of the Department of Defense (DoD) Inspector General, we acquired the DoD amputee list from TRICARE and Walter Reed National Military Medical Center staff. This list contained 1,288 living service members who served in OEF/OIF/OND with major amputations that occurred during active duty as of August 17, 2011. As of September 30, 2011, 838 (65 percent) of the 1,288 in the DoD OEF/OIF/OND amputee population were discharged from active military service (veterans) and were our population of interest.

Over 98 percent of this group of amputees were male. The average (mean) age when the service member was injured was 25 years old. Seventy-six percent of them served in the Army, and 20 percent in the Marines. Ninety-three percent of all amputees were enlisted service members. Seventeen percent had served in OEF while 84 percent served in OIF/OND. Seventy-four percent lost one limb, 25 percent lost two limbs, and 1 percent lost three or four limbs. Fifty-eight percent were diagnosed with PTSD after their discharge from military service. Thirty-five percent had a diagnosis of a mood disorder, and 15 percent had a diagnosis of substance abuse.

Daily Living

To assess how well veterans were doing, we conducted in-person visits to a statistically representative sample of the OIF/OEF/OND veterans with at least one lower extremity amputation and as many veterans with upper extremity amputations as we could. The responses of many of the veterans were inspiring as many of them—80 percent of those with upper extremity amputations and 90 percent of those with lower extremity amputation—reported that their lives were full. Many of the amputees also reported that they had adjusted to their prosthetic limb and did not mind people asking them about it.

Most veterans were able to engage in their social relationships and reported that visiting friends and maintaining friendships was not limited at all. However, the majority also noted that they were more dependent on others than they would like to be and that they were limited in the kind of work that they could do. When asked about activity limitations, most veterans reported limitations with vigorous activi-

ties such as running, lifting heavy objects, and sports. Working on hobbies was problematic for those with upper extremity amputations while walking for a mile was difficult for those with lower extremity amputations.

Among those veterans who were working, the ranges of limitation for "going to work" were similar between lower limb and upper limb only amputees. Veterans also have adapted to living with pain. For veterans with lower extremity amputations, many veterans expressed limitations based on pain tolerance and complications, such as skin breakdown.

Satisfaction with the prosthetic was assessed by asking veterans to report on the fit, appearance, and reliability of their prosthesis. Over 90 percent of veterans with lower extremity prosthetics reported satisfaction in all three areas as well as being satisfied overall. Veterans with upper extremity amputations reported that their overall satisfaction with their prosthetics was just below 70 percent. Upper extremity prosthetic breakdown was reported by a greater proportion of veterans and occurred more frequently.

While veterans with upper extremity amputations reported limitations with individual activities, most veterans have adapted their overall routine to minimize challenging activities as most report no or mild difficulty with regular daily activities or normal social activities. These veterans' loss of upper extremity function is similar to the general public with unilateral upper extremity amputations.

Veteran Assessment of VA Prosthetic Care Delivery

We asked veterans open-ended questions about what the VA did well and what they could improve on. While veterans praised their experiences with VA, they also noted areas where the VA should improve on the delivery of prosthetic services. Some of the veterans we interviewed reported experiencing such poor service that they avoid using VA care by using other health insurance, participating in research studies, or discontinuing prosthetic use.

A common complaint by veterans using prosthetic limbs dealt with the facility approval process for obtaining prosthetics through fee-basis and contract care. Many felt that the VA process should be simplified, streamlined, and require fewer visits to get approval for a new prosthetic or major repair. Participants also expressed concerns about the length of time and reliability of paperwork for processing prosthetics requests, particularly between the VA and outside vendors. Several veterans reported that they had to facilitate this paperwork to obtain their prosthetics.

Veterans also reported difficulties with accessing prosthetic services at VAMCs due to drive times, wait times, and unavailability of prosthetic experts. Some veterans noted that their busy schedules made any appointment a major inconvenience and were unsure whether the VA was sensitive to this issue. Others reported that rescheduling a VA appointment could be challenging as schedules could be full and the appropriate clinic might be held infrequently.

Veterans also reported that VA personnel were unfamiliar with their prosthetics or did not have access to or expertise with the latest technologies. This was particularly reported by those with upper extremity prosthetics. One veteran stated his frustration from having to educate VA staff about his prosthetic and the overall needs of veterans with amputations.

Recommendations

Our report contained three recommendations for the Under Secretary for Health:

- Consider the wide-ranging medical needs of traumatic amputees beyond the prosthetic and mental health concerns identified in this report; then adjust, if necessary, the provision and management of health care services accordingly.
- Consider that VHA evaluate the needs of veterans with traumatic upper limb amputations to improve their satisfaction.
- Consider veterans' concerns with the approval processes for fee-basis and VA contract care for prosthetic services to meet the needs of veterans with amputations.

The Under Secretary for Health agreed with our recommendations and presented an action plan. We will follow-up as appropriate.

AUDIT OF THE MANAGEMENT AND ACQUISITION OF PROSTHETIC LIMBS

In this report, we evaluated VHA's management and acquisition practices used to procure prosthetic limbs, and examined the costs paid for prosthetic limbs. Overpayments for prosthetic limbs were a systemic issue at all 21 Veterans Integrated Service Networks (VISNs). Overall, we identified opportunities for VHA to: improve controls to avoid overpaying for prosthetic limbs; improve contract negotiations to obtain the best value for prosthetic limbs purchased from contract vendors; and

identify and assess the adequacy of in-house prosthetic limb fabrication capabilities to be better positioned to make decisions on the effectiveness of its labs.

Improved Internal Controls Needed

We reported VHA's PSAS needed to strengthen payment controls for prosthetic limbs to minimize the risk of overpayments. We identified overpayments in 23 percent of all the transactions paid in FY 2010. VHA overpaid vendors about $2.2 million of the $49.3 million spent on prosthetic limbs in FY 2010. VHA could continue to overpay for prosthetic limbs by about $8.6 million over the next 4 years if it does not take action to strengthen controls. On average, VHA overpaid about $2,350 for each of these prosthetic limb payments. Overpayments generally occurred because VHA paid vendor invoices that included charges in excess of prices agreed to in the vendors' contracts with VA. Strengthening controls to ensure invoices submitted by vendors are consistent with contract terms should and can be accomplished without compromising the quality of the prosthetic limbs provided to veterans.

At the four VISNs we visited (VISN 1, 8, 12, 15[2]), we found that Contracting Officer's Technical Representatives (COTRs) either did not conduct reviews of prosthetic limb invoices or conducted only limited reviews of invoices. Instead, Prosthetic Purchasing Agents were reviewing vendor quotes, creating purchase orders, and reviewing invoices prior to making final payments. This is contrary to the Government Accountability Office's Standards for Internal Controls in Federal Government that require key duties and responsibilities be divided to reduce the risk of error or fraud.

Actions Needed to Ensure the Best Value When Procuring Prosthetic Limbs

We found that VISN Contracting Officers were not always negotiating to obtain better discount rates with vendors and some items were purchased without specific pricing guidance from either the Procurement and Logistics Office or PSAS. To illustrate, one VISN we reviewed had a strategy to ensure that they received a discount on prosthetic related contracts of at least 10 percent. Another VISN that was reviewed only obtained an average discount of 8 percent; if they followed the other VISN's lead in seeking a minimum of a 10 percent discount from vendors, they could have saved about $58,000 in FY 2010. Without negotiating for the best discount rates obtainable, VHA cannot be assured it receives the best value for the funds it spends to procure prosthetic limbs. We noted that while strengthening acquisition practices to ensure contracting officers consistently negotiate better discount rates should result in lower costs, it should in no way compromise the quality of prosthetic limbs procured.

We also reported VA paid almost $800,000 for about 400 prosthetic limb items using "not otherwise classified" (NOC) codes in FY 2010. NOC codes are used by VA to classify items that have not yet been classified or priced by Medicare. While this may not be a significant amount in aggregate, the prices paid for individual items that have not yet been classified can be significant. For example, absent pricing guidance VA was paying about $13,700 for a type of Helix joint before it was classified. Once the item was classified, the price dropped to about $4,300. To avoid situations like this, we reported VHA needed to develop guidance to help VISN staff determine reasonable prices for items that Medicare has yet to classify and price.

Improved Prosthetic Limb Fabrication and Acquisition Practices Needed

We did not identify information that showed either how many limbs specific VHA labs could fabricate or how many limbs they should be fabricating. PSAS management did not know the current production capabilities of their labs and could not ensure labs were operating efficiently. VHA guidance states that PSAS should periodically conduct an evaluation to ensure prosthetic labs are operating as effectively and economically as possible. We found that PSAS suspended their review of labs in January 2011 after reviewing only 9 of 21 VISNs. Because reviews of all VISNs were not conducted, PSAS was unaware of its in-house fabrication capabilities and management does not know if labs are operating as effectively and efficiently as possible.

We also reported VISN prosthetic officials did not always identify the appropriate number of contractors needed to provide prosthetic limbs to veterans. VHA guidance recommends three to five vendors receive contract awards depending on the geographic area and workload volume. However, three of four VISN prosthetic managers interviewed were under the assumption they were to award contracts to all vendors who responded to their solicitation, provided those vendors met VA's criteria to qualify as a contract vendor. The VHA guidance conflicted with prosthetic

[2] VISN 1—New England Healthcare System; VISN 8—VA Sunshine Healthcare Network; VISN 12—VA Great Lakes Health Care System; VISN 15—VA Heartland Network.

limb contract guidance that states maximum flexibility be given to individual medical centers to determine the number of contracts required to meet their needs.

Due to the inconsistencies in guidance, differing procurement practices existed among the four VISNs visited. Three of the four VISNs did not identify an appropriate number of contract vendors and VISN contracting officers made awards to nearly all vendors that submitted proposals, many of which were located in the same general areas. As a result, overlaps and gaps in service existed and VISN contracting staff may have been performing unnecessary contract work. Additionally, VHA could not be assured the decision to make contract awards was effectively aligned with workload volume or with what individual medical centers required to meet their needs in serving patients.

Use of VA's Electronic Contract Management System (eCMS) Needs to Improve

Use of eCMS is mandatory for all procurement actions valued at $25,000 or more. We found that contracting officers did not consistently use eCMS to document contract awards to prosthetic limb vendors. Nearly all of the eCMS contract files for awards made to vendors at the four VISNs visited were missing key acquisition documentation.

Missing documentation included evidence of required oversight reviews and determinations of responsibility of the prospective contractors through a check of the Excluded Parties List System. Further, contract invoices were not included in eCMS. As a result, we could not readily verify whether a COTR had reviewed vendor invoices prior to certification to ensure they accurately reflected that goods received were in accordance with contract requirements, including prices charged.

Recommendations

We made eight recommendations to the Under Secretary of Health. They include strengthening controls over the process for reviewing vendor quotes, purchase orders, and verification of invoices and costs charged by prosthetic limb vendors. In conjunction with this, we recommended VHA take collection action to recover the $2.2 million overpaid to vendors. We also made recommendations to ensure contracting officers conduct price negotiations to obtain the best value for prosthetic limb items. In addition, pricing standards need to be established and an assessment of the capabilities of VHA's prosthetic labs needs to be conducted. The Under Secretary for Health agreed with our recommendations and presented an action plan. We will follow-up as appropriate.

AUDIT OF VHA'S PROSTHETICS INVENTORY MANAGEMENT

This report provides a comprehensive perspective of the suitability of VHA's prosthetic supply management policies. In assessing VAMC prosthetic inventory management, VHA agreed that inventories maintained above the 30-day level would be considered excessive unless there was evidence VAMCs needed a higher inventory level to meet replenishment and safety requirements. VHA also agreed prosthetic inventory levels of 7 days or less would create a risk of supply shortages.

We found VHA needs to strengthen VAMC management of prosthetic supply inventories to avoid disruption to patients, to avoid spending funds on excess supplies, and to minimize risks related to supply shortages. Further, because of weak inventory management practices, losses associated with diversion could go undetected. VHA needs to improve the completeness of its inventory information and standardize annual physical inventory requirements.

Inventory Systems Are Not Integrated

VAMC inventory managers need real-time information from VA's Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) and its Computerized Patient Record System (CPRS) to keep PIP quantities accurate and manage prosthetic inventories effectively. However, VHA's PIP does not integrate with IFCAP and CPRS. As a result, when warehouse staff record received supplies in IFCAP and when clinical staff record used supplies in CPRS, PIP is not automatically updated. Consequently, staff must manually record all supplies received and used in PIP. This work is labor-intensive and reduces the time staff have to actively manage supply inventories, and introduces errors into these systems.

Inefficiencies from Using Two Inventory Systems

VHA policies require VAMCs to use PIP to manage prosthetic supplies and GIP to manage surgical device implants (SDIs). VAMCs use of two inventory systems caused staff confusion about the responsibility for managing SDI inventories and created inefficiencies in managing SDIs stored in Surgery Service closets, crash carts, and operating rooms. As a result, VAMCs did not use either PIP or GIP to

manage about 7,000 (28 percent) of 25,000 SDIs. The estimated inventory value for these items was almost $8 million. By replacing PIP and GIP with one automated system, VHA can help VAMCs manage these inventories and avoid excess prosthetic inventories and shortages.

Inadequate Staff Training

Inadequate training was a major cause of VAMCs accumulating excess inventory and experiencing supply shortages. VHA's Inventory Management Handbook requires staff to receive training from qualified instructors on basic inventory management principles, practices, and techniques and how to use PIP and GIP effectively. However, staff at the six VAMCs[3] we visited had not received training from qualified instructors. Because staff did not receive adequate training, they did not consistently apply basic inventory management practices and techniques.

VHA requires VAMCs to conduct annual wall-to-wall inventories of quantities on hand with inventory accuracy rates of at least 90 percent. However, none of the six VAMCs we audited had the required documentation of physical inventories. VAMCs' failure to consistently conduct and document physical inventories was also a contributing cause of reporting inaccurate quantities on hand. When VAMCs do not keep quantities on hand current, the automated inventory systems cannot accurately track item demand, which VAMCs must know in order to establish reasonable stock levels.

Insufficient Oversight

Insufficient VHA Central Office and VISN oversight contributed to VAMCs maintaining excess inventory and supply shortages. VHA's Inventory Management Handbook states that GIP will be the source of reported inventory data and lists seven performance metrics VAMCs must report every month. However, because the Handbook does not specifically require VAMCs to extract performance metric data from PIP, VAMCs did not report the required performance metrics for prosthetic inventories.

In addition, VHA's Handbook does not sufficiently define the role of VISN prosthetic representatives' (VPRs) inventory oversight responsibilities. The VPRs, who had jurisdiction over the audited VAMCs, stated they conducted VAMC site visits. However, the frequency of the site visits varied from quarterly to annually and during the site visits VPRs did not consistently perform a complete assessment of prosthetic supply inventory management.

VHA Handbook Inadequacies

Although VHA's Inventory Management Handbook provided a reasonable foundation for VAMC management of prosthetic supplies, the Handbook needed more guidance to ensure VAMCs do not accumulate excess supplies or experience supply shortages. We identified several Handbook inadequacies VHA must improve to help ensure VAMCs maintain reasonable inventory levels. For example, the Handbook did not have clear guidance on establishing normal, reorder, and emergency stock levels or timeliness standards for recording supplies received and used in PIP and GIP. A comprehensive and clear Handbook is an essential VHA control to ensure proper stewardship and accountability of VAMC prosthetic inventories.

Recommendations

Our report included recommendations for VISN and VAMC directors to eliminate excess prosthetic inventories and avoid prosthetic shortages, develop a plan to implement a modern inventory system, and strengthen management of prosthetic supply inventories. In addition, we recommended VHA officials collaborate with the Executive Director, Office of Acquisition, Logistics, and Construction, to develop a training and certification program for prosthetic supply inventory managers. The Under Secretary for Health agreed with our recommendations and presented an action plan. We will follow-up as appropriate.

CONCLUSION

Veterans with amputations are a complex group of patients with specialized needs both medically and administratively. There are opportunities to improve the prosthetic and medical care that VA delivers to these individuals. While overall veterans with amputations have had positive experience with VA, there is room for improvement in the delivery of prosthetic services.

Administratively, until VHA strengthens management and acquisition practices to procure and fabricate prosthetic limbs, VA will not have assurances that its prac-

[3] VA Medical Centers in Decatur, Georgia; Indianapolis, Indiana; Northampton, Massachusetts; Nashville and Murfreesboro, Tennessee; Salem, Virginia; Clarksburg, West Virginia.

tices are as effective and economical as possible. Furthermore, VHA must increase its inventory system capabilities, provide staff training, implement sufficient oversight, and establish adequate policies and procedures. By taking these actions, VHA will reduce the risk of spending taxpayer dollars on excess prosthetic supply inventories and disrupting patient care caused by supply shortages.

Madam Chairman, thank you for the opportunity to discuss our work. We would be pleased to answer any questions that you or other members of the Subcommittee may have.

Prepared Statement of Lucille B. Beck, Ph.D.

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee: thank you for the opportunity to speak about the Department of Veterans Affairs' (VA) ability to deliver state-of-the-art care to Veterans with amputations. I am accompanied today by Joseph Webster, MD, Medical Director for VHA's Amputation System of Care; Joseph Miller, Ph.D., National Program Director, Orthotic and Prosthetic Services, and Norbert Doyle, MBA, VHA's Chief Procurement and Logistics Officer.

VA continually strives to improve our programs and we appreciate independent reviews that can validate our successes and offer recommendations for improvement. On March 8, 2012, VA's Office of Inspector General (OIG) published a report on Prosthetic Limb Care in VA facilities. In this Report, OIG concluded that more than 99 percent of Veterans with a traumatic amputation who were discharged from active military duty had transitioned to VA care within 5 years of discharge. OIG also found that Veterans reported receiving excellent care at VA facilities, and that all required orthotic and prosthetic VA providers were appropriately certified; however, Veterans did express concern with the availability of care through fee basis or contract care. VHA concurred with OIG's three recommendations: to consider the wide-ranging medical needs of traumatic amputees and adjust, if necessary, the delivery of appropriate health care services; to evaluate the needs of Veterans with traumatic upper limb amputation and improve their satisfaction; and to consider Veterans' concerns with VA approval processes for fee basis and contract care for prosthetic services.

On the same day, OIG also published a report on the Management and Acquisition of Prosthetic Limbs. In this Report, OIG found that overpayment for prosthetic limbs was a systemic issue in each Veterans Integrated Service Network (VISN), and that internal controls needed to be strengthened to better control the process. VHA concurred with OIG's recommendations in this report. OIG found that VA spent approximately $54 million on artificial limbs in fiscal year (FY) 2010, including total contracts to vendors valued at close to $49 million. VA acknowledges it could have saved $2.2 million, and has adopted practices to achieve greater savings.

Later that same month (March 30, 2012), OIG published a third report, an Audit of Prosthetics Supply Inventory Management. In this Report, OIG concluded that VA needs to strengthen management of prosthetic supply inventories at its medical centers and make better use of excess inventories. VHA concurred with OIG's recommendations in this report, and has developed action plans to improve oversight and management processes to better ensure VHA delivers the quality care Veterans deserve while exercising responsible stewardship of prosthetics supplies.

My testimony today will first cover the range of services available to Veterans across our system of care, focusing specifically on demand and utilization of health care services, quality of care, gaps in service, and the ability for Veterans to access VA or contract care that best meets their needs. I will then describe the impact of procurement reform and suitability of acquisition and management policies in support of our clinical care objectives.

Demand for Quality Amputation and Prosthetic Care

VA's Prosthetic and Sensory Aids Service is the largest and most comprehensive provider of prosthetic devices and sensory aids in the world. VA provides a full range of equipment and services, including artificial limbs, durable medical equipment, hearing aids, eyeglasses, ramps and vehicle modifications, and implantable devices, such as replacement hips or biological tissues. All enrolled Veterans may receive any prosthetic item prescribed by a VA clinician, without regard to service-connection, when it is determined to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

VA's Prosthetic and Sensory Aids Service has a robust clinical staff of orthotists and prosthetists at more than 75 locations, and also partners with the private sector

to provide custom fabrication and fitting of state-of-the-art orthotic and prosthetic (O&P) devices. Moreover, VA maintains local contracts with more than 600 accredited O&P providers to help deliver care closer to home. Commercial partners help fabricate and fit prosthetic limbs for Veterans across the country. When utilizing the services of these community partners, VA covers the full cost of the prescribed limb, as well as any repairs. In FY 2011, VA spent more than $108 million to purchase devices or services from more than 1,290 local business communities across the country.

VA promotes the highest standards of professional expertise for its workforce of more than 300 certified prosthetists, orthotists, and fitters. Each VA lab that is eligible for accreditation is accredited either by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc. (ABC), the Board of Certification/Accreditation International (BOC), or both. This accreditation process ensures quality care and services are provided by trained and educated practitioners.

Since its creation in 2009, VA's Amputation System of Care (ASoC) has expanded to deliver more accessible, high quality amputation care and rehabilitation to Veterans across the country. The ASoC utilizes an integrated system of VA physicians, therapists, and prosthetists working together to provide the best devices and state-of-the-art care. This System provides care through more than 375,000 clinical visits to more than 30,000 Veterans with limb loss, including more than 1,000 Veterans from Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND).

The ASoC consists of four levels of care. Seven (7) Regional Amputation Centers provide comprehensive rehabilitation care through an interdisciplinary team and serve as resources across the system through the use of tele-rehabilitation technologies. These Centers provide the highest level of specialized expertise in clinical care and technology and provide rehabilitation and consultation to patients with the most complex conditions. The seven locations include: Bronx, NY; Denver, CO; Minneapolis, MN; Palo Alto, CA; Richmond, VA; Seattle, WA; and Tampa, FL. Fifteen (15) Polytrauma Amputation Network Sites provide a full range of clinical and ancillary services to Veterans closer to home. One-hundred eleven (111) Amputation Rehabilitation Teams provide specialized outpatient amputation care, and 22 Amputation Points of Contact facilitate referrals and access to services. All sites in the ASoC are fully operational.

To support the continued delivery of high quality care, VA has developed a robust staff training program. We offer clinical education, technical education, and business process and policy education, in addition to specialty product training, to help our staff provide better services to Veterans. Clinical education describes the nature of the clinical environment and recommends ways to help maintain productive and positive outcomes in the clinical setting. Technical education trains providers in the nature of products, materials, and supplies, explaining how a microprocessor in a knee may work or how to harness advanced techniques for thermoforming plastics to improve the fit and comfort of the prosthetic socket. Finally, business process and policy education instructs providers how to help standardize processes in the clinical and health care environment to ensure consistent, quality care. Training is often available through facility-specific courses, monthly video tele-conferences, manufacturer-offered courses, educational seminars, curricula for independent study, and other forums. Further, VA has one of the largest orthotics and prosthetics residency programs in the Nation, with 18 paid residency positions at 11 locations across the country.

Research is another important element of VA's amputation care program, with a number of research projects aimed at evaluating new prosthetic devices and improving clinical care. VA's Office of Research and Development spent more than $13 million in FY 2011 on prosthetics and amputation health care research and is issuing Requests for Applications for studies to investigate a variety of upper limb amputation technologies and applications. VA also works with the Department of Defense (DoD) to support joint research initiatives to determine the efficacy and incorporation of new technological advances. Recent examples of this collaboration include:

- DEKA Arm, a robotic arm with fluid finger, wrist and elbow movements that is currently being deployed for home trials with 29 research subjects to provide data on the usefulness of this device in everyday life. This project began in April 2012.
- i-Walk Foot, which became commercially available in 2011; VA prosthetists have provided 57 units to date;
- Genium/X–2 Knee, which became commercially available in 2010; VA and DoD have been involved in the research and development of these products, which represent a significant advance in microprocessor prosthetic knee technology.

VA has promoted training in this new technology, with more than 40 prosthetists, 25 physicians, and 35 physical therapists having completed training.

The partnership between VA and DoD extends further to provide a combined, collaborative approach to amputation care by developing a shared Amputation Rehabilitation Clinical Practice Guideline for care following lower limb amputation. VA is supporting DoD by collaborating on the establishment of the Extremity Trauma and Amputation Center of Excellence (EACE). The mission of the EACE encompasses clinical care, including outreach and clinical informatics, education, and research, and is designed to be the lead organization for policy, direction, and oversight in each of these areas. EACE is currently being implemented and will obtain initial operating capacity by the end of FY 2012. VA will provide four positions for the EACE, including the Deputy Director, Deputy Clinical Program Director, and Deputy Research Director.

Procurement Reform and Acquisition and Management Policies

Clinical care is an important part of our system to provide prosthetic devices to Veterans. Procurement, acquisition, and management policies reflect a complementary and essential piece of this system as well. VA is reforming its procurement practices to extract better prices and more competition in obtaining the devices and supplies Veterans need where appropriate. Title 38, United States Code (U.S.C.), section 8123, grants to VA broad authority to procure prosthetic appliances and services in any manner "the Secretary may determine to be proper without regard to any other provision of law." When exercising this authority the Department may procure prosthetic appliances and necessary services required in the fitting, supplying, training, and use of prosthetic appliances by purchase, manufacture, contract, or in other manners as appropriate. This flexibility was granted to ensure that Veterans receive devices and supplies that are suitable for them and that meet their clinical needs. Many of the products VA purchases are either going to become a part of a Veteran or will be a critical part of their daily lives, helping them walk, work, and interact with their families. The §8123 authority permits VA to limit competition when physicians require specific devices or equipment to support patient care. Also, Federal Acquisition Regulation (FAR) and VA Acquisition Regulation (VAAR) authorize limiting competition under these circumstances. If the Secretary elects to use §8123 in this manner, all applicable FAR and VAAR requirements must still be followed.

When products are generally available and interchangeable, competitive procurements may be more appropriate. VA must comply with all applicable FAR and VAAR requirements in such procurements.

VHA is working to place appropriate limits on the use of the title 38 authority so that it secures fair and reasonable prices for products while still delivering state-of-the-art care, and so we can improve opportunities for Veteran-owned and small businesses. VHA is pursuing three strategies to extract cost savings while preserving high quality, patient-centered health care and appropriate clinical determinations. First, we are transferring purchasing authority from prosthetics purchasing agents to contracting specialists for any purchase above $3,000 (the micro-purchase threshold). VHA has notified the field that certified contracting specialists will be required to contract for these items. For items less than $3,000, micro-purchase requirements continue to apply. We conducted a pilot program to evaluate the impact of this change from January until March in Veterans Integrated Service Networks (VISN) 6, 11, and 20, and beginning this month, we are transitioning to national implementation. Second, VHA is pursuing a phased approach to standardize and define commodities for its products where appropriate. When we can purchase products, devices, or supplies that are generally available and interchangeable, we will comply with the FAR to ensure we are obtaining the best price possible. In the long term, VHA will develop a catalog of such items to facilitate better, more cost effective purchasing decisions. Again, we must balance this goal while still preserving clinical quality and patient care. Finally, VHA is updating policies and directives to better guide clinical and procurement staff on the proper use of §8123. These updates will allow us to more accurately and timely provide services to the benefit of Veterans.

VHA is also increasing its audits of purchases to identify best practices and conduct better oversight. As we gather more data on how these changes are working, we can continue to refine and enhance our programs. We are using new templates, checklists, and justifications to streamline and simplify our processes and improve communication between staff and leadership so we have a comprehensive view of our procurement activities. VHA will ensure proper controls are in place to review vendor quotes, purchase orders, and verify invoices and costs by developing a com-

prehensive database of all existing contracts. We will correct non-compliant contracts as required and evaluate contractor performance as required by the FAR, and institute collection activities when warranted for VA overpayments. To improve the guidance provided to certified prosthetists, we are developing contract templates, clearer guidance, and notices that will be disseminated later this summer to our VISN and facility contracting offices. VHA's Service Area Organizations, which provide support, oversight, and guidance to our facilities, will review the award of every new prosthetic limb base contract to ensure price negotiations took place, and will review a random sample of delivery orders between May and September 2012, to ensure the base contracts include the correct prices. We will determine if base prices can be established following a system-wide review of non-Medicare classified limb items by the end of the fiscal year. In some circumstances, VHA may be better suited to fabricate items in-house. To better identify when we should pursue this approach, we will be contracting for an external review to assess how expanded use of in-house functions would impact patient satisfaction, capabilities, staffing, and Veterans' needs.

Once VHA has procured devices and supplies, management of our inventories and resources is also essential. In the recently published OIG report auditing VHA's prosthetics and supply inventory management practices, the OIG concluded VHA had made overpayments because of inefficiencies in our system and inadequate training and guidance. We appreciate OIG's efforts and recommendations, and in response, we are better defining our policies and guidance to the field, improving our information technology (IT) systems to better track supplies, strengthening our training programs, and increasing oversight and audit functions. We have directed our facilities to reconcile physical inventories and take action to eliminate excess inventories without creating supply shortages. We are revising our standards for facilities to require at least one prosthetic supply inventory manager to become a certified VA Supply Chain Manager. A new, comprehensive IT system will be in place in 2015 to replace our existing inventory systems, but in the interim, we have issued a patch that will enhance the ability of the prosthetics package to interface with inventory management software, facilitating better information sharing. Through these steps, we will better utilize existing and available resources as we deliver prosthetic and amputation services and products to Veterans.

Conclusion

VA supports high quality amputation and prosthetics care by supporting groundbreaking research into new technologies, training a highly qualified cadre of staff, and pursuing accreditation of all eligible prosthetic laboratories in VA's Amputation System of Care. We are improving our oversight and management of prosthetic purchasing and inventory management to better utilize the resources we have been appropriated by Congress as we serve America's Veterans. High quality patient care is our top priority, but we understand we must pursue this objective in balance with other aims. These aims include: supporting Veteran-owned and service-disabled Veteran-owned small businesses, ensuring responsible fiscal stewardship of the funding provided to VA by Congress, and complying with all applicable laws and regulations in this regard. We appreciate the opportunity to appear before you today to discuss this important program. My colleagues and I are prepared to answer your questions.

Statement For The Record

Christina M. Roof

'Chairwoman Buerkle, Ranking Member Michaud and distinguished members of the subcommittee, I would like to extend my gratitude for being given the opportunity to share with you my views and recommendations at today's hearing regarding the Department of Veterans Affairs Prosthetic and Sensory Aid Services, and how we can all work together in *Optimizing Care for Veterans with Prosthetics.*

To fully understand the magnitude of what we are about to discuss, we must start by examining the statistics of our returning servicemembers, as well as forecasting what their needs will be. As the face of warfare has so drastically changed during recent conflicts, so have the injuries servicemembers are sustaining and thankfully surviving. Injuries that would have been fatal 20 years ago are now being treated and survived through advances in military field medicine. In the decade since the Sept. 11, 2001 terrorist attacks, 2,333,972 American military personnel have been deployed to Iraq, Afghanistan or both, as of Aug. 30, 2011 according to the Department of Defense (DOD). Of that total, 1,353, 627 have since left the military and 711,986 have used VA health care between fiscal year 2002 and the third-quarter fiscal year 2011.

Currently, 58.2 percent of those still currently in uniform have served a deployment or multiple deployments since 9/11. These are the same men and women that will turn to VA after their service. These men and women, approximately 800,000 servicemembers, will transition back into civilian life over the next several years. It is of the utmost importance that VA be prepared and equipped with only the finest personnel, prosthetics and technology to care for these men and women. As a nation, we must be able to ensure that when our wounded warriors return from the battlefield, they will have access to the highest quality of care possible.

As previously stated, recent conflicts have given way to a surge in the survival of physical injuries such as, but not limited to, amputations, hearing and sight loss, spinal cord injuries and brain injuries; all conditions which will be treated by or provided resources from the Veterans Health Administration (VHA), more specifically Prosthetic and Sensory Aid Services (PSAS).

When someone thinks of prosthetics, they usually think of a prosthetic arm or leg. Which is correct, however prosthetics encompasses so much more. I believe the simplest way to describe the care and services PSAS provides, is to say if something is in a veteran (surgical), on the veteran, or for a veteran, it falls under the respon-

sibilities of the PSAS department. For example, items such as: prosthetic limbs, surgically implanted devices, such as heart valves, specialized footwear for diabetics, walking canes, eye glasses, wigs, wheelchairs, hearing aids, Service and Guide Dogs and thousands of other items or services needed to ensure only the highest quality of care to our veteran community will be provided through PSAS.

Astoundingly, the number of veterans requiring the services and care of PSAS has risen from 25 percent to nearly 50 percent over the past five years. When compared to the total growth in the number of veterans seeking care from every other VHA department, which is about 13 percent, PSAS has grown by more than 78 percent during the time same period. PSAS also saw a huge growth of approximately 1,800 percent in the number of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) women veterans under their care from 2005–2009. This number is projected to steadily rise with our continued involvement in Afghanistan until 2024 and our presence in Iraq or Operation New Dawn (OND).

It is a known fact that VA has long been a leader in the development of new prosthetics and groundbreaking research. Over the past several years, VA's prosthetic development has revolutionized the way in which prosthetics work around the world. However, with these new prosthetics and medical advances also come new challenges for VA and PSAS, including ensuring that prosthetists, both inside the VA and those with whom the Department contracts, have the skills and proper training to service these new devices. If we are to optimize prosthetic care, we must ensure the credentialing, training and abilities of the PSAS personnel tasked with treating veterans.

That being said, I believe an issue hindering PSAS and veterans equal access to care, is what I believe to be a broken qualification standards and credentialing for prosthetic orthotic professionals. This lapse in uniformed standards across the nation are hurting veterans' access to quality and timely PSAS care and services. Currently, VHA has established requirements for VA prosthetists and orthotists, and the position requirements vary by General Schedule (GS) grade level. Certification is required at the GS–12 grade level or above. However, many times these prerequisites for credentialing are not properly enforced. While OIG was able to verify that all required prosthetists and orthotists staff in Regional Amputation Center (RACs) and Polytrauma Amputation Network Sites (PANS) were certified according to VA policy in their March 2012 report, I have serious concerns as to whether or not all other PSAS departments around the country are adhering to the same requirements for their prosthetists and orthotists staff.

Furthermore, in regards to women veteran's care there is also a distinct lack of certified mastectomy fitters in the VA. There is actually a shortage of fitters and technicians throughout the system. These broken qualification standards are the reason for this. They do not allow medical centers to properly recruit and retain qualified individuals into these roles. The government needs to maximize an individual's function. Having a certified prosthetist orthotist fitting shoes is not an efficient use of that clinical practitioner's time. VA should have the ability to hire GS 5/6/7 fitters and technicians to accomplish this work and free up certified prosthetists and orthotists to do more direct patient care to maximize a Veteran's function and independence.

I urge PSAS to immediately develop and implement uniformed qualification standards that shall encompass all areas of orthopedic and prosthetic care, beyond the GS level. I would further recommend regular continuing education and credentialing verifications to accurately verify that the prosthetists and orthotists treating our severely disabled veterans are providing cutting edge, quality care to every single veteran they care for.

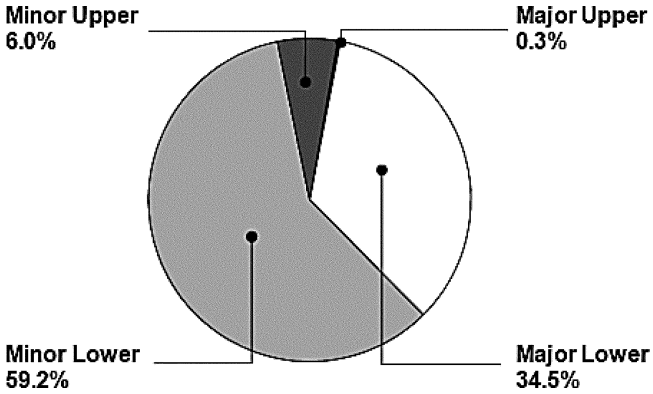
Amputations are another injury PSAS serves as the primary care and rehabilitation providers. According to the Defense Manpower Data Center, the numbers below illustrate the number of amputations sustained during service, as of November 2011.

- There are 1,286 service members who are now amputees as a result of the Iraq and Afghanistan wars.
- In 2011, 240 deployed troops had to have at least an arm or a leg amputated, compared with 205 in 2007, the height of the surge in Iraq, according to data published by the Armed Forces Health Surveillance Center.
- The increase in 2011 coincides with the surge of troops in Afghanistan, who often dismount on foot patrols in the country's austere and rugged terrain.

Troops wounded in Iraq and Afghanistan also have suffered the loss of multiple limbs—of the 187 service members with major limb loss in 2010, 72 of them lost more than one limb, according to the report from the Army's Dismounted Complex Blast Injury Task Force.

While the number of veterans having sustained a battlefield amputation has steadily risen, it is also very important to remember that PSAS not only cares for those veterans having sustained battlefield amputations. They also perform and care for thousands of veterans every year who undergo amputations related to other medical issues while already under VA care. This can be due to a number of medical issues, such as diabetes or infection.

For example, in FY 2011, 6,026 veterans underwent an amputation, with 2,248 having major amputations. Of the 6,026 veterans, 107 (1.8 percent) were female and 24 of the 107 women were veterans of OEF/OIF/OND. The chart below provided by VA OIG in March 2012 shows the distribution of amputations performed at all VA facilities in FY 2011.



Regardless of the cause, PSAS is tasked with providing and caring for all amputees and that is why they must get it right for every veteran amputee they care for.

This is another issue in which I believe PSAS could be more effective and improve their care models, specifically speaking to female amputees. The number of women veterans utilizing PSAS has continued to rise over the past five years. From FY07 to FY11, the number of items provided to female veterans rose 191% from 638,000 to nearly 1.9 million. With that in mind, VHA decided to update VHA Handbook 1330.01 in 2010 to reflect this change. VHA Handbook 1330.01 as amended states:

"Women Veterans Program Manager (WVPMs) need to work closely with the Prosthetics Service and Supply, Purchase and Distribution Department to ensure that supplies specific to women's health are properly stocked, easily requested, and provided in a timely manner (e.g., intra-uterine devices (IUDs), breast pumps, compression stockings, etc.)."

While I absolutely agree with this part of the amended handbook, I also believe that this handbook and several other internal publications still fall short when outlining the policies and procedures that guide the care of VA's female amputee population. I strongly recommend that PSAS immediately adapt several policies, as well as the limb prosthetics they purchase to better fit and meet the needs of women veterans undergoing care for amputations.

While I can give my recommendations to this committee, I felt that it would be more appropriate for an actual female double amputee to share her concerns with you regarding this issue. A very close friend of mine, Sue Downes, lost both of her legs in Afghanistan when multiple Improvised Explosive Devices (IEDs) hit her convoy in the winter of 2008. Sue was the only survivor in her Humvee that day. Sue is the first woman double amputee from the war in Afghanistan. She is resilient to say the least and has a sense of dedication to country and her fellow soldiers like I have never seen before. Sue survived her grueling eight hour ordeal in Afghanistan and was transferred to Germany to be stabilized and then to Walter Reed Medical Center where she and her family would spend the next 20 months. Army doctors told Sue, that she most likely would be confined to a wheel chair for the rest of her life. However, Sue was a wife and is a mother of two young children, thus she told the doctors, *that was simply not an option and she would walk.* Given the fact that Sue was the first female soldier double amputee the hospital and staff struggled to find prosthetics legs that would correctly fit and support her female frame. Up until this time, the Department of Defense (DOD), and most VA facilities, had become accustomed to treating, individualizing and fitting male amputees and

thus only had the equipment and experience fitting our male wounded warrior amputees. This was a milestone for both DOD and VA. They now needed to be changed to meet the needs of America's new returning wounded warrior amputees—women.

While, VA PSAS does provide the world's leading limb and prosthetics care and equipment, many women amputees I have spoken with strongly believe that their facilities in their VAMC's PSAS departments, more specifically limb care and fitting, are still designed to primarily meet the needs of their male counter parts.

Sue told me that when she was first being treated at Walter Reed Army Hospital they made a statement to her, that it was very difficult to work with her injuries since her body was so different from a male when it came to prosthetics. Sue stated, "Our bodies are totally different than our male counterparts. So even though working with me was a challenge, we got through and actually helped the physicians start to master treating female double amputees."

"I feel like that since I left Walter Reed I have had to fend for myself within the VA system. I live in a rural area of Tennessee and have to drive two hours each way for my prosthetics visits. Thus far, VA has yet to meet my needs in fitting my two prosthetic legs properly. While I have encountered several caring individuals from VACO PSAS since Christina Roof has become involved in my case, I still feel like I am not given the same care or respect as my male counterparts. I feel as though I am often yelled at because of certain female issues beyond my control. For example, I cannot help if I fluctuate in weight and that I retain water certain times of the month, causing my sockets not to fit properly. I feel like I always have to "beg" for new fittings because I'm constantly changing in volume and water weight in my legs."

Sue continued, "I can't shave what legs I have left either. It is embarrassing and prevents me from wearing anything other than long pants. I am not going to walk around with hairy legs. As a female double amputee life is hard enough, the fact that I just want to feel like a normal woman should not be too much to ask. So, if VA PSAS does not want women amputees to shave their legs then maybe they could provide us laser hair removal treatments. I am not asking for special treatment, I am just asking to feel as normal as possible. As far as the types of prosthetics go, yes I would like to look like I have normal flesh colored legs, instead of two metal rods. Again, I just want to look as normal as possible, so my kids do not have to answer questions to schoolmates about why their mom has metal legs. I love my country and would do it all again, but I, we, have sacrificed for our country and would at least like somewhat of a normal life back. Is that too much to ask? Yes, to women looks matter. My image and outer appearance means a lot to me as a strong woman. While I have recently received a pair of much better legs, I really just want a single pair of cosmetic legs. However, every time I ask my VA PSAS department they tell me that it will cost too much and to just "make due" with what they have already given me."

Sue is not alone in feeling as if not all of her needs as a woman amputee are being met. I have spoken with several women who are encountering the same types of issues. I cannot say whether these problems are due to a lack of education at the individual VAMC level, problems in credentialing or purchasing, or purely a funding problem. Whatever the cause may be, I sincerely ask this committee to immediately examine and take actions on what can be done to meet the needs of our women amputee wounded warriors.

A problem I also believe to be hindering the optimization of every veteran under PSAS for an amputation is the lack of "Complete Patient Centered Care". What I mean by this is, that I believe veterans receiving care for amputations are not treated as a "whole" person needing assistance in multiple areas, but rather are treated in a more reactionary way by individual departments who might not always share information with each other. While I am aware of and applaud VA's initiative called "Patient Aligned Care Teams" (PACT), however VA has been very slow to implement this initiative even in their pilot sites, and I also believe that this is a model of care that must be integrated into the care of all veterans, not just amputees. That being said, I will keep my comments focused on amputees today.

Amputees are a special population of veterans and usually have more medical complex medical needs than other non-amputee veterans have. This being said, the current broken system of often-reactionary care has caused many problems and unnecessary stress for the veterans already having to deal with the loss of a limb. While I understand that several VAMCs are utilizing this team approach to a veterans care, I strongly believe that all severely disabled veterans need to have the option of receiving this team approach, regardless of location. If we are truly to optimize a veterans quality of health care, we need to ensure that veterans in all parts of the country have access to the same care approaches, such as the team approach.

Veterans having sustained a single or multiple amputations will need far more than simply "limb" care. This group of veterans will have very complex medical needs that need to be addressed and treated in conjunction with all other medical care they are receiving. For example, an amputee will have most likely suffered a Polytraumatic Injury and will need much more assistance and guidance than other veterans will. This will range from medical care coordination between an army of doctors, social workers and care providers. This may include, but is in no way limited to, people such as a Neurologist for the treatment for Traumatic Brain Injuries (TBI), Plastic Surgeons to repair physical wounds and skin grafts for burns or limb re-construction, Psychiatrists and Psychologists for mental health care, Social and Case Workers to inform the veteran about their eligibility for benefits such as clothing allowances, home adaptations and so much more. This is why I believe it to be critical that VA PSAS, and VA as a whole, start treating the entire veteran in a proactive manner, instead of treating the veteran by individual symptoms and needs that may arise. Each veteran receiving care for an amputation should be assigned a dedicated "Care Team" that meets on regular basis to discuss the veterans care and treatments by each of the individual physicians and care providers assigned to the veterans "Care Team." This is a very simple and cost free way of ensuring every veteran undergoing care for their amputations and related medical issues will receive the highest quality of coordinated care VA has to provide.

This "Care Team" should be composed of the veterans PSAS representative, social worker and every physician who regularly treats the veteran. This will help ease the stress the veterans experience trying to remember to tell their different doctors about something they learned from another doctor, will greatly improve the quality and safety of the care the veteran receives and will provide the highest quality of coordinated care VA has to offer.

Another issue we must revisit, is the issue of timely access to quality prosthetics care and services. I strongly believe that access to PSAS care, services should be a top priority for VA, and that overall PSAS has done an outstanding job developing several new methods to meet the needs of today's veteran population, I also believe that there are several factors actually hindering a veteran's access to timely and quality PSAS care and internal hurdles PSAS staff must overcome every day in order to meet the most basic of today's veteran's needs. In order to optimize the PSAS system of care and internal issues there must be several changes addressed immediately.

An issue hindering a veteran's timely access to PSAS care and services is the fact that VHA has not established, nor does it maintain any system of national patient records or the physician's original corresponding request to PSAS. I believe this not only negatively affects the veteran, but also poses a threat to the integrity of VA's purchasing policies and procedures.

The lack of a centralized tracking and data exchange system available to physicians and purchasing agents simply hinders a veteran's timely access to care. Moreover, due to fragmented patient records, veterans may not receive the care they need should they have to visit any VA Medical Center (VAMC) or Community-based Outpatient Clinic (CBOC) other than their home VAMC or CBOC. For example, if a veteran utilizing a wheel chair is on vacation or on travel for their job, and the wheel chair requires immediate assistance or service from PSAS, the veteran will most likely encounter bureaucratic obstacles at the nearest PSAS department as result of the missing PSAS data exchange system. This same fragmentation puts veterans at a high risk in the event of an emergency. Whether it is another Hurricane Katrina, or even a snowstorm in Buffalo, VHA's lack of a national record and request system means that a veteran's order cannot be processed if those local employees that are unable to get to work. Moreover, if veterans are displaced, there will be a substantial delay in replacing essential equipment. This is a simple IT solution that VHA has no ability to execute due to the centralization of VA's IT.

A recent OIG report found that Prosthetics was lacking some basic inventory controls, but this too indicated a lack of appropriate IT resources to have a modern inventory system to track and monitor stock and reorder levels. This extends out to surgical implants where there is a high risk of expiration- costing VA millions of dollars and possibly veteran lives.

VA's issue, negatively affecting PSAS, associated with not having a comprehensive modern inventory solution goes back to the calamity of the Core Financial and Logistic System (Core FLS) programs, and more recently the abandoning of Financial and Logistic Integrated Technology Enterprise (FLITE) and Strategic Acquisition Management (SAM) programs. Although VHA is trying to salvage some aspects of these programs, any real implementation is several years away. I urge VA to act swiftly on developing a data exchange system for the use of PSAS personnel to avoid

a potentially large backlog where veterans would be unable to obtain the immediate resources and care provided to them by VHA PSAS.

Currently, VA has no way of tracking vital information on patients' care and purchasing orders, thus opening themselves up to potential fraud and abuse, and the inability to provide the highest quality care to the veterans they serve. The inability to provide all veterans equal access to care through centralized purchasing units—instead of the current fragmented paper copy system—also prevents PSAS from maximizing efficiencies.

Over the past couple years, VA has been moving to professionalize the acquisition workforce and adhere to archaic federal acquisition laws and regulations, none of which were written with an individual's health care needs in mind. It is my understanding that VHA has concluded a pilot to move procurements from the Prosthetic and Sensory Aids Service to VHA Procurement for those items over the micro purchase threshold.

I implore the committee to make it clear to VA that not only do they have the authority to procure outside of Federal Acquisition Regulations (FAR)- 38 USC 8123- they have a duty to do so to ensure that our veterans are provided the most appropriate devices in the most expeditious manner possible. We have slowly begun to hear rumors of delays where veterans, even those most at risk such as amputees, spinal cord injuries, and those with ALS (Amyotrophic Lateral Sclerosis) are having their life critical devices held up in a bureaucratic nightmare. Congress and VA must recognize a clinician's autonomy and ability to prescribe what is best for that individual veteran.

While VA's Senior Procurement Executive has repeatedly touted a new Strategic Acquisition Center, the fact remains that this is simply in addition to the National Acquisition Center, the Denver Acquisition Logistics Center, and the Technology Acquisition Center. At the department level, VA seems to be building a substantial level of duplication, all in an attempt to standardize prosthetics procurement for veterans. Duplications of efforts are not the fiscally responsible way to run any federal agencies, nor is it helpful in optimizing a veterans care and access to PSAS services.

However, when this executive is asked, the Department will state that this is not meant to reduce the ability to give veterans the most appropriate items, their actions run contrary in that without these contracts, VA is forcing these orders to be competed. Even within a given contract award, there is a push for procurements to be distributed amongst all awardees. This means there is still a complete lack of respect for a veteran and their clinical team's decisions. These inefficient practices must immediately be addressed and corrected, if we wish to provide timely and quality access to PSAS services for our veteran community.

Finally, a large problem that poses a hurdle to care to veterans requiring PSAS resources is the location and availability of resources to veterans living outside of major metropolitan cities. Over 4 million of the veterans enrolled in the VA Healthcare System live in rural areas. There is an overwhelming national misconception that all veterans in need of PSAS have equal access to the comprehensive care and other programs provided by VHA's PSAS. Unfortunately, this is not true. Access to the most basic primary care is often difficult in rural America, let alone the extensive individualized care that accompanies amputations or other serious conditions in which PSAS would provide care. Currently, PSAS does not have the necessary prosthetic or orthotic professionals in-house needed to meet the demand for services by the veterans' community. This is especially true for veterans living in rural areas. Some veterans have to drive hours for something as simple as getting their prosthetic limb adjusted or for physical rehabilitation. PSAS has approximately 600 contracts with local vendors across the nation to provide care closer to home for these rural veterans. However, as VA moves to their new procurement model, I am sincerely concerned that when a veteran has a unique situation, or medical need, requiring the services of a vendor not on contract with PSAS that this will no longer be an option under this new model of care where PSAS procurements are accomplished through VHA's acquisition service. I concur with the IG's recent report on limb procurement that VA needs to assess its internal capabilities and determine the correct number of contracted vendors to have in a particular area. This should not preclude a Veteran from being able to utilize a vendor not on contract when that Veteran has a unique medical need or lives in an extremely remote area. I believe strongly in the authority granted PSAS by Congress in 38 USC 8123.

Alarmingly, a 2006 study of the Carsey Institute reported that the death rate for rural veterans is up to 60 percent higher than the death rate of veterans residing in urban areas. Given the difficulties that already accompany being an amputee then couple it with the multiple obstacles rural veterans often face in their efforts to receive medical and PSAS care is resulting in many veterans missing appoint-

ments or foregoing care for a number of reasons beyond the long distances they must travel. VA has stated that over 50 percent of the veterans they treat live in areas of the country they consider to be "remote" or "highly rural". This statistic alone should be more than enough of a reason to establish a better system of care of locations were that care can be received.

I do however applaud several VAMCs PSAS departments who are actively seeking out and treating rural veterans. For example, PSAS teams from Colorado and Wyoming have established a Prosthetic Treatment Center Mobile Laboratory. According to VA "A certified Prosthetist-Orthotist will travel to rural areas in Colorado and Wyoming in a van equipped with a mini prosthetic-orthotic fabrication laboratory, computer assisted design and manufacturing capabilities, and telehealth equipment. This program will bring expertise in high end-orthotics and in prosthetic fabrication and fitting to rural Veterans, and the van will be used for tele-consultations with prosthetic and orthotic rehabilitation specialists, the Amputation Rehabilitation Coordinator, podiatrists, and wound care specialists from the Denver VAMC. This mobile laboratory will provide rural Veterans with access to the Regional Amputation System of Care (RAC) based in the VA Eastern Colorado Health Care System. This mobile laboratory will provide a more consistent standard of care for rural veterans than is currently possible with community vendors."

I would lastly like to note that PSAS has been under "acting leadership" for nearly a year and a half. A department offering services of this magnitude cannot hope to improve the services they provide to to veterans as long as they are languishing without a leader to provide the proper direction. Prosthetics needs to have a senior leader appointed as soon as possible. I believe this leader should at minimum be currently serving at the Chief Consultant level, if not Chief Officer given the unique nature of the program and it's far reaching, significant impact it has on all veterans, especially our most vulnerable veterans with severe disabilities.

In closing, the current conflicts, along with an aging veteran population and tighter budgets have placed VA PSAS under tremendous strain. Congress and VA have both made an effort to ensure that the budget for medically prescribed devices is substantial enough to ensure that veterans receive the highest quality devices. Unfortunately, many at VA seem to be devolving themselves into a bureaucracy where the people who were successfully procuring prosthetic items are no longer going to be involved. VA PSAS has IT systems that are woefully out of date, placing veterans at risk for not receiving their required care, while also putting VA at risk for increased fraud, waste and abuse. High-risk populations, such as rural and women veterans, continue to be the ones in danger of not receiving the care they have earned through their selfless service. Congress has already recognized that federal procurement laws and regulations do not always work for the personalized health care many of our most severely disabled veterans require. I beseech you to ensure VA respects the autonomy of their physicians and the preferences of veterans by continuing to use 38 USC 8123 to provide medically prescribed devices to veterans in the most efficient way possible. I also urge this subcommittee to have the strictest of oversight to ensure VHA PSAS is provided with the necessary resources to develop and implement a national prosthetics record, a modern inventory system and the clinical and administrative staff required to properly support our veterans and optimize their prosthetics care.

Madam Chair, and distinguished members of the subcommittee, I would like to again thank you for inviting me to share my views and recommendations on this critical matter with the subcommittee today. I stand ready to address any questions or concerns you may have for me. Thank you.

May 11, 2012

The Honorable Ann Buerkle, Chairwoman
Subcommittee on Health
House Veterans Affairs Committee
335 Cannon House Office Building
Washington, D.C. 20510

Dear Chairwoman Buerkle:

Pursuant to Rule XI2(g)(4) of the US House of Representatives, I have not received any federal grants in Fiscal Year 2012, nor have I received any federal grants or contracts in the two previous Fiscal Years relevant to the May 16, 2012, Subcommittee on Health hearing on *Optimizing Prosthetic Care for Veterans.*

Very Respectfully,

Christina M. Roof

Question For The Record

Letter and Questions From: Hon. Michael H. Michaud, Ranking Democratic Member, Subcommitte on Health - To: Ms. Lucille Beck, Ph.D., Acting Chief Consultant, Prosthetics and Sensory Aids Service, Veterans Health Administration, U.S. Department of Veterans Affairs

May 23, 2012

Ms. Lucille Beck, Ph.D.
Acting Chief Consultant
Prosthetics and Sensory Aids Service
Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Dr. Beck:

In reference to our Subcommittee on Health Committee hearing entitled "Optimizing Care for Veterans with Prosthetics" that took place on May 16, 2012. I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 23, 2012.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Jian Zapata at *jian.zapata@mail.house.gov,* and fax your responses to Jian at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

MICHAEL H. MICHAUD
Ranking Democratic Member
Subcommittee on Health

Enclosure

CW:jz

QUESTIONS FOR THE RECORD FROM THE HOUSE COMMITTEE ON VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH

Hearing on *Optimizing Care for Veterans with Prosthetics*

1. Until the VA began upgrading its internal capacity to provide prosthetic care, a senior VA PSAS official testified before Congress that 97% of prosthetics for veterans were provided by contract prosthetists. The OIG Report entitled, "Healthcare Inventory," notes that with respect to the prosthetic care received by recent veterans with amputations, there are high satisfaction rates (90.9% for lower limb amputees and 69.6% for upper limb amputees). Some of the most positive feedback from individual veteran amputees in the OIG survey involved praise for VA in permitting choice and location of contract prosthetists (see p. 62):

a. *QUESTION:* Given the fact that veterans view choice and location of contract prosthetists among the best aspects of the VA prosthetic care system, and the fact that veterans have high satisfaction rates with contract prosthetists, why would the VA not support passage of H.R. 805, the Injured and Amputee Veterans Bill of Rights, as a step toward addressing Recommendation No. 3 of the Healthcare Inventory report, to improve the "VA approval process for fee-basis and VA contract care for prosthetic services to meet the needs of veterans with amputations."

2. The OIG Report on Prosthetic Limb Care in VA Facilities (Report No. 11–02138–116) states that the VA has made a significant investment in its capacity to serve veterans with amputations since 2009 through its Amputee Systems of Care Program (ASoC), a comprehensive series of settings in which amputee and prosthetic care is provided.

a. *QUESTION:* Can you tell the Subcommittee how much the VA has invested in these upgrades to its internal capacity to serve veterans with amputations since 2009?

3. The OIG Audit of the Management and Acquisition of Prosthetic Limbs (Report No. 11–02254–102) states that of the $1.8 billion VA spent on prosthetic items in FY 2010, only $54 million (3 percent) was spent on prosthetic limbs.

a. *QUESTION:* Compared to the significant investment made to enhance VA's internal capacity to fabricate prostheses, do you believe it is cost-effective for the VA to consolidate prosthetic fabrication internally in VA centers or would it be more cost-effective to continue to rely on contract prosthetists located in the vicinity of the veterans themselves, working in coordination with a VA rehabilitation team?

4. The OIG report estimates that it costs the VA Prosthetic and Sensory Aids Service (PSAS) approximately $12,000 on average to purchase a prosthetic limb from a contract prosthetist but that it costs the VA only $2,900 to fabricate a prosthetic limb from a VHA prosthetic lab. This figure seems exceedingly low considering the highly specialized services that go into the fabrication and fitting of a prosthetic limb.

a. *QUESTION:* Can you tell the Subcommittee which costs specifically were factored into this estimate of VA cost for the fabrication of a prosthesis through its own prosthetic labs? For instance, were the following costs included in the calculation:

i. Labor costs, including a portion of the salary and benefits for the prosthetist and prosthetic technician to design, fabricate and fit the limb as well as the administrative staff to process paperwork, tend to the laboratory and clinical facility, etc.
ii. Facility costs, including a portion of overhead for the clinical and laboratory facilities used in the fabrication of the device, the storage of inventory and materials, and the housing of machinery.
iii. Machinery and supplies, including the capital costs of purchasing industrial ovens, laboratory work equipment, tools, grinders, computer-assisted design/computer-assisted manufacture devices and software, and other ancillary items that may not be incorporated into a final prosthesis.

5. The OIG Report suggests that internal VA guidance suggests that each VISN should contract with three to five (3 to 5) private prosthetists to augment the capacity of the internal VA programs to serve veteran amputees' prosthetic needs. Several VISNs have chosen to contract with far more than this guidance suggests.

a. Does the fact that some VISNs have chosen to contract with many more private practitioners than 3 to 5 suggest that there is veteran demand for access to private practitioners? Is this not consistent with maintaining veterans' choice and enhancing quality under the VA prosthetic benefit?

Responses From: Veterans Health Administration, U.S. Department of Veterans Affairs - To: Hon. Michael H. Michaud, Ranking Democratic Member, Subcommitte on Health

1. Until the VA began upgrading its internal capacity to provide prosthetic care, a senior VA PSAS official testified before Congress that 97% of prosthetics for veterans were provided by contract prosthetists. The OIG Report entitled, "Healthcare Inventory," notes that with respect to the prosthetic care received by recent veterans with amputations, there are high satisfaction rates (90.9% for lower limb amputees and 69.6% for upper limb amputees). Some of the most positive feedback from individual veteran amputees in the OIG survey involved praise for VA in permitting choice and location of contract prosthetists (see p. 62):

a. Given the fact that veterans view choice and location of contract prosthetists among the best aspects of the VA prosthetic care system, and the fact that veterans have high satisfaction rates with contract prosthetists, why would the VA not support passage of H.R. 805, the Injured and Amputee Veterans Bill of Rights, as a step toward addressing Recommendation No. 3 of the Healthcare Inventory report, to improve the "VA approval process for fee-basis and VA contract care for prosthetic services to meet the needs of veterans with amputations."

Response: The Department of Veterans Affairs (VA) acknowledges the need to continually improve its approval processes for fee basis and contracted services.

Such improvements for contracted prosthetic services require changes in administrative business practices as noted in VA's response to the Office of the Inspector General report on "Management and Acquisition of Prosthetic Limbs" (March 8, 2012) including: conducting quote reviews for services, certification of invoices by contracting officers, and having clearly defined performance measures stipulated in contracts.

VA recognizes the unique needs of injured and amputee Veterans, which is why their care is managed by an interdisciplinary medical team that provides high quality, comprehensive amputation rehabilitation services. Fabrication of a prosthetic limb is one important element of the rehabilitation care plan. A VA physician prescribes the necessary prosthetic limb, VA or the contracted prosthetist fabricates that limb, and the Veteran's care and "medical rehabilitation" (including functional effectiveness of the fabricated limb) continues to be managed and supervised by VA providers and the Veteran.

Veterans with severe injuries and amputation have unique needs that set them apart from other patients at VA facilities—but they are not set apart in their rights. The basic tenets of patient care should not vary based either on the condition or injury experienced by a Veteran or the type of medical services a Veteran receives. H.R. 805 would confer unique rights upon a limited group of Veterans. Giving special rights to injured and amputee patients that are not available to other enrolled Veterans would result in inconsistent and inequitable treatment among our Veteran patients.

VA adheres to strict standards of patient treatment. A VA regulation requires that upon admission, patients or their representatives must be informed that a list of patients' rights is posted at each nursing station in all VA facilities. Patients who are concerned about the quality of their care have a number of options already available for addressing these issues. Every VA medical center has a patient advocate dedicated to addressing the clinical and non-clinical complaints and concerns of our Veterans and their families. Many facilities also include a "Letter to the Director" drop box where Veterans can communicate directly with the Director and raise issues and concerns. In addition, VA's Prosthetic and Sensory Aids Service maintains a Web site that offers Veterans and family members an opportunity to ask questions or raise concerns directly with VA officials. The Department also works closely with Veterans Service Organizations to identify and respond to any concerns with quality and access to care.

If extended to the entire patient population, the Department would support the majority of "rights" that are included in this 'Bill of Rights' (e.g., the right to receive appropriate treatment, the right to participate meaningfully in treatment decisions, etc). However, a few of the "rights" raise serious concerns. Specifically, the Veteran's "right to select the practitioner that best meets [his or her] orthotic and prosthetic needs, [including] a private practitioner with specialized expertise," is not sound from a medical perspective, as the Veteran could select a person without the requisite qualifications to provide quality care.

2. The OIG Report on Prosthetic Limb Care in VA Facilities (Report No. 11–02138–116) states that the VA has made a significant investment in its capacity to serve veterans with amputations since 2009 through its Amputee Systems of Care Program (ASoC), a comprehensive series of settings in which amputee and prosthetic care is provided.

a. Can you tell the Subcommittee how much the VA has invested in these upgrades to its internal capacity to serve veterans with amputations since 2009?

Response: In 2009, the Veterans Health Administration (VHA) began the implementation of the Amputation System of Care (ASoC), which provides specialized expertise in amputation rehabilitation incorporating the latest practices in medical rehabilitation management, rehabilitation therapies, and technological advances in prosthetic components. From fiscal year (FY) 2009 to 2011, VHA invested approximately $20 million in enhancement of amputation care. Of the $20 million, approximately $11 million was spent on dedicated staff; $7 million on prosthetic labs, rehabilitation and telehealth equipment; and $2.4 million on education and training to maintain the skills and competencies of the staff.

The ASoC is comprised of a tiered system of care of graded levels of expertise and accessibility:

- 7 Regional Amputation Centers (RAC) provide comprehensive rehabilitation care through an interdisciplinary team and serve as resources for other facilities in the system through tele-rehabilitation.

- 15 Polytrauma/Amputation Network Sites (PANS) provide the full range of clinical and ancillary services to Veterans closer to home.
- Amputation Clinic Teams (ACT) provide limited inpatient and prosthetic capabilities.
- Amputation Points of Contact (APOC) include at least one person at each facility identified as the point of contact for consultation and assessment.

3. The OIG Audit of the Management and Acquisition of Prosthetic Limbs (Report No. 11–02254–102) states that of the $1.8 billion VA spent on prosthetic items in FY 2010, only $54 million (3 percent) was spent on prosthetic limbs.

a. Compared to the significant investment made to enhance VA's internal capacity to fabricate prostheses, do you believe it is cost-effective for the VA to consolidate prosthetic fabrication internally in VA centers or would it be more cost-effective to continue to rely on contract prosthetists located in the vicinity of the veterans themselves, working in coordination with a VA rehabilitation team?

Response: To meet the expectations of our Veterans to provide the highest quality care and to provide devices closer to their homes, VA continues to offer and develop in-house clinical presence in partnership with community providers. When assessing the cost effectiveness of providing prosthetic fabrication of an artificial limb, VA considers more than just the price offered by contractors in the private sector.

Reimbursement of care of amputees in the private sector generally is measured by the number of prosthetic limbs provided because the reimbursement structure is based on products, not clinical care services. VA does not limit its care performance measure to examining the number of limbs provided, but also recognizes the unique professional nature, value, and role of orthotists and prosthetists in the rehabilitation of Veterans. These specialists provide clinical relevance and expertise, help educate professionals from other medical disciplines, and support research.

When a Veteran is sent to the private sector for a prosthetic limb, the private sector prosthetist or orthotist provides the "product" prescribed by the Veteran's VA health care provider(s). In the private sector reimbursement is based on the product, not the services provided. In such a system, the vendor receives the same payment whether the patient is seen once or many times. Private sector prosthetists and orthotists do not provide medical or rehabilitation care, which remains the responsibility of the Veteran's VA health care team.

In FY 2011, the VA Orthotics and Prosthetics (O&P) Service provided 420,427 patient visits in-house to 262,112 Veterans. The majority of these visits were for clinical care outside of fabrication of prosthetic devices. Looking only at fabrication, VA maintains a highly skilled and trained team of professionals working in state-of-the-art accredited facilities. However, VA's patient population is very geographically diverse and demands a balance between in-house fabrication, clinical expertise, and convenience resulting from local vendors who fabricate the prescribed limb.

4. The OIG Report estimates that it costs the VA Prosthetic and Sensory Aids Service (PSAS) approximately $12,000 on average to purchase a prosthetic limb from a contract prosthetist but that it costs VA only $2,900 to fabricate a prosthetic limb from a VHA prosthetic lab. This figure seems exceedingly low considering the highly specialized services that go into the fabrication and fitting of a prosthetic limb.

a. Can you tell the Subcommittee which costs specifically were factored into this estimate of VA cost for the fabrication of a prosthesis through its own prosthetic labs? For instance, were the following costs included in the calculation:

i. Labor costs, including a portion of the salary and benefits for the prosthetist and prosthetic technician to design, fabricate and fit the limb as well as the administrative staff to process paperwork, tend to the laboratory and clinical facility, etc.

ii. Facility costs, including a portion of overhead for the clinical and laboratory facilities used in the fabrication of the device, the storage of inventory and materials, and the housing of machinery.

iii. Machinery and supplies, including the capital costs of purchasing industrial ovens, laboratory work equipment, tools, grinders, computer-assisted design/computer-assisted manufacture devices and software, and other ancillary items that may not be incorporated into a final prosthesis.

Response: VHA Prosthetic and Sensory Aids Service reported these data from VHA PSAS National Prosthetic Patient Database (NPPD), and Orthotics Work Order Lab (OWL). The $12,000.00 average cost to purchase a prosthetic limb from a contract prosthetist is based on data from the NPPD for new limbs that are commercially purchased. There is reasonable confidence in the commercial costs reported since these data follows the same process as all Prosthetic purchase orders.

The reported $2900 VA costs for fabricating a prosthetic limb within VA are based on data entered by VA clinicians from the facilities providing cost estimates of labor and materials, only. The reported costs entered by the clinician in OWL reflect only direct labor costs for fabrication, and material costs for prosthetic components. In summary:

i. Direct labor costs are only for Prosthetists, and does not include administrative staff;
ii. No facility costs are included;
iii. Only costs of the actual device components and some supplies are included. No machinery and overhead supply costs are included (e.g., capital costs of purchasing industrial ovens, laboratory work equipment, tools, grinders, computer-assisted design/computer-assisted manufacture devices and software, and other ancillary items that may not be incorporated into a final prosthesis).

5. The OIG Report suggests that internal VA guidance suggests that each VISN should contract with three to five (3 to 5) private prosthetists to augment the capacity of the internal VA programs to serve veteran amputees prosthetic needs. Several VISNs have chosen to contract with far more than this guidance suggests.

a. Does the fact that some VISNs have chosen to contract with many more private practitioners than 3 to 5 suggest that there is veteran demand for access to private practitioners? Is this not consistent with maintaining veterans' choice and enhancing quality under the VA prosthetic benefit?

Response: The OIG Report found multiple contract vendor awards in some Veterans Integrated Service Networks (VISN) without balanced consideration of geographic access and specialty demand for Veterans. The large number of awardees did not increase Veteran access, as many of these vendors were within walking distance of other providers. VA concurred with the OIG recommendation to assess its internal capabilities and to develop criteria to establish an appropriate number of contracts. VA is committed to assessing these contracts and its internal capabilities to generate a realistic number of awardees for these contracts.

VA relies on these contract vendors to provide quality service that is convenient to our Veteran population and will maintain Veterans' choice, while balancing this duty with the fiscal responsibility to secure the best value for taxpayers. VA must weigh several factors in determining the appropriate number of awards. For example, VISNs with a larger rural population may require more awards than a compact urban VISN. VA is in the process of reviewing all of its contracts and policies regarding the provision of prosthetic devices and services, while ensuring that our top priority will always be quality care for Veterans.

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