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EVOLUTION OF VA-DOD COLLABORATION IN RESEARCH AND AMPUTEE CARE FOR VETERANS OF CURRENT AND PAST CONFLICTS, AS WELL AS NEEDED REFORMS IN VA BLIND REHABILITATION SERVICES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

JULY 22, 2004

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EVOLUTION OF VA-DOD COLLABORATION IN RESEARCH AND AMPUTEE CARE FOR VETERANS OF CURRENT AND PAST CONFLICTS, AS WELL AS NEEDED REFORMS IN VA BLIND REHABILITATION SERVICES

THURSDAY, JULY 22, 2004

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The committee met, pursuant to notice, at 9:33 a.m., in room 334, Cannon House Office Building, Christopher H. Smith (chairman of the committee) presiding.

Present: Representatives Smith, Brown-Waite, Evans, Snyder, Rodriguez, Strickland, Berkley, Udall, Davis, Ryan, and Herseth.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. The hearing will come to order.

Ladies and gentlemen, good morning, and thank you for being here today. It is estimated there are about 157,000 veterans who are legally blind, and that about 44,000 of them are enrolled in VA health care. Slightly more than 2,000 of those veterans have received treatment in the VA's Blind Rehabilitation Centers. One focus of today's hearing is on changes that may be needed in the VA's approach to caring for blinded and visually-impaired veterans.

Last fall, Rob Simmons, the chairman of our Health Subcommittee, requested that the General Accountability Office examine VA's blind rehab programs. GAO found that as a consequence of the growing number of veterans in need of blind rehab services and VA's reliance on care in 10 regional centers, the average length of time veterans waited to be admitted to Blind Rehabilitation Center is excessive. GAO reported to us, and VA agreed, that waiting time management for blind rehabilitation needed to be improved. VA has committed to make these improvements I am happy to say. Today GAO will discuss how VA needs to reform its management of the program itself and we look forward to that testimony.

The Committee is also very interested to hear VA's plans to make visual-impairment services more available to veterans where they live, as opposed to forcing veterans to come to specialized centers themselves.

A second focus of today's hearing is to learn more about recent efforts on the part of the VA and the Department of Defense to im-

prove care for veterans suffering the effect of traumatic amputation.

An interesting observation was contained in an October 1, 2003, article that appeared in The Christian Science Monitor concerning servicemembers wounded in our conflicts. The article reported that, and I quote, "while combat deaths have been relatively low since the Vietnam War, the ratio of nonfatal casualties to war fatalities is increasing—from three to one in World War II to more than five to one in Iraq. Beyond the human dimension, the costs of such casualties, which tend to be overlooked as part of the cost of national security and foreign policy, will continue for decades as well. Among those costs: rehabilitation, retraining, post-combat counseling, long-term medical treatment and assisted-living care."

Today's hearing will examine several facets of the important treatment being provided to these survivors and how this treatment affects the lives of those who have been wounded.

While VA's future course for providing rehabilitation to blinded veterans may be uncertain, it appears that Army and VA care givers responsible for meeting the needs of servicemembers with traumatic amputation have made substantial progress in charting a clear course for discovering and responding to the needs of this seriously wounded population. They have done this through the sharing of resources, the use of the latest technologies and by adopting and working toward common goals. And we applaud them.

VA and DOD are engaged in a remarkable and hopefully a productive collaboration in research and innovation for a young, resilient population. So resilient, in fact, that many of these soldiers and Marines plan to return to their active duty assignments following rehabilitation, an option unheard of in prior generations of warfare. We wish them Godspeed and we just salute them for their courage and for their commitment. We also salute the professional dedication of those contributing to this collaboration and wonder what it would take to translate this quest for excellence to the rest of the two department health care endeavors.

We will also hear how technological and medical advances are changing the nature of rehabilitation for today's servicemembers and for tomorrow's veterans. While highlighting these advances, the hearing will also focus on providing the most appropriate care to address rehabilitative needs of all of our veterans.

Let me just turn to our very distinguished chairman of the Health Subcommittee, Rob Simmons of Connecticut, for any comments he might have.

OPENING STATEMENT OF HON. ROB SIMMONS

Mr. SIMMONS. Thank you, Mr. Chairman, and thank you for focusing the attention of the full committee on this issue. In fact, it is an issue that came up in our subcommittee proceedings, but by agreeing to hold this hearing in full committee, I think it demonstrates your interest and your leadership on this issue, and we appreciate that greatly.

The issue of blindness for veterans is one that we often think of in terms of either battlefield or service connected injuries and we know that that can happen and that that can be a problem. But

for me the issue of blindness comes because of the fact that my mother, who is in her nineties, has suffered from macular degeneration. Again, an affliction that affects so many of our veterans populations.

My mother, in every other respect, is perfectly healthy and very active, but we noticed a few years ago that she was having what seemed to be sight and coordination problems when she was driving, and it was only later that we realized that she was going blind.

As our veterans population ages, as they benefit from the health care that the VA provides, the issue of macular degeneration or blindness as a consequence of the aging process becomes increasingly important, and I think that if we have a concern for their health and for their quality of life, then this is an important issue for us to look at.

I am particularly pleased that among the witnesses today is Penny Schuckers, from West Haven Veterans Administration Hospital in Connecticut. She has a very distinguished career, having studied at Moravian College, Temple University, and then the University of Alabama. She has taken leadership courses throughout her VA career, to include leadership courses offered here in Washington, DC, and she served in the VA medical centers in Lebanon, PA, Augusta, GA, and now has reached the apex of her career, of course, in coming to Connecticut. So Penny, welcome, and we look forward to hearing your testimony.

And Mr. Chairman, thank you again, and I yield back.

The CHAIRMAN. Thank you, Chairman Simmons.

The chair recognizes Mr. Evans.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman.

VA's specialized programs for war wounds are said to be its reason for being. With new combat injuries occurring almost daily now, we have to coordinate these programs with state-of-the-art health care services. And research is essential to ensure the best quality outcome.

Programs to address the service disabled, such as blindness in particular, have run full circle. Once designed to serve the needs of young servicemembers, new VA programs now serve the aging veteran populations who have survived with these acute traumatic injuries. Veterans access these services for age related conditions or problems associated with these conditions. These programs now must be reassessed to ensure that we consider them again to meet the basic rehabilitation needs of a new generation of veterans who suffer from post traumatic stress disorder.

I think we will hear good news today regarding some important innovations that are being developed to address blindness and other disabilities in the VA and DOD. If necessity is the mother of invention, then war is sadly the crucible for innovation in treating traumatic injury. We have persons with us today who are providing some of the inspiration for developing effective treatments and de-

vices to restore the functionality veterans have sacrificed for this Nation.

Some of the investments the VA DOD and the private sector are making in new technologies could revolutionize amputee care and some of these advances may even have applications for veterans with Parkinson's and other neurological diseases. Unfortunately, VA's rehab program has had problems and can't resolve these overnight.

Staff vacancies and the lack of innovation in services are just beginning to be addressed by new leadership with VA's programs for visual impairment. Some veterans complain that VA's reimbursements are not the best to fund for prosthetics. We attempted to address the needs of a new generation of veterans, but we can't forget those veterans of past conflicts.

Yes, I think we can help and we are encouraged by the recent innovations and the dedication of VA and DOD to these missions. Mr. Chairman, I look forward to the testimony and your witnesses and I yield back to you at this point.

[The prepared statement of Congressman Evans appears on p. 65.]

The CHAIRMAN. Thank you, Mr. Evans. Dr. Snyder.

Let me welcome our first panel to the witness table, if you would. I will begin with Ms. Cynthia Bascetta, who is a director of Veterans Health and Benefits Issues at the General Accountability Office. For the past 4 years, she has led reviews of VA's budget and planning process and evaluations of specific programs in the Veterans Health Administration and the Veterans Benefits Administration. Before that she directed GAO's work on Social Security Administration's disability programs. Ms. Bascetta joined GAO in 1983 after beginning her career at the U.S. Department of Labor's Occupational Safety and Health Administration, where she prepared regulatory impact analyses of the major workplace health standards and has been a frequent witness and very helpful to this committee and to the Congress, I might add.

Dr. Michael Kussman was appointed Acting Deputy Under Secretary for Health for the Veterans Health Administration of the Department of Veterans Affairs effective April 6, 2004. After receiving his medical degree in 1968, Dr. Kussman began his military career in 1970, serving with the 7th Infantry Division in Korea. Some of his military decorations include the Distinguished Service Medal, Legion of Merit with three oak leaf clusters and the Order of Military Medical Merit. Dr. Kussman is board-certified in internal medicine and serves on the faculty of the Uniformed Services University of Health Sciences.

We have already heard the introduction by Rob Simmons of Penny Schuckers. I would just add that the program that she heads was awarded a 3-year accreditation from the rehab accreditation commission and was the first program ever, VA or non-VA, to be surveyed under the Blind Rehabilitation Standards in 2000 and 2003 and was found with no deficiencies. She was recognized this year as the distinguished Federal Manager, Connecticut Federal Executive Association.

We will then hear from Mr. Bruce Davis, who has been the Visual Impairment Services Team Coordinator for the Department of

Veterans Affairs Medical Center in Gainesville, Florida since April of 1986. He has 21 years of experience with the veterans center there and is responsible for planning, developing, implementing, and evaluating the VIST program. He received his master's in social work from Florida State University in Tallahassee, Florida.

We will, finally, hear from Nancy Strohm, who is the Visual Impairment Services Team coordinator at the VA Medical Center in Lebanon, PA. She has nearly 13 years of experience in her field and has previously worked at the medical center's Nursing Home Care Unit. Ms. Strohm received her master's in social work from Marywood College in Scranton, PA.

Ms. Bascetta, if you could begin with your testimony.

STATEMENTS OF CYNTHIA A. BASCETTA, DIRECTOR, VETERANS HEALTH AND BENEFITS ISSUES, GENERAL ACCOUNTABILITY OFFICE; MICHAEL J. KUSSMAN, ACTING DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; PENNY L. SCHUCKERS, CHIEF, EASTERN BLIND REHABILITATION CENTER AND CLINIC, WEST HAVEN, CONNECTICUT, VA MEDICAL CENTER; BRUCE W. DAVIS, VISUAL IMPAIRMENT SERVICES TEAM COORDINATOR, NORTH FLORIDA/SOUTH GEORGIA VA MEDICAL CENTER; AND NANCY J. STROHM, SOCIAL WORKER, VISOR COORDINATOR, LEBANON, PENNSYLVANIA VA MEDICAL CENTER

STATEMENT OF CYNTHIA A. BASCETTA

Ms. BASCETTA. Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity to be here today to discuss our work related to VA's rehabilitation services for legally blind veterans.

I would like to start with an observation about the contrast between VA's outmoded blind rehabilitation services and its state-of-the-art work with DOD on prosthetics for soldiers seriously injured in combat.

The mind-set at Walter Reed appears to reflect an intense focus on individualized care, not one size fits all, and a commitment to maximizing the capacity of injured soldiers to return to their normal lives. Certainly Blind Rehabilitation Centers, known as BRC's, remain a key delivery mode for blind veterans. Nevertheless, we are recommending the VA also reflect a more modern view of disability by making outpatient services more widely available to help maximize blind veterans' potential more efficiently and effectively. And I would like now to summarize the work that led us to this conclusion.

As you know, VA developed its blind rehabilitation program in the late 1940's to offer comprehensive inpatient training to young soldiers blinded in combat. Today, decades later, the demographics have shifted dramatically to a much older population experiencing gradual blindness caused by disease. As the veteran population ages, these services will continue to grow in importance.

VA estimates that there are nearly 160,000 legally blind veterans and about 44,000 of them are enrolled in VA health care. In 2003, 73 was the average age of veterans admitted for inpatient care at BRC's; 28 percent were over 80 years old. NIH cites age related eye

diseases as an emerging major public health problem with those 80 years of age and older, accounting for 69 percent of blindness.

Could blind veterans benefit from outpatient services? We believe so. During our review, we asked VA to examine the files of veterans waiting to be admitted to five of its ten BRC's. They found that 25 percent of these veterans could potentially be better served through outpatient services if such services were available. They included healthy veterans who required only limited or specialized training. Other veterans who are currently not being served include those who are frail and lack the stamina to participate in an intensive and lengthy BRC program as well as those who prefer not to leave their homes for long periods of time or who cannot leave because they are primary care givers.

The needs of these veterans could also be met on an outpatient basis closer to their homes or in their own homes. While VA made impressive gains in moving from hospital based care to outpatient care for its overall healthcare services, blind rehabilitation has lagged behind. This has occurred even though VA's own studies laid out the potential benefits of outpatient alternatives and the Congress and other stakeholders have noted the importance of increasing blind rehabilitation on an outpatient basis. The math on the highlights page shows the limited availability of these services, which are described in more detail in my written statement.

VA's past leadership of the blind rehabilitation program held a long-standing belief that services should be provided primarily in BRC's. Continued reliance on the inpatient delivery model is still evident in VA's recently announced plans to build two new BRC's without parallel attention to expanding the continuum to include outpatient care. Recently, however, VA has taken important steps to begin expanding outpatient services.

This spring, for example, VA set a goal of removing from BRC wait lists those veterans seeking admission for computer training only. As of July 1st, 52 out of 674 veterans, almost 80 percent, had been removed from BRC wait lists and scheduled to receive computer training if they still wanted it from non VA sources.

Another key step is the drafting of a uniform standard of care policy that calls for a full continuum of care, including more outpatient services, by VA's Visual Impairment Advisory Board. The Board also noted its concern that allocations are insufficient to cover the costs of outpatient blind rehabilitation and has been working proactively with VA's CFO to develop a new allocation amount to better reflect the costs. This could provide additional incentives for networks and medical centers to expand their blind rehabilitation outpatient services.

Mr. Chairman, this concludes my prepared remarks, and I would be happy to answer any questions that you or the other committee members might have.

[The prepared statement of Ms. Bascetta appears on p. 74.]

The CHAIRMAN. Ms. Bascetta, thank you very much for your testimony and for the excellent report you have produced and we will wait until all the panelists have concluded before we go to questions.

And Dr. Kussman, if you could proceed.

STATEMENT OF MICHAEL J. KUSSMAN

Dr. KUSSMAN. Mr. Chairman and members of the committee, good morning. I am pleased to testify today on the VA's blind rehabilitation program. VA's blind rehabilitation program is recognized as providing world class care to its veterans. It is a program designed to improve the quality of life for blinded and severely visually impaired veterans through the development of skills and capabilities needed for independent living, emotional stability, and successful integration into the veterans community and family environment.

Nonetheless, we are not without challenges to enhance and improve our services to continue to meet the needs of visually impaired veterans of the twenty-first century. As the veteran population ages, the demand for blind rehabilitation services has increased and VA has developed and enhanced the strategies to meet these growing demands. I know that a key interest of this committee today is how VA is meeting the blind rehabilitative needs of returning from Iraqi Operation Freedom and Operation Enduring Freedom service personnel with multiple energies such as traumatic brain injury, traumatic visual impairment and blindness.

As you know, VA clinical program offices are working collaboratively with the Department of Defense to assist with the training and integration services to meet the needs of all returning OIF/OEF service personnel and I am relieved to report to you today that the blind rehabilitative services that have been required by a very small number of returning service veterans so far, blind rehabilitation care has been provided to 11 patients who were injured in OIF/OEF time period. The number will undoubtedly grow and we stand ready and committed to support the special blind rehabilitative needs of these young men and women.

During the capital asset realignment for enhanced services CARES process, VA recognized the need for a change in its long-term strategy for blind rehabilitative services given the aging of the veteran population and the associated increase in demand for blind rehabilitative services. The CARES initiatives addressed the service provision needs and identified additional possible venues for blind rehabilitation programs thereby creating the opportunity to develop new strategies to reduce waiting times and waiting lists for Blind Rehabilitation Centers.

The CARES commission recommended that VA optimize access to care for veterans by continuing its commitment to inpatient programs while developing more outpatient based bond rehabilitation opportunities. The secretary greeted and supported the strategic emphasis on the importance of placing blind rehabilitation services closer to populations and in outpatient settings.

These efforts will be included in future planning guidance and will be incorporated into the fiscal year 2005 strategic planning submission. In addition, the secretary committed to opening of new inpatient Blind Rehabilitation Centers in Biloxi and Long Beach.

But we recognize that some access issues, such as waiting times issues raised by GAO, cannot wait for the CARES implementation process for resolution. Therefore, VA is working to improve access through multiple venues, including the use of innovative technology.

Computer Access Training, CAT program, is one example of that innovation. CAT teaches blinded veterans how to use the computer, e-mail and other automative assisted computer programs thereby increasing independence and function. The Rehabilitation Strategic Health Care Group and Prosthetics and Sensory Aid Services, SHG or Strategic Health Care Group, are working collaboratively to fund—to provide funds and contractors to bring CAT to veterans in their home area where feasible. VA believes this to be a cost effective alternative, which will reduce waiting times, increase access and benefit blinded veterans.

Blind Rehabilitation Centers are reviewing CAT enrollment lists to ensure that CAT will be provided locally in veterans' communities to ensure more timely access. VA also recognizes that a critical element to success in improving access in ensuring that there is appropriate alignment of financial incentives.

VA is currently restructuring the veteran's equitable resource allocation of their model to recognize the generally higher costs associated with blind rehabilitative care. We anticipate that this will realign incentives to support improved outpatient access. A recent GAO draft report recommended that VA improve the accuracy of reported waiting times for inpatient blind rehabilitation services and we concur with the report.

The report accurately conveys the current availability and complexity of reporting waiting times for admission to our Blind Rehabilitation Centers. VA concurs with the GAO's impression about the need for a systems approach to data management, which could reduce variability and provide greater consistency in reporting waiting times.

VA was aware of the issues and is developing a computerized blind rehabilitation national database that will track waiting times for all inpatient and outpatient blind rehabilitation patients. This database is in beta testing now and will be available system wide by September 2005. We anticipate that the database will significantly improve VA's ability to manage waiting times by improving the quality of waiting time data.

In the interim, VA has developed a compliance reporting requirement for Blind Rehabilitation Centers to improve accountability and accuracy for current data entry by medical centers. This new guidance will be published during the first quarter of FY 2005 and Blind Rehabilitation Center staffs are fully aware of these revisions.

Finally, I wish to bring to your attention VA's action to establish a vision for future rehabilitative care model for visually impaired veterans. VA's Visual Impairment Advisory Board, an Interdisciplinary Board of Providers, Researchers, Network Representatives and Consumers who advise the under secretary for health of matters related to the needs of veterans with vision impairment, has identified treatment of severe visual impairment as a critical need for the veteran population and has charted a path for VA to address those issues.

We have comprehensive, internal census. We have done an internal census for existing eye care and rehabilitation processes, infrastructure and staff. The primary focus of this effort was to conduct a gap analysis. This preliminary report, which was delivered on

July 8th, and the review board is now reviewing it. This review is expected to be completed by mid 2005.

The VIRB, the review board, will then report its findings to the health systems committee for further evaluation. The proposed continuum of care model of services enhances the quality of care and VA's ability to provide greater access to high quality vision rehabilitation services in the right place at the right time.

This continuum of care is the lynchpin of the VA's blind rehabilitative care model that will directly address GAO's recommendation that VA define a standard of care for blind rehabilitative services. The continuum of care model forms the foundation for the standard of care and sets the vision for the future. The comprehensive vision rehabilitation services being developed by the VA are a model for national vision blind rehabilitation plans.

We are committed to providing the highest quality of care for veterans requiring blind rehabilitative services. This concludes my testimony and I welcome the opportunity to respond to your questions. Thank you.

[The prepared statement of Dr. Kussman appears on p. 94.]

The CHAIRMAN. Thank you very much, Dr. Kussman. Ms. Schuckers.

STATEMENT OF PENNY L. SCHUCKERS

Ms. SCHUCKERS. Mr. Chairman and members of the committee, it is an honor to speak with you today in my role as chief of the Eastern Blind Rehabilitation Center. Thirty-five years ago a sociologist named Robert Scott published his research on America's blindness system.

The CHAIRMAN. Pardon me. Would you just press the button on your mike. Okay, go ahead.

Ms. SCHUCKERS. Thank you. Should I start over? Thank you. Good.

At that time, he concluded that only the rehabilitation training provided by the VA allowed nearly blinded adults to regain their independence. In this way, it makes sense. These key techniques and travel skills, now the international standard, were first developed in the VA system. Over the past 35 years, we are proud of how our service to the blinded veteran has evolved in response to the changing needs and technological advancements.

Coincidentally, the same year as Scott's landmark publication in 1969, the Eastern Blind Rehabilitation Center became the third blind rehab center to open. Last Thursday, the EBRC hosted an alumni reunion to celebrate its thirty-fifth anniversary.

Today our 34 bed centers serve 16 states. We have 27 blind rehabilitation instructors and provide full-time nursing coverage. We have three blind rehabilitation outpatient specialists stationed in Boston, West Haven and Baltimore. Our regional consultant oversees the service delivery of 42 VIST coordinators. We pride ourselves in our dedicated staff, strong programs and leadership in excellence to care for our blinded veterans needs in the most appropriate way possible.

In 1969 and through the early 1970's, the EBRC served a veteran population, which included young, totally blinded Vietnam veterans. Many wanted to return to work or to school and to con-

tinue to support their families. The state of blind rehabilitation was limited. Low vision, electronic aids and computers were all but non-existent.

As the 1970's progressed, the Eastern Blind Rehab Center veteran population technology and blind rehabilitation began to change. Vietnam veterans returned for refresher courses and to attempt the state-of-the art technology such as the now defunct sonic guide for mobility. Low vision used the first closed circuit televisions; our researchers worked with the private inventor named Kurzweil who developed an experimental machine, which recognized and spoke written text.

In the 1980's, the age of the newly blinded veterans increased to fifties and sixties. The majority, although still legally blind, had some useful vision. More specialized optical aids were available in low vision, braille was taught for labeling, not reading, as cassette recorders were used for note-taking.

In the 1980's, the EBRC's average length of stay shortened to 3 months. In the 1990's, our blinded veterans continued to get older, averaging in their sixties and seventies, and more female veterans appeared. Most were blinded from diseases related to aging. More had severe physical impairments and many exhibited memory or cognitive decreased memory or cognitive functioning. We increased nursing staff to ensure 24 hour skilled coverage. Electronic and computerized aids for the blind increased and the EBRC began to evaluate and prescribe the most promising of these devices.

In 1993, we created a department devoted solely to this speciality, the computer access training program. Through the 1990's, the EBRC's length of stay continued to shorten now averaging 2 months. There were modified techniques for wheelchairs and mobility challenged veterans and increased touch typing instruction to better prepare the many veterans for those who wanted to continue onto the computer access training program.

In 2000, the EBRC became the first blind rehabilitation in the United States to receive full accreditation from the Council on the Accreditation of Rehab Facilities. We also earned full accreditation with no deficiencies again in 2003. In the past 3 years, the EBRC experienced an unprecedented shift in its veteran population.

Never before have we experienced the age disparity of our inpatient population. Many veterans are the oldest we have ever had, in their eighties and nineties, but we also are seeing the youngest in 25 years. Our talented staff is eager to provide rehabilitation training concurrently to both the old and young veterans even though they have extremely disparate needs and abilities.

We also refocused our local outpatient training to improve service delivery. Some veterans are tracked directly into our outpatient low vision training; some into more expanded BROS training to obviate the need for inpatient training and some directly to admission to the EBRC.

Quality, veteran choice, continuity of care, and increased independence for each blinded veteran continue to be our foundation and our guide for the future. At the EBRC, we will continue to explore and evaluate training alternatives and best practices for our ever-changing veteran population.

Thank you for this opportunity to present an update of our programs and quality improvements that are going on at the Eastern Blind Rehabilitation Center. At 35 years of service, we are still in our prime.

[The prepared statement of Ms. Schuckers appears on p. 105.]

The CHAIRMAN. Ms. Schuckers, thank you very much for your testimony and for your fine work.

Mr. Davis, if you would proceed.

STATEMENT OF BRUCE W. DAVIS

Mr. DAVIS. Thank you, Mr. Chairman. Mr. Chairman and members of the committee. For the past 21 years, I have been the Visual Impairment Services Team Coordinator at the Malcolm Randall VA Medical Center in Gainesville, Florida. The North Florida/South Georgia Veterans Health System is committed to providing quality services to our blind veterans. In 1983, we had identified a total of 275 legally blind veterans. Those veterans were served by two part-time VIST coordinators.

As of July 12, 2004, we had identified 1,114 legally blind veterans within the North Florida/South Georgia veterans health care system. They are currently served by three full-time VIST coordinators, two part-time VIST coordinators and one full-time blind rehabilitation outpatient specialist. My personal caseload is comprised of 454 legally blind veterans.

As the VIST coordinator at the Gainesville VA Medical Center, I am responsible for coordinating the efforts of a multi-disciplinary team to provide comprehensive medical and rehabilitative services for the blind. We work to identify the legally blind veterans in our primary service area and invite them to participate in the services provided by the Department of Veteran Affairs. This is accomplished by an active outreach effort to local and state agencies that work with the visually impaired as well as with other consumer advocate groups.

We also work with medical center staff to identify and refer veterans with visual impairment to the VIST program. We invite all veterans to participate in the annual VIST review, which is comprised of a medical examination, eye examination, hearing screening and a psycho social assessment.

During the VIST review, we assess the veteran's adjustment to vision loss, his or need for blind rehabilitation and his or her need for adaptive equipment. We also review the veteran's eligibility for VA compensation, pension and other benefits. Based on these findings, referrals are then made to VA blind rehabilitation programs, local blind rehabilitation training with our BROS, low vision services, veterans benefits, prosthetic and sensory aids, medical subspecialties and other local and state benefits and services as indicated.

I serve as the point of contact for the blinded veteran within the medical center. I assist the veteran and their families with the establishment of primary care, coordination of appointments, prosthetics requests, pharmacy concerns, eligibility questions, VA benefits, travel consults and other requests for services.

I run two support groups for blinded veterans to help them and their families adjust to their vision loss. These groups meet month-

ly at the Gainesville VA Medical Center and at the Florida Center for the Blind in Ocala. We have a variety of speakers present information on topics ranging from the causes of vision loss to veteran benefits. We sponsor activities that allow the veterans to reintegrate themselves into the activities which they may have given up due to their vision loss. These have included an annual bowling activity, support group luncheons and deep sea fishing trips.

As a subject matter expert on blindness within the medical center, I conduct ongoing in-service training to eye care professionals, nursing staff and other medical center personnel. I also meet regularly with state and local agencies for the blind as well as fraternal organizations, such as the Lion's Club, to inform them of VA services for the blind. I also provide ongoing consultation for the part-time VIST coordinators at the Tallahassee and Daytona Beach outpatient clinics.

In an effort to reach out to the community, we have sponsored an annual visual awareness day open house. We invite agencies, veteran service organizations and private vendors that work with the blind to display their services and adaptive equipment.

We work closely with the State Division of Blind Services, WUFT Radio Reading Service and the Bureau of Braille and Talking Book Services to invite both legally blind veterans and other visually impaired citizens from throughout North Florida and South Georgia to attend. The open house is also available to all VA employees and allows them an opportunity to learn more about visual impairment and the services that are available to assist the blind in leading more productive and independent lives.

We are working with an aging veteran population. There is a positive correlation between the incidents of blindness and age. Sixty-nine percent of our legally blind veterans at this time are over the age of 75. This shift in demographics has required our VIST program to identify alternative methods of providing rehabilitation services for our veterans.

We currently have one blind rehabilitation outpatient specialist who is providing training for those veterans who are unable to participate in one of the VA residential blind rehabilitation programs. She also works with those veterans who are returning from the VA blind rehabilitation programs to help them reintegrate those newly acquired skills into their home setting.

The North Florida/South Georgia Veterans Health System recently funded a new full-time VIST coordinator position at the Lake City Division to help meet the needs of the veterans in North Florida and Southern Georgia. This has allowed these veterans to receive services closer to their home instead of traveling to Gainesville for VIST services.

The VIST program at the Gainesville VA Medical Center is working to implement enhanced services that will provide—that will improve patient safety. We are working with the pharmacy and prosthetic departments to implement script talk which will allow blind veterans to independently identify their medications. We are also implementing a means to provide computer access training with the local agencies for the blind and other vendors in an effort to shorten the wait list for those services at the regional VA Blind Rehabilitation Centers.

Mr. Chairman and members of the committee, I have tried to give a few examples of the spectrum of rehabilitation services that we provide at the Gainesville VA Medical Center and I will be happy to answer any of your questions.

The CHAIRMAN. Mr. Davis, thank you very, very much for your testimony.

Ms. Strohm.

STATEMENT OF NANCY J. STROHM

Ms. STROHM. Mr. Chairman and members of the committee, I have been the Visual Impairment Services Team Coordinator at the VA Medical Center in Lebanon for the past 9 years. I am here to provide you with an overview of the visual impairment services outpatient rehabilitation program, better known as VISOR.

The VISOR program was developed in response to the needs of local veterans. In the summer of 1998, the leadership of the Blinded Veterans of Pennsylvania, Incorporated, suggested that Lebanon might open up a facility like West Haven. I sent them to Charlene Szabo, CEO, who listened and asked for a proposal. After reviewing it, she suggested that we might be able to develop a less costly alternative that would still meet their needs.

Following the review of various service delivery models nationwide, an outpatient program with a residential component was proposed. Our stakeholders and leadership in VISN 4 supported the proposal. The VISOR program is the treatment segment of the VIST program at Lebanon. Because each veteran has unique needs and circumstances, there are three treatment modalities along a continuum of care offered within the VISOR program. They include the VISOR outpatient clinic, VISOR home care and VISOR HOPTEL, an intensive 10-day residential program.

The VISOR team is made up of five professionally trained blind rehabilitation specialists, including myself, who cover the core disciplines of blind rehabilitation. Certain members of our team are also competent in social work and recreation therapy. Together, we attempt to help veterans and their families return to activities they participated in and enjoyed before vision loss became debilitating.

The three-part VISOR model ensures that veterans receive the right care in the right place. Assessments, treatment and yearly follow-up all take place within the clinic at the pace that is right for the veteran. A total of 333 different veterans were treated in the VISOR outpatient clinic so far this fiscal year. When necessary, veterans may also be assessed and treated in their homes through VISOR home care. So far this fiscal year, the VISOR team has done 100 home visits.

To be eligible for the VISOR HOPTEL program, veterans must be legally blind and capable of self care to safely occupy the HOPTEL. They are also expected to be in good enough physical condition to withstand the rigor of the intensive VISOR curriculum. One hundred seventy veterans have completed this program since July 2000. Veterans who do not qualify are treated with individualized programs within the VISOR outpatient clinic.

The VISOR HOPTEL program begins on a Monday with family involvement. The veterans and team work throughout the weekend so that newly learned skills can be reinforced. Each day begins

with group therapy and ends with some type of recreation. Veterans are taught the core courses in groups, one to one and are given independent assignments that help to enhance their sense of self-esteem.

A support group on the ninth day includes former VISOR graduates, which help participants to transition to an ongoing support network. This type of group is run simultaneously for family members as well. A typical veteran who participates in VISOR HOPTEL has macular degeneration and is over the age of 74. Veterans have reported that they are extremely satisfied with their care.

An analysis of data by the blind rehabilitation outcomes project indicates that the VISOR HOPTEL model is efficacious for these types of veterans. We are particularly proud of the rates of change veterans make in the areas of reading mail or newsprint, paying their own bills, assembling and measuring things, communicating in writing and orienting themselves to unfamiliar environments after completing the VISOR HOPTEL program.

Comments that are symbolic of sentiments shared by veterans and family include: "This program gave us hope," "It gave us a sense of security and mobility," "I have been able to do home repairs that I wouldn't have thought of doing before I came to VISOR," and "Thank you for giving our father back to us."

Mr. Chairman and committee members, I have attempted to provide you with an understanding of the VISOR program and the variety of interventions on the continuum of care that are needed for veterans who are visually impaired to achieve independence, have confidence restored, resume life roles and lead an enjoyable life. I would be pleased to answer any questions that you may have. Thank you.

[The prepared statement of Ms. Strohm appears on p. 109.]

The CHAIRMAN. Ms. Strohm, thank you very much for your testimony, as well.

Let me just begin the questioning. Ms. Bascetta, some of the witnesses who will testify later today expressed the grave concern about the possible delusion of abilities at the BRC's because of the establishment of outpatient clinics.

As a matter of fact, Tom Miller, executive director of the Blinded Veterans Association, makes it plain, and I quote him briefly, "The reader of this report could be left with the impression that the BRC is not the most effective model for service delivery. It is absolutely essential to understand that the overarching purpose of the comprehensive residential BRC program is to assist the severely, visually impaired veteran with acceptance and adjustment to vision loss."

He goes on to say, "It has been clearly demonstrated over the past 56 years that the comprehensive residential training environment facilitates the process of acceptance, adjustments and skill acquisition. Any criticism BVA may have for long wait times or lists should be in no way construed as minimizing the importance of or the need for the comprehensive residential BRC's."

I raise that because I think there is a tension, it could be a constructive tension, it could lead to, you know, more of both. As you pointed out, Doctor, there is already envisioned a CARE center, a blind rehab care center for Long Beach and Biloxi in your testi-

mony, and I think that it shows that there appears to be no backing off from those very important centers.

But, you know, as we expand in other areas, I would hope that there would not be any kind of diminution for the centers. You might want to comment on that and Ms. Bascetta as well.

Ms. BASCETTA. Well, I would certainly reemphasize, as we did in our written statement and as I said in my oral statement, that the inpatient component is clearly critical. It is the most intensive component on the continuum. We are simply making the point that the lack of availability of services on the outpatient side creates inefficiencies and ineffectiveness in VA's ability to treat more veterans and to treat them in a more tailored way suitable to their specific needs.

Dr. KUSSMAN. Mr. Chairman, I highly agree with your statement, that clearly we are committed to expanding and continuing the inpatient, but at the same time, the GAO is correct and we are looking at expanding the continuum of care looking at the proper level of care and the proper place at the proper time and that is what part of our gap analysis is and we are confident that we will be able to maximize the appropriate place for our patients along that continuum of care.

The CHAIRMAN. I appreciate that. And you know, my concern isn't that necessarily it would be by design, but it might be because of shrinking budgets or inadequate budgets that could lead to that. And I think perhaps that is what Mr. Miller, who also wanted to get across—at least as I read his testimony—that we fight for every dollar for a veteran's health care. We do it in a bipartisan way, but difficult choices are made when you are left with insufficient resources and then the choices might end up being that the centers take a hit.

Let me just ask you, Ms. Bascetta, have you reviewed the VA's new approach to waiting time management? Do you agree that this will solve the problem?

Ms. BASCETTA. I haven't reviewed the new approach.

The CHAIRMAN. Okay.

Ms. BASCETTA. No, but I would be happy to do that.

The CHAIRMAN. Could you? And provide us as well with whatever your analysis might be?

Ms. BASCETTA. Certainly.

The CHAIRMAN. I appreciate that. Let me just ask one final question because we do have a large roster of members who I am sure want to ask questions in four panels today. John Fales, the president of the Blinded American Veterans Foundation makes the point in his testimony that "Amateurs and new comers not attuned to the field of rehabilitation and those who think they can save public money with their so-called new ideas are actually going back to the practices of the past that have consistently failed for decades. Years of decentralization have devastated the VA blind rehabilitation services by reckless local micro management."

I wonder would any of you want to comment on that? Dr. Kussman, you might want to take the first crack at it. Decentralization, has it led to—are the VISN directors, are the medical directors perhaps not doing all that they can do? I mean, we have

three fine examples today of people who have made it a priority and have done an exemplary job, but is that uniform?

Dr. KUSSMAN. With all due respect to the testimony you alluded to, I believe that all the VISNs and the facility directors are committed to supporting our program. As I mentioned in my testimony, we are trying to readjust the VERA allocation to be sure that more dollars go to support, on an individual basis, support a blind rehabilitation. Obviously, as, Mr. Chairman, you mentioned before, there are challenges in a resource constrained environment, but clearly we are committed to doing that and the VERA, change in the VERA allocation is a tangible evidence of that I believe.

Ms. BASCETTA. I would agree with that. I would simply point out that as you know the VERA model is an allocation model, it is not a reimbursement model, and that networks in the medical centers have discretion to use their allocation as they see fit.

Florida is a good example of a network that despite the current allocation model, has moved heavily into the outpatient area and that would be, I presume, because the leadership in that network has decided that that is a more appropriate way to serve those veterans. But certainly in a resource constrained environment, those decisions are being made by the networks and the medical centers.

Mr. DAVIS. I just wanted to concur with that. In VISN 8, the Sunshine Health Care Network, we have been able to expand our program adding two additional BROS in the Tampa as well as the Orlando clinic and we are currently in the process of developing a VISN 8 strategic plan, which will address those needs, the inpatient as well as the outpatient.

Ms. SCHUCKERS. If I could, just quickly, part of my leadership training that Congressman Simmons had talked about was a project that worked with the VERA allocation for blind rehabilitation. And in the research that I did and that was accomplished with that, we found that the allocation model for the inpatient program was fairly accurate and it worked, but the outpatient model was not supported as well with the allocation. So we made a recommendation that that allocation be kind of shifted slightly. And we think that it is going to be much better in terms of helping to provide the initiative to support these kind of outpatient blind rehabilitation programs. So we look forward to that.

The CHAIRMAN. Gotcha. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. I think I will hold my remarks until the end and ask the same request.

The CHAIRMAN. Without objection, the opening remarks will be made a part of the record.

Mr. EVANS. Thank you.

The CHAIRMAN. Chairman Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman. I have a question for Ms. Schuckers. In reviewing her testimony on pages 2 and 3, she details a very dramatic improvement in technologies for dealing with the blind. We start back in the 1970's with what I would consider the traditional mobility, braille and adjustment types of programs, and then as we progress through her testimony, we get the computer access training program, we get voice recognition systems, digital recorders, stay at home training. I mean, it seems to represent a rapid development of technology, which is very helpful

in dealing with the multiple cases that we encounter with veterans and blindness.

And I have a particular chauvinistic pride, I guess, in Connecticut and West Haven and I expect that they are doing these great things, but then my question goes to the system. How are the other VISN's and some of the other blind centers keeping up? Are they all at the same standard or is there a variation without the system—throughout the system and do we need to focus a little bit on how we can export some of this progress and some of this technology to other parts of the country.

Ms. SCHUCKERS. Obviously I can speak mostly for Connecticut because that is the blind center that I work with, but I do know that we work very closely with the other blind centers, the chief state and touch on a, you know, monthly basis, conference calls. We also do an annual national training. So we try to make sure that—the goal is that if a veteran gets care in Tucson, Arizona, they are going to get the same kind of access to the technology and access to the training that they can get at West Haven, Connecticut or, you know, whatever blind center they go to, they can get that type of care.

It is something that as blind rehabilitation professionals, they are trained, they have a master's level degree. It is actually a master's in education, special education with the emphasis in blind rehab. So the training is there, it is available. We encourage professional growth and development and I think that it is there for the other blind centers.

Mr. SIMMONS. Thank you very much and are there components to these technical advancements that needs support from us by way of pilot projects or special investment? The answer is yes.

Ms. SCHUCKERS. The answer is yes. Absolutely. More than yes. Absolutely. We are always looking forward. VA blind rehab is, as I alluded to in my testimony, has been and is still a national/international leader in the development and part of our mission is to make sure that what we do is help to provide this even, you know, into the community and share the things that we learn and share the research and share the evaluations that we do. So we are there and doing that right now and absolutely, your support is much appreciated.

Mr. SIMMONS. Thank you very much, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you very much.

Dr. Snyder?

Dr. SNYDER. Ms. Bascetta, your recommendation for standards of—a uniform standard of care policy that the VA has agreed to, if I was a veteran with visual impairment, would you explain to me how my life would be—explain to me what my life is like today that would be different once the VA does what you recommend they do.

Ms. BASCETTA. Well, I think the most important goal of the blind rehabilitation program, whether the services are delivered on an inpatient or an outpatient basis, is to maximize the functional capacity of the veterans by helping them use, as best as possible, whatever sight they might have and that the bottom line goal is that they can live as independently as possible.

Dr. SNYDER. That didn't answer my question, though. Take me as a veteran today. You are recommending a change. Describe for me what services or how my life—what my life is today that is going to be changed when your recommendation—how will it be different after your recommendation is fully implemented?

Ms. BASCETTA. I see. Right now your choices would be much more limited as to where you could receive the blind rehabilitation training. VA spent about $56 million on inpatient services; only about $5 million on outpatient.

With our recommendation, there would be much more flexibility for a veteran to receive care closer to their own home on an outpatient basis, perhaps even in their own home, perhaps by VA partnering with state and nonprofit providers in the local community if VA doesn't have the services in-house in particular locations. So we would hope that there would be much more flexibility for a veteran needing this kind of assistance to achieve their goal of independent living more quickly and more efficiently.

The CHAIRMAN. Thank you very much, Doctor.

Ms. Berkley.

Ms. BERKLEY. Thank you, Mr. Chairman. Could I ask that my complete remarks and opening statement be submitted for the record.

The CHAIRMAN. Without objection, yours and any other member's will be made a part of the record.

[The prepared statement of Congresswoman Berkley appears on p. 67.]

Ms. BERKLEY. Thank you. Thank you all for being here. I appreciate your coming in and talking to us about these issues.

In Southern Nevada, the community that I represent, there are 424 legally blind veterans that are receiving care at the VA. Although Southern Nevada's VA has a blind rehabilitation outpatient specialist, and I believe we are one of 23 in the entire VA health care system, and we also have a Visual Impairment Service Team coordinator, it is still unable, the VA is still unable, to provide all the services to all blind veterans in need.

Consequently, about a hundred of our Southern Nevada blind veterans travel over 400 miles to Arizona's Southwest Blind Rehabilitation Center. These veterans are going to spend an average of 4 weeks to 6 months away from home, away from friends and family, to learn the skills necessary to live as independently as possible.

As you probably all know, the VA in Southern Nevada is scheduled to receive a full service hospital outpatient clinic and long-term care facility. We are optimistic that when this new medical complex and campus is built, we are going to have the ability to expand services to include more local training services, such as short stay blind rehabilitation programs.

I think, Doctor, if I could ask you, do you envision when our VA medical complex is completed that we will be able to keep our blind veterans at home for the services that they need?

Dr. KUSSMAN. Yes, ma'am. I don't know the specifics, obviously, about the numbers you just quoted, but I mean clearly, as mentioned, our goal is to provide the right level of care at the right price at the right time and to expand our capabilities at the local

level so veterans don't have to travel as far as you just mentioned. Any specifics about a blind rehab center in Las Vegas would certainly have to be looked at in conjunction with our gap analysis of where we are going to go, but certainly we hope that with the new facility and our continuum of care plan, we will be able to expand the capabilities at the local level.

Ms. BERKLEY. Could you tell me who I would go about—who I would talk to regarding this issue because as long as we are building this from scratch, we might as well put it in at the beginning.

Dr. KUSSMAN. I will be happy to carry that message for you.

Ms. BERKLEY. Would you tell me who you are carrying it to so I could follow up?

Dr. KUSSMAN. I am sorry?

Ms. BERKLEY. Could you tell me who you are going to carry my message to so I could follow up? Who is in charge that I would talk to them about this?

Dr. KUSSMAN. Well, there is a mix of people. Clearly our special—and our chief consultant related to blind rehabilitation, Mr. Crawford, myself as the acting deputy under secretary, Dr. Perlin as the under secretary. So we will all look at that and Ms. Miller, who is the deputy under secretary for operations and maintenance, will look at that, and be happy to get back to you.

Ms. BERKLEY. That would be great. Thank you.

Dr. KUSSMAN. Yes, ma'am.

Ms. BERKLEY. Ms. Bascetta. Hi, how are you? I am kind of curious. Given the fact that we are going to have this new medical complex and we are talking about outpatient services for the blind, which will give more flexibility and different types of services available, how would that—and I think maybe Congressman Snyder asked this question, but how does that help my veterans that are having to leave now for a number of weeks or months? How would those additional opportunities help the veterans that I represent, the extra—well, the 424 that are receiving care already, but the hundred that have to leave the community in order to get the services they need.

Ms. BASCETTA. Right. How I would respond is that I would like VA to be able to provide information regarding how many of the patients that are currently targeted for the BRC, for the inpatient care, how many of them could be better served with outpatient services. We did find that there were not an infrequent number of times in which an outpatient service would obviate the need for inpatient care or sometimes if it doesn't completely obviate the need, it could at least give someone some service in the short run that could help them live more independently or meet one of their essential needs.

So while if you have veterans who definitely need the inpatient care, right now I think the closest place to Nevada is Palo Alto or Tucson. Those outpatient services, at least in the short term, would help them out.

The CHAIRMAN. The chair recognizes Ranking Member Rodriguez.

Mr. RODRIGUEZ. Thank you, Mr. Chairman.

Let me ask you, I think one of the things that the CARES proposal talked about was the disparity of services throughout the Na-

tion, that one of the things that we found was that depending on where the veteran resides, that determines the types of services that he gets or doesn't get. I want to get your feedback.

I recall distinctly in the 1970's when we talked about mental illness and about trying to come up with less restrictive environments, independent living—taking care of people at home. How do we make sure that people don't fall through the cracks? Because in all honesty, as far as I am concerned, a lot of the homeless, a good number of them, are people that suffer from mental illness that fell through the cracks.

How do we make sure we are not doing the same thing? As we try to provide independent living and all that kind of stuff we have to make sure number one, people get access to the service and two that we continue to monitor to make sure they don't fall through the cracks.

Especially now, because I am convinced that we are getting more soldiers today that come back with more serious injuries that maybe before—I hate to say it this way—used to get killed. Because of their protective gear, now they don't get killed, but they come back with more serious injuries and serious illnesses. Thank God they are living, but it is also our responsibility now that they are not falling into a trap. Unfortunately, the mental ill and homeless that reside throughout the country that are out there in the streets and that we have, in all honesty, become careless to.

Dr. KUSSMAN. Yes, sir, it is a complex question, but as you are probably aware of, individuals related to OIF and OEF that are suffering disabilities that clearly make them enter the disability process of the military, we are case managing these patients with processes that we put in place that are new for the VA or we are putting our social workers in military facilities and points of contact that all our VA facilities, both from our regional offices for the VBA and the VHA to, lack of a better term, micro manage, if you will, and case manage those cases and enrolling them in the VA and being sure that they get the full spectrum of care that they need as they transition along the continuum of care from DOD to the VA.

So I certainly have great expectations that people who are injured and some of the very complex cases that you described because they are surviving because of the body armor, we will be able to be sure that they do not fall through the cracks and get the full spectrum of service that they need.

Mr. RODRIGUEZ. Let me just add you mentioned case management. When I first got elected, my first experience, I have to share this with you, you did have case managers. My staff was new and we didn't know all the procedures, so I said, "Well, I don't know. Let's see what we can do." We called and I personally called. We had to ask for an investigation because we would, you know, we would send you data and you did away with the case managers and we never received a response.

It turned out that a lot of our staff did a lot of the case management for the VA system because of the fact that we, in Congress, cut back on that case management for the initial services. Somehow we have to make sure that we do the right thing on this. Sure, we want to bring down the cost and be more cost effective in terms

of taking care of somebody at home, and I agree it is more humane, but we have to make sure that we don't forget the mission there. For those that reside in rural America, how do we deal with that?

Mr. DAVIS. When the Visual Impairment Services Program was initially created back in 1966, it was created with this in mind and throughout the country at each medical center where there is a Visual Impairment Services Team coordinator, that is our role and function is to maintain that annual contact and additional contact, as needed, throughout the course of the year for those blind veterans and that—as well as case managing the, you know, those new veterans coming into the system.

Mr. RODRIGUEZ. Do you have any idea how many case managers we have and that their case loads are right now?

Ms. SCHUCKERS. Yes. Right now we have a hundred and sixty-four VIST coordinators out there in the country either full-time or part-time. There are only 27 facilities that do not have Visual Impairment Services Team coordinator whose primary job is identifying the blinded veteran and case managing that blinded veteran and ensuring that they get into the right care. So I think that those people are out there to do that job.

Mr. RODRIGUEZ. Thank you.

[The statement of Hon. Ciro D. Rodriguez appears on p. 69.]

The CHAIRMAN. Ms. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman, and thank you all for being here. You mentioned earlier the disparities in age at the hospitals, and I know that we have many returning servicemembers from Iraq who are obviously much younger than the 80 or 90 year olds that you mentioned. What kinds of problems are there in treating them together and have they considered bringing perhaps the younger service—younger servicemembers from Iraq together in a group largely because they really look to one another for support, for help, encouragement. How is that working and what are we—what other thoughts are you having about that?

Ms. SCHUCKERS. I can speak specifically for Connecticut. We have had four of the Iraqi Freedom time period veterans with us, soldiers, and it is a small number. So it is very difficult to say, well, we will bring them all in at the same time because their needs may be—the serviceman may be needed at different times. So that is one thing.

Another thing, though, is that I can tell you that one patient that we had who came in. He was a younger veteran, a younger soldier. Very active. It was a parachute accident in training that caused his blindness and he was with us for about 8 weeks. During that time, he made friends with some of the even the older veterans and when he left at his exit interview that I do with the veterans, he said to me how much he learned from the older veterans and how they were role models for him and that he was gathering their e-mail addresses so they could stay in touch by e-mail.

Whenever possible, of course, we try to bring in more active patients all at the same time or a younger veteran with another younger veteran if we can. It is not always possible. The training—the basic blind rehabilitation training is pretty much the same though. We just try to individualize that care plan for that patient to whatever his actual needs and his goals.

If he wants to go back to work, we will definitely push him towards the computers and towards some of the other things. If he is—you know, whatever the goal is, that is what we try to work with him on. So for right now, it is working for us. If, in the future, we can do something more, we would like to.

Dr. KUSSMAN. If I could just add to that. We are well aware of the potential necessity of watching that very closely. As I mentioned in my testimony, so far we have only had 11 people who have transitioned in the continuum care from DOD to us. If need—there clearly is benefit for having a conservation of putting people together, particularly their own age group.

We have been sure, as was mentioned, that they get a special attention to be sure that they—our staff, wherever it is, emphasize and maximize their needs that might be different than the 80 year old or the 70 year old, but if indeed the numbers increase or there was any indication that there would be a benefit to have one centralized place, we certainly would consider that, but right now it appears that it would not be a benefit because of the small numbers, but we are also making sure that each case is individualized and we are watching that very carefully.

Ms. SCHUCKERS. The other key is family support. I am sorry. The other key is family support. And as the Congresswoman from Southern Nevada had talked about, that is really a critical component. If they are traveling, you know, to—they are from the east coast and they have to travel to a place on the west coast for that care, that is really hard.

And again, you know, just from our work at Connecticut, we had one patient who that was his goal was to be closer to family as well and the family came in and helped to learn—and they learned what his disability was and really helped him to get through this.

Mrs. DAVIS. You know, you may have answered this question earlier, but is the VA having difficulty in finding blind rehabilitation counselors? I understand that that is a concern and what is being done to—for outreach recruitment training and within the blind community as well?

Dr. KUSSMAN. The answer is yes. I mean, we have some holes and that we have recruiting actions out. We have looked at that and we believe that from a salary perspective, we are very competitive around the country for that. So it is not a dollar issue and certainly we would be willing to consider anything to get what we need and to make ourselves competitive. But it really is a resource availability issue and we are working with all the places that train people to do this to encourage people to come.

We believe we have an environment under which it is very good to work if you are one of these specialties and we just need to recruit and be aggressive about that and we are doing that.

Mrs. DAVIS. Thank you. And going to the electronic database and the sharing of that information, how is that going for you as well because we are looking at that seamless transition in terms of sharing data and being able to collect it. What are the problems that you are encountering?

Dr. KUSSMAN. Well, with the individual servicemembers who are significantly damaged with their sight or other injuries, we believe

we have a pretty good handle on that because as I said, we are case managing them as they move from the DOD to the VA.

We are working very aggressively and diligently with DOD to set up the electronic transfer of information and we hope it won't be too much longer where we can have that easy flow of electrons so we can track people as they move from one system to another.

Mrs. DAVIS. But now you are working without it, basically.

Dr. KUSSMAN. Yes.

Mrs. DAVIS. Yes. Okay. Thank you.

The CHAIRMAN. Ms. Brown?

Thank you, Ms. Davis.

Thank you. I just thank our distinguished panel for your testimony and for your leadership. We greatly appreciate it and, you know, it helps us, in a bipartisan way, to do a better job in writing law and doing our critical function of oversight. So we do thank you and look forward to this partnership going forward. Appreciate it.

I would like to now invite Panel 3, if you don't mind us going out of order here, and I apologize to Panel 2 in that we just noticed that in the interest—this hearing today is really a double-hatted hearing.

We were briefed very recently—when this hearing on blinded VIST was already in the works, we were briefed about the extraordinary partnership between Walter Reed and DOD on research and this collaboration and with a limited number of days before the district work period.

We thought somehow we have got to—we have got to get the good news out and get this on the record and also to thank our men in uniform who have suffered who are here with us today to tell their stories briefly as well. So we have actually put two hearings into one and so I want to thank our witnesses for their patience and we will go to Panel 3 at this point.

Beginning with Dr. Brett Giroir, who is the deputy director of the Defense Science's office of the Defense Advance Research Project Agency. He is board certified in pediatrics and critical care medicine. Dr. Giroir served for 5 years on the Defense Sciences Research Council and currently serves as a member of the Department of Defense Steering Committee on human studies and a member of the external advisory board for NASA's National Center for Space Biology

We will then hear from U.S. Army Lt. Col. Paul Pasquina. Dr. Pasquina currently serves as the residency program director and chief of physical medicine and rehabilitation, as well as medical director, of the amputee program at Walter Reed Army Medical Center. Dr. Pasquina received his medical degree at the Uniform Services University of Health Sciences. In addition to being certified in physical medicine and rehab, he is also sub speciality board certified electro diagnostic medicine as well as pain medicine. Dr. Pasquina served as the director of the lab amputee clinic ambulatory care clinic inpatient service in the Department of Physical Medicine and Rehabilitation.

We will then hear from Mr. Charles Scoville who is the current program manager for the U.S. Army amputee patient care program. His most recent assignment, prior to retiring from the Army in 2003, was as chief physical therapist, Army Medical Specialist

Corps, and consultant to the surgeon general U.S. Army. Mr. Scoville has presented nationally and internationally in an variety of physical therapy related topics, has over 10 reference articles and is a recipient of the American Orthopedic Society for Sports Medicine, the 2002 O'Donoghue Award.

The committee is also pleased to introduce some very special witnesses, I say to my colleagues, apparent today who will be available to answer any questions of members. Sometimes, you know, we think of war and what Congress and this committee can do. In abstract terms, we focus on policy and programs and numbers. Having three living here in our presence today, however, is humbling, it is a humbling experience. It brings the war, as well as what we try to do in this committee, back home for all of us to see in a very real way.

I want to thank our men who are here today whether you are aspiring, whether you—we are exceedingly grateful for your sacrifice and we thank you for being here and again for what you have done for our country. And they are Sgt. David Sterling who sustained a traumatic below the elbow amputation earlier this year in Iraq caused by an explosion from rocket propelled grenade. He utilizes the SensorSpeed Hand MyoElectric prosthesis as his primary prosthetic device, but has other devices available to him depending on the task.

We will then also hear from Staff Sgt. Ryan Kelly. Sgt. Kelly was injured in Iraq by an improvised explosive device in July of 2003 and is a below the knee amputee. He has been evaluated in Walter Reed's gait lab and with a variety of foot types, he is in the most advanced prosthetic feet available.

Mr. Robert Conetta was injured by an explosion of August of 1968 while serving in Vietnam. He lost his leg above the knee and his right eye. He received his early care at Walter Reed and was one of the first individuals to receive the hydraulic knee, then a new device. Four months ago he received a C–Leg through the VA and reports using this advanced technology has been a dramatic improvement for him.

First of all, again, thank you gentlemen for being here all of you. Again, we greatly appreciate your sacrifice and I would like to begin with Dr. Giroir at this point.

STATEMENTS OF BRETT P. GIROIR, DEPUTY DIRECTOR, DEFENSE SCIENCES OFFICE, DEFENSE ADVANCED RESEARCH PROJECTS AGENCY; LT. COL. PAUL F. PASQUINA, CHIEF, PHYSICAL MEDICINE AND REHABILITATION, WALTER REED ARMY MEDICAL CENTER; AND CHARLES SCOVILLE, PROGRAM MANAGER, U.S. ARMY AMPUTEE PATIENT CARE, WALTER REED ARMY MEDICAL CENTER; ACCOMPANIED BY STAFF SGT. RYAN KELLY, UNITED STATES ARMY; SGT. DAVID STERLING, UNITED STATES ARMY; AND ROBERT CONETTA, UNITED STATES ARMY VETERAN

STATEMENT OF BRETT P. GIROIR

Dr. GIROIR. Good morning Mr. Chairman, committee members, and staff. I am Dr. Brett Giroir, deputy director of the Defense Sciences Office at the Defense Advanced Research Projects Agency.

I am pleased to appear before you to discuss DARPA's vision for the future of amputee care, a vision that we are pursuing collaboratively with our colleagues at Walter Reed and the Veterans Administration. As I begin, I ask that my written testimony also be included in the record.

Our vision is simple, but bold: to drastically improve the quality of life for amputees by transforming current artificial prostheses into biologically integrated fully functional limb replacements. We envision artificial limbs that allow fine motor control, such as the ability to type on a keyboard or play a musical instrument, and also enable the patient to actually feel precisely what the artificial limb is touching.

A major caveat is in order at this point. We are, of course, in the early stages of this research and it will take considerable time to fulfill the vision completely, but the only way to achieve the vision is to pursue it with focused commitment.

Let me begin by saying a few words about DARPA. DARPA is a research agency within the Office of the Secretary of Defense with a special mission: to maintain the technological superiority of the U.S. military and prevent technological surprise from harming our national security.

DARPA does this by sponsoring high risk, high payoff research that bridges the gap between fundamental discoveries and their military applications. As a result of this mission, DARPA has a tradition of sponsoring research that at first may seem like science fiction, but then becomes everyday fact. The most widely known examples of this are the Internet and stealth technology.

Our vision for amputee care stems directly from two programs within my office, the Defense Sciences Office, which is responsible for achieving breakthrough discoveries in physics, mathematics, material science and in biology. Our Bio-interfaces Program established the first interdisciplinary research teams combining biology, information science and microsystems technology with the specific goal of developing novel techniques to study biological systems from individual nerves to the entire brain. In fact, Dr. John Donaghue, the lead neuroscientist at the new VA Center of Excellence at Providence, has received support from the Bio-interfaces Program since 2001.

The second program, Human Assisted Neural Devices or HAND, has been highly publicized this past year. In this program, Dr. Miguel Nicolalis and his colleagues at Duke University have demonstrated the ability to capture and decode the electrical signals from thousands of individual nerve cells within the brain. His team has demonstrated that a monkey could control a computer cursor by using its brain directly without the use of muscles or nerves.

What this means is that this technology could, in the future, result in prosthetics that patients will control just as naturally as they control their own limbs. Realizing that these programs, as well as other DARPA programs in wound healing, sensors, information processing, infection proof materials and new power sources, could enable revolutionary new prosthetics, DARPA reached out to our colleagues at Walter Reed and the VA.

Our relationship with the VA is analogous to our relationship to Military Services for the majority of our work. We support high

risk research needed for a breakthrough which, if successful, will radically alter our concepts of what is possible. When we do succeed, we identify what we term a transition partner in the Services, an organization to perform the critical final stages of design, engineering and when applicable, clinical development and testing. For amputee care, the VA and Walter Reed are our primary transition partners.

To achieve our vision of artificial limbs that work literally as well as natural ones, major advances will be required in many fields including better decoding of brain signals, improved device control architectures, more biologically relevant sensors, new infection proof corrosion resistant materials and finally more compact, highly efficient power supplies.

We have already started projects at Walter Reed that lay the ground work for these innovations, including a new database for amputee clinical research and a novel rehabilitation training program based on virtual reality simulations. We at DARPA have also hired a neurologist and intensive care specialist who is also an Army colonel who served in Afghanistan to be the new program manager of our prosthetics efforts.

In summary, there is a great deal of enthusiasm and indeed true passion for this line of research at DARPA. We have visited the patients at Walter Reed. We have discussed their needs and their aspirations and they have truly provided our inspiration. I fully expect that our current efforts will coalesce into a significant research thrust for DARPA in the coming years, a thrust which we will bring to fruition together with our colleagues at Walter Reed and the VA. Thank you very much.

[The prepared statement of Dr. Giroir appears on p. 114.]

The CHAIRMAN. Dr. Giroir, thank you very much for your testimony and for your extraordinary leadership. Dr. Pasquina.

STATEMENT OF LT. COL. PAUL F. PASQUINA

Lt. Colonel PASQUINA. Chairman Smith and members of the committee, I am Dr. Paul Pasquina, chief of physical medicine and rehabilitation and the medical director of the amputee care program at Walter Reed.

It is with great pleasure that I appear before this committee to discuss the health care of our armed forces servicemembers, an issue to which I have dedicated my career to and one that I remain very passionate about. The medical providers at Walter Reed Army Medical Center have faced significant challenges during Operations Enduring and Iraqi Freedom, but nothing compared to the challenges currently facing numerous injured soldiers and their families.

Our medical staff takes great pride in caring for these brave individuals and we are committed to ensure they receive the best that medical, surgical and rehabilitative care have to offer. While the number of combat amputees remains only a portion of those soldiers injured overseas, this group of patients is representative of the unique challenges currently facing the military medical system and has provided a great opportunity to improve the collaboration between the Department of Defense and the Department of Veterans Affairs, as well as a multitude of public and private interest

groups, universities, medical care givers and researchers throughout the United States and the international community.

Combat amputees represent a unique patient population due to the complex nature of their wounds and extent of their comorbidities. Comorbid conditions, such as loss of vision, spinal cord injury, traumatic brain injury, fractures, as well as severe nerve and vascular injuries, presents significant medical, surgical and special rehabilitative challenges.

In addition, this group of patients is at an increased risk for development of secondary complications such as infection, heterotophic ossification and venus thrombosis, all of which are potentially life threatening and therefore require close medical monitoring and attention, not to mention each patient has a unique set of psycho social needs, which greatly impact on issues such as pain management, adjustment to disability, movement through the military disability system as well as reintegration back into the community or back to active duty service.

Walter Reed is committed to ensure that our patients receive the highest quality of care. This means that this care must not only be comprehensive, but also must be cutting edge. To have a successful program, we recognize that it takes a significant amount of team work, expert opinion, research collaboration and partnership with organizations that share our same values.

Under the direction of Secretary Principi and the leadership of key individuals within the VA, Walter Reed is very grateful of the support the VA has shown to us over this past year and their continued commitment to work together to ensure our soldiers get the best of care.

Examples of this partnership can be found in nearly all aspects of our care program. Most notable include joint task force meetings and educational conferences, research collaboration, sharing of expert opinion and amputee peer support programs, the transfer of patients between DOD and specialized treatment facilities, especially for those patients in need of spinal cord, brain injury or blind rehabilitation, embedded VA counselors and social workers at Walter Reed, shared recreational activities, such as the winter and summer disabled sports clinics, VA funded transportation of patients back to Walter Reed as needed for subsequent and specialized care not otherwise offered at remote locations, and the creation of a national database for patient tracking, long-term follow-up and the ability to contact veterans in the future as new technology and advances in treatment are discovered.

I am personally very proud of the great work that is being done between the VA and DOD and the partnership that is growing to ensure our beneficiaries receive the best of care. I also recognize the complexities of providing health care to such a large population of individuals with a multitude of medical problems and unique psycho social needs, which make no system perfect.

I am extremely grateful to the support our injured soldiers have received from Congress to ensure the needs of this most deserving group of individuals are met. I am also grateful for the continuous outpouring of support and well-wishing from numerous Americans and media organizations to our returning soldiers reminding them that their sacrifices for this country are appreciated by all of us.

My only hope is that we all recognize that we are at a unique opportunity in history to bring together expert clinicians, researchers, modern technology and science to help improve the quality of life to not only our veterans, but to thousands of Americans who deal with disability every day. Thank you.

[The prepared statement of Lt. Colonel Pasquina appears on p. 120.]

The CHAIRMAN. Thank you very much, Dr. Pasquina. Mr. Scoville.

STATEMENT OF CHARLES SCOVILLE

Mr. SCOVILLE. Chairman Smith, members of the committee, thank you for inviting me to appear before you today to discuss the care of our servicemembers and veterans who have lost a limb. The global war on terrorism is causing a surge in combat injuries, including amputations of major limbs. Over 144 servicemembers lost one or more limbs as a direct result of Operation Iraqi Freedom, Operation Enduring Freedom. Thirty-five percent of all amputees from OIF and OEF involve the loss of an upper extremity. This compares to approximately 5 percent in the civilian sector.

This is a unique population, which the Department of Veterans Affairs and the Department of Defense Health Care Systems are specifically prepared to address. In December of 2001, projecting potential for a large number of amputee patients, Lt. Gen. Peake, then surgeon general of the United States Army, directed the development of an amputee patient care program. The VA has worked very closely with the Department of Defense and the Army in developing this program to meet the needs of our patients.

VA social workers, benefit counselors, vocational educational rehab counselors and researchers have been detailed to Walter Reed Army Medical Center in support of the care of our patients. Our mission is to rehab our military amputee patients to the highest possible level of physical function so that the loss of a limb does not prevent them from returning to their military profession. Likewise, if they elect not to return to their active duty roles, they are able to make the decision based on factors other than the loss of a limb and function at a level where they can carry out a full active and productive life.

As advances in prosthetics and treatment approaches become available, it is imperative that we develop sound, scientific rationale for utilization of these devices and approaches. The amputee care program at Walter Reed is one of the focal points of DOD/VA researchers working collaboratively to develop common methodologies to advance rehabilitation programs and prosthetic capabilities.

Many recent advances in prosthetics have been integral to returning our patients to this highest level of activity. These include the Utah3 elbow, which allows simultaneous elbow-wrist and elbow-hand motion, the SensorSpeed Hand and the C–Leg. While the U.S. military is among the first to receive many of these devices, the VA also makes these devices available for their patients where appropriate and the VA and DOD are working closely together to ensure that the patients have access to necessary maintenance and service of these prosthetic devices regardless of their geographical location.

We are working together with VA, DARPA and ours to develop a database system, which will allow us to track the patients; the system currently is an intranet system within Walter Reed and we are completing the necessary paperwork to make an Internet system available for wider use. I thank you for your continued commitment and support to the quality of care of our armed forces.

[The prepared statement of Mr. Scoville appears on p. 132.]

The CHAIRMAN. Thank you very much for your testimony. I would like to just ask if Sgt. Sterling or Staff Sgt. Kelly or Mr. Conetta would like to make any comment or just, again, feel free if you would like to, maybe in answer to a basic question, to respond as to how you felt about your care that you received. How would you rate it? Did you feel that you got everything that you needed from the VA in the case of Mr. Conetta and from the Army in terms of our two sergeants?

STATEMENT OF STAFF SGT. RYAN KELLY

Staff Sgt. KELLY. I will speak first, if that is all right.

The CHAIRMAN. That would be great.

Staff Sgt. KELLY. Speaking for myself, sir, I am very satisfied with the medical treatment I received at Walter Reed and I have also had one opportunity to leave and seek care at a VA medical facility concerning prosthetic devices. I found that they were very accommodating as far as outsourcing to a prosthetic office closer to my home of record. It is still a bit of a drive, but it is a lot closer than the actual VA hospital is where I live in West Texas. I was able to get the prosthetic device I actually was shooting for, which is a running device. I even brought it today. So on both accounts, medically I have been very happy with what I have been able to receive in terms of prosthetics.

The CHAIRMAN. I appreciate that.

STATEMENT OF SGT. DAVID STERLING

Sgt. STERLING. Mr. Chairman, thank you for inviting us here today. I am astounded by the technology advances today from the Vietnam war, the other prosthetics that I have seen throughout the United States. I have the SensorSpeed Hand that you were hearing about. It is 250 times faster than any other hand on the civilian market right now. I am actually able to catch and throw a bean bag, which, according to the company that makes the hand, is physically impossible. (laughter.)

The CHAIRMAN. That speaks well of you. You must have been a great shortstop.

Sgt. STERLING. But to answer your question, sir, the care and the technology that we have been given is phenomenal.

The CHAIRMAN. Mr. Conetta.

STATEMENT OF ROBERT CONETTA

Mr. CONETTA. I want to thank you for being invited here to give a brief statement. Back in '68, I came back from Vietnam, lost a leg and lost an eye, and I was fitted one of the top two or three, with the first hydraulic from Walter Reed, which helped me get on with my life, and also I am now fitted with the C–Leg, which I only have about maybe 5 months maybe. And what a drastic change

from going from a hydraulic to now. And I think research still has to continue and not stop because something got better. It now has to go on to the next step until—research should never stop making something better for someone. And I want again to thank you, everyone, for being here.

The CHAIRMAN. Thank you.

Dr. Pasquina, let me ask you. What can Congress do to assist you and the VA so that there is a truly seamless transition from your care and the care that you provide to the VA and in your view, is that as seamless as it can be? Is it a matter of resources? Are we providing enough?

Lt. Colonel PASQUINA. I think the resources that are being provided certainly are adequate at this time. The question is the difference between adequate and optimal. And while right now we seem to be working through a lot of the bugs and moving through the seamless transition, obviously we are doing our best to prevent anybody falling through the cracks.

What I try to convey is that our patient population is very diverse with a multitude of problems that require specialized treatment. So to be able to provide that specialized treatment throughout the United States takes on a different question, and that is a question of health care of the United States, not necessarily just related to the VA or DOD. I think a significant amount of inroads have been made to try to improve the transition and I am extremely happy with what has taking place.

I think the more challenging mission that we all face is that as we can anticipate or potentially need to anticipate potential patients in the future, we have to recognize that these individuals to my right and to my left are in their twenties and they will be dealing with this disability not for the next 5 years, but for the next, hopefully, 50, 60 years and we need to be ready for those challenges in the future. So I believe there needs to be a dynamic process and as needs come about, we need to address those as soon as possible.

The CHAIRMAN. I appreciate that. And, you know, I think you just made an extremely profound statement, adequate versus optimal. It seems to me that if our only error is to be on the side of optimal, I would rather err on the side of having too much, which I don't think is possible especially given today's budgetary climate, to make sure that these gentlemen get everything and their comrades everything that they deserve and then some.

And you also mentioned the issue of comorbidity and secondary complications, and Dr. Giroir, you might comment on this. If additional funds are approved in the 2005 defense appropriations bill to improve amputee care at Walter Reed Army Medical Center for prosthetic limb development and implied collaborative research, will DARPA be a recipient of all or a portion of these funds? Are you confident that you will get those funds that you need?

Dr. GIROIR. I am not aware personally that any of those funds that were allocated to the Army will actually get to DARPA. I believe they will be—my understanding would be—those would be used by the Army. DARPA is currently using its research funds to do the very advanced research that is necessary to transition the

technologies to Walter Reed. So we, again, consider this a very synergistic relationship.

The CHAIRMAN. Understood.

Let me just go to Ms. Davis.

Mrs. DAVIS. Thank you. Thank you, Mr. Chairman, and thank you all for being here. I think particularly we are pleased that you are here, both from Iraq and from Vietnam, to testify. We know that there are many complicating issues and I hope that we can work towards the optimum care because I agree, that is what is required and you need to help us identify where those obstacles are in addition to money. Sometimes it is a mind set as well.

Could you, for a few minutes—you mentioned the psycho social issues. And I have been very concerned about having the continuing care for returning servicemembers to receive care from the mental health community, which we know is a part and parcel of really the impacts of being in a war and the continuing post-traumatic disorders that occur as a result of that.

I don't know whether each of you would like in your own way to mention the kind of support that you might have had, emotional support in going through this, and where, in fact, in working on with your associates as well, where you think we can improve on that.

Sgt. STERLING. Well, ma'am, speaking personally, each soldier responds differently to stressful situations. Some may have a higher level of post-traumatic stress syndrome than others. Myself, I have had a couple of instances. My wife and my son were there to support me as well as the care givers at Walter Reed and other soldiers there. The mental health community has always been really strong at Walter Reed. If we have any issues, we just go speak to one of the counselors and the problems are addressed immediately.

Personally, I cannot see where anything may need to be adjusted or improved upon. With any problem, you will not overcome it unless you want to. And that is a problem with I think a lot of soldiers with PTSD. Maybe they don't want to admit that they have it. But once you come to the realization that you do have it or you may think you have it, the truth is the only way to overcome that obstacle.

Mrs. DAVIS. Thank you.

Anyone else want to comment?

Staff Sgt. KELLY. Answering your question, ma'am, one of the greatest sources of support I have found is through peer support. And that is one of the greatest things I found at Walter Reed is that there is a large population—unfortunately, but there is a large population of amputees in our age group that we can find comradery and support just in knowing somebody else is going through the same thing.

And just going—bringing the highlights of something that the VA did is the winter sports clinic we participated in. I was able to participate in with I don't know the exact number, 20 or 30 other OIF/OEF veterans and to me, just the continual support of those programs that allow us throughout the year to kind of band back together and catch up on what we have been doing and just that support that is provided and events like that to me have been just paramount in the successful mental health transition.

And anything that this committee can do to help support those types of activities, not just while the war is going on, but throughout our lifetime, would be just paramount in our healthy transition.

Mrs. DAVIS. Thank you. I appreciate that. We need to be sure that those services and that kind of support is available and in turning to the issue of prosthetics and the maintenance of prosthetics, I think it is one thing when we are able to provide initially or in an ongoing way any upgraded opportunity for many of our servicemembers, but I am also concerned about the maintenance of that and being certain that when people return home, that they have the kind of care that they need. Do we have that kind of network that is developing so that there is an opportunity to get the care, you know, in home communities that is available?

Mr. SCOVILLE. We have worked very closely with Fred Downs and the VA to make sure that as people leave, our social workers are arranging with the areas they are going, with the VA coordinators, with our military facilities in the area to make sure that the patients are able to get all the prosthetic care that they need.

If it is unavailable locally, if they are still active duty, they come back to Walter Reed. If they are in the veterans health care system and it is a—one of the new devices where we are the only people using it, the VA brings the people back to Walter Reed where we can provide that service. So it is a very well coordinated effort with each of our patients.

Mrs. DAVIS. Yes. Thank you. And just one quick—well, I guess it is not such a quick question, but I also want to acknowledge and recognize DARPA and the wonderful, wonderful individuals that are contributing to the miracle, really, that you all have experienced.

I understand that there is a development of a national center for rehabilitation that is being worked on with the VA and the Department of Defense. Is that something that you all are involved in? Is that something that DARPA is intimately involved in and how do you see that going in? Will servicemembers today be involved in that in any kind of an ongoing way?

Dr. GIROIR. Yes, ma'am, and perhaps Dr. Aisen later on this afternoon might be able to make more comments on that, but I have been remarkably pleased at the collaboration and the cooperation we have experienced, both at Walter Reed and at the Veterans Administration, in terms of working together in a very integrated fashion, that DARPA assumes its traditional role of far out research that can have a large impact, and that work then being transitioned very effectively through the VA system and through Walter Reed.

So yes, we are engaging in talks about how we can be more involved. We have joint conferences, we have joint meetings, we have research meetings. As I stated before, we certainly anticipate that some of the VA researchers may be candidates for DARPA funding for their more advanced research. And again, the transition, the plans for transition are going extremely well in prosthetics, but also in other areas that we found can greatly impact on our veterans.

Mrs. DAVIS. Thank you. All right. We look forward to further hearing about that. Thank you.

Mr. SCOVILLE. Thank you.

The CHAIRMAN. Chairman Simmons?

Mr. SIMMONS. Thank you, Mr. Chairman.

First to Robert Conetta, as a fellow Vietnam veteran, I say to you, welcome home. It is good to have you here.

I have two questions, and I will ask them in sequence and then maybe we can get an answer. First to you, Mr. Conetta. Your story is an interesting one for several reasons, to me, at least, as a Vietnam veteran and somebody who continued to serve in the reserves for over 30 years.

My recollection is that many of our comrades who were wounded in that war were brought home, were treated well, were given the best that science had to offer, but essentially their military careers came to an end as a consequence of those wounds. Not always, but in many cases, and I assume that was the case in your case, that your military career came to an end.

I am interested to have you respond to the question as to how you got involved with the upgrade. We have just heard testimony that veterans who are fitted with devices from time to time are called back for upgrades. Is that something that you initiated or did the VA initiate for you and if you could think about that for a moment, I would like to phrase my second question and then you can—we can answer in sequence if that is all right.

The second question goes to our two young sergeants who are here today, both with prosthetic devices, both in uniform, both still on active duty I believe. Is that correct? And if that is correct, I guess my question to you is do you envisage or do you imagine that as a consequence of your treatment for your wounds and your fitting with these devices that you may, in fact, continue on active duty or in fact continue in the reserves and the guard in some capacity? Is that an option for you or something that you can consider because of the nature of your treatment?

So going back now to Mr. Conetta, if he could answer my question to him first and then if you gentlemen can answer the second question, I would be interested in hearing what you have to say. Mr. Conetta?

Mr. Conetta, you suffered grievous wounds many years ago. You were fitted with the best that science had to offer. Now 4 months, 5 months ago, you got something new and better. How did that come to pass? Did they grab you out of the streets of New York or did you initiate that?

Mr. CONETTA. Well, to answer part of your question, in my case I probably would have stayed in active duty if I could have. I would have loved to have done that. I think the military is a good thing and I know when I came from New York—and one of the things that we learned from—that I didn't have was teamwork. And I found out being in the military, teamwork was the number one thing. I know growing up I was always like I want to be number one, I want to be number one. I don't care about two, three, and four. So the military changed my way of that.

Mr. SIMMONS. I was raised in New York, too. So I know what you are talking about.

Mr. CONETTA. As far as the C–Leg was, I found out through the Internet. One or two other veterans that, Vietnam veterans who re-

ceived it, one was in Wyoming, I believe, and the other one was in Florida I think. And I did the research on it and I found out it was the way to go. I guess research is the key thing here. I think the VA and the military, they sort of like go hand in hand. I think it would be better to have an organization like the VA and the military to work together.

Mr. SIMMONS. Thank you very much.

As for our two sergeants currently in uniform, again, thank you for your testimony. You have heard that Mr. Conetta probably would have liked to have stayed in the service if he could have, but it didn't work out that way. How is it working out for the two of you and do you feel that there—you will have an opportunity, if you wish, to continue to serve as a consequence of the treatments you have received?

Staff Sgt. KELLY. Sir, to answer your question, I am not sure if in the introduction they mentioned I am an Army reservist and my intention when I got wounded last year in July was from the beginning to stay in and continue on in the reserves.

And through much research on my part and assistance through staff and even my congressional members from my state district, I came to an understanding that the cost, this benefit to me staying in was pretty stiff being a reservist mainly because many of the regulations and the federal law that governs benefits for veterans and treatment medically for reservists would entail me having to turn down a lot of my Army benefits by staying in.

And I am newly married and, you know, possibly having a family in the future. To have to turn down those benefits possibly forever was a little too much for me to handle. So I would like to stay in, I still would, but as it stands now, I have an Army—retirement date of 9 August.

Mr. SIMMONS. Sgt. Sterling?

Sgt. STERLING. Yes, sir. I am an 11 Bravo infantryman. I lost my right hand. So that kind of limits me to my MOS. I am basically unfit for duty in my current MOS. If I wish, I could easily reclass to stay in. Just as Sgt. Kelly said, there are benefits that would be lost to staying in. Just Ryan Kelly and myself both haven't been in very, very long. Guys closer to retirement, it probably would be easier for them to stay in and finish out their retirement and go from there, but at my current state, the technology I have will make my integration back into civilian life easier. I could probably retire two more times before I have to retire for good.

Mr. SIMMONS. I want to thank you both for your testimony. It has been inspirational for all of us. We gather around this horseshoe week in and week out under the leadership of our fine chairman and our colleagues on both sides of the aisle working in a bipartisan fashion to try to bring good health, hope, and future to those who serve us in uniform, and we very much appreciate your personal testimony here today. Thank you.

And thank you, Mr. Chairman.

The CHAIRMAN. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman.

Dr. Pasquina, I don't know what heterotrophic ossification is.

Lt. Colonel PASQUINA. Heterotrophic ossification is the formation of additional bone where it really shouldn't be. So after an injury,

bone can start forming on soft tissues and that can grow out of control and therefore cause additional pain and problems with prosthetic fitting and adjustments.

Dr. SNYDER. Is it like at the time of the injury little seeds of bone get planted in the soft tissue and they will kind of take off on their own or is it an extension from the fragments——

Lt. Colonel PASQUINA. That is essentially one of the theories and right now it is not that well understood. There is research ongoing to understand it better. There seems to be neurologic component too since the nature of the injury seems to be more common in folks with comorbid head injury or spinal cord injury or nerve injuries. So there seems to be a dynamic affect between the healing of the body and formation of bone and the nervous system.

Dr. SNYDER. Is this something that occurs the first few months after the injury or is it something that can occur years later?

Lt. Colonel PASQUINA. Typically within the first 6 months.

Dr. SNYDER. Six months? And what percentage of your 144—or what percentage do you see that in?

Lt. Colonel PASQUINA. That is something that we are actively studying now. I would say in close to 75 percent of the folks we are seeing bone formation. Some of that becomes problematic, some of it less problematic. And in fact meeting with some of the folks and the research that has taken place through DARPA, understanding the biology behind some of those mechanisms in the future may be very helpful for not only this patient population, but wound healing in general and bone healing. And perhaps some of the scientific advances may even contribute to understanding osteoporosis and some of the other medical conditions that face a large percentage of our population.

Dr. SNYDER. Yes, sir. Thank you.

Mr. Conetta, you had said that you found out about the C–Leg technology by being on the Internet and exploring on the Internet. Does that mean that——

Mr. CONETTA. I have a little trouble. I have a tenant in my ear.

Dr. SNYDER. I am sorry.

Mr. CONETTA. It seems to be bouncing off the wall.

Dr. SNYDER. It is these rooms here. As I understood you, you found out about the C–Leg in response to Mr. Simmons on the Internet. And I assume that what you meant was that then you went to the VA and said, "Is this something appropriate for me." My question is, had you been getting your care at the—through the veterans system on a regular basis and did anyone there ever say, "This is something you ought to explore" or was—if you hadn't yourself run across it on the Internet, is it something that perhaps you would not have heard about?

Mr. CONETTA. I think the answer to your question, for instance, getting the C–Leg for me was—the therapy when I got it, it wasn't there. It was tough to find. I mean, I looked for therapists to show me. So everything I have done now is really self-taught, but I see now there is going to be a change and I would have loved to have that change made because there are a lot of veterans, especially Vietnam veterans, and—I am not labeling just Vietnam veterans, I am talking about all veterans should have this opportunity to get

a C–Leg like this and get the therapy for it. I would love to see that.

Dr. SNYDER. Over the last 30 years, had you been going to the VA prosthetic clinic on a regular basis for an annual checkup or did you hear outside the VA?

Mr. CONETTA. No, I haven't. I really found out—like this leg that was made for me was outside the VA. I found out not many veterans or VA hospitals could make this type leg being that it was new. The training for some of these people that make the prosthetics wasn't there at that time and I managed to get it outside the VA.

Dr. SNYDER. And Staff Sgt. Kelly and Sgt. Sterling, I am not understanding, in my ignorance, what you said about one of your considerations in whether to pursue, in your case, Sgt. Sterling, your training into a different—from 11 Bravo to a different MOS and in yours, Staff Sergeant, in terms of staying around, that financially the benefits just looked too good to stay in.

And could you run through that for me again what—specifically what benefits you would lose by staying in and apparently there is no accommodation then for folks that have—is it because of your specific status that you have, a severe injury, that with a prosthesis that you want to stay in? What is it about the benefits? Explain that to me.

Staff Sgt. KELLY. Sir, to answer your question, in my case, as a reservist, and I think it would transcend any reservist sustaining an amputation, is the rumor exists in the fact that as an able-bodied reservist, I was one weekend a month, 2 weeks a year. I didn't have health care through the reserves and if I got injured at drill, they would take care of whatever happened during that weekend drill, but other than that, I was—I had to seek my own civilian health care and health care provider.

Seeing now that I have gone to Iraq, sustained a combat injury, a below knee amputation, I come back, I meet the requirements to be medically retired, but I also, with the new advances in technology, I am in a position where I conceivably, and as demonstrated by other soldiers, I could continue to serve in the same function I did before. And another desire I have is to get back overseas and hopefully—was hopefully going to be able to go back to Iraq.

The dilemma comes in whereas if I were to take retirement today, around the 9th, August 9th, immediately I am entitled to participate in Tri-Care for my family, me and my family, which is a huge benefit in today's society where health care is so expensive. Furthermore, I can pursue educational benefits that far outweigh my reserve GI bill. My reserve GI bill pays approximately $275 a month and that is what I get in my GI bill as a reservist.

And now with my disability being the percentage that it is, if I take a retirement, I will be eligible to participate in voc rehab, which is a wonderful benefit, but it is—my understanding and what I have been directed is it is only eligible to retired veterans with disabilities over, I believe, 20 percent.

So for me to stay in the reserves, continue to serve, even to volunteer to go back to Iraq, I would be forfeiting the health care, the access to Tri-Care, as the rules stand now, and furthermore, the

way the Army Medical Board system is set up, and I have been very adamant about researching this, is that to be found fit for an injury like a below knee amputation, I am basically telling the service that this is not a disabling injury and by doing that, I am not able to ever again gain Army—I am not talking about VA benefits, but Army retiree benefits for this injury unless I sustain another, you know, secondary injury, like a parachuting injury and I damage my knee and it is—they can tie it together.

But unless I have that secondary trauma later on in my military career, I am forfeiting the access to get this through the rating through my amputation. And now that I am a family man, the benefits were just too—the costs were too great for me to stay in even though it goes against my true desire and I think—and I can just—I will just speak for myself—was to stay in. My wife is a reservist. She is looking at another deployment to Iraq. So I would love to be able to go back and participate.

Dr. SNYDER. Do you have anything to add to that, Sgt. Sterling?

Sgt. STERLING. I think Sgt. Kelly pretty much summed it all up.

Dr. SNYDER. Okay. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Snyder.

Just one final question, Sgt. Kelly. You mentioned your running device and that you have it with you. Could you just shed some light on that for us.

Staff Sgt. KELLY. Yes, sir. Actually I brought two devices with me. One is my running leg and the other is a water leg. The leg I have right here is a—I think it is a flex foot system kindly we call it the C-sprint. I am not sure of the exact name. And this I actually got on convalescent leave when I went to the VA and they outsourced to a civilian provider. And through that, that time, I was able to get this prosthetic device and it allows me to run. I did a mile and a half yesterday on the track. So I am getting back to where I can run fairly regularly.

And then the other device is a water leg. It is an active ankle foot that allows me to participate in certain water activities and easily go in and out of the water without damaging the device because it is adapted for water use and it also—its claim to fame is it allows me to put my leg into flection and it allows me to swim and I can lock it. So if I got into scuba diving or any exercising swimming, it would allow me to do that.

The CHAIRMAN. Thank you very much.

Would any of you like to add anything before we close this part of our testimony? If not, I do want to thank you deeply for the insight you have provided us. I think you know we are a very activist committee. We take information, and your testimonies are outstanding. We act on them and, you know, we do it in a bipartisan way, but we do act on them and these insights will be very, very helpful going forward.

And also, just let me say, we invited a large number of press to be here to hear what is a good news story of where the military and the Department of Defense are really stepping up to the plate to meet a very real need and doing it in an absolutely professional manner. If we were here to criticize, I can assure you we would be

filled with cameras and every news organization, 60 Minutes, everybody would be here.

We sent out the same notice to tell a story that is a good news story and we get a few people from the press. We gratefully acknowledge their presence, but there is not the interest. And that just tells you, you know, they like bad news, they don't like when you are doing it right. I want to thank you for doing it right and this committee deeply appreciates your work, and to our sergeants and to our veterans, thank you so much for being here and for your sacrifice.

Let me now, if I could, invite our next panel, beginning with Mr. Thomas Miller who was appointed Executive Director of the Blinded Veterans Association in December of 1994. Prior to this, Mr. Miller served as Director of Governmental Relations for 8 years acting as direct liaison between the BVA, Congress, the Department of Veterans Affairs and other agencies of and for the blind. Blinded in Vietnam from combat injuries, Mr. Miller has been a BVA life-member since 1968 and has been elected to the National Board of Directors, served as President, National Vice President and National Secretary. He has also served for 13 years as the Secretarial appointee to the Federal Advisory Committee for Prosthetics and Special Disabilities Programs for the Department of Veterans Affairs.

Next we will hear from Mr. John Fales, a/k/a "Sergeant Shaft," who is the President of the Blinded American Veterans Foundations. He served in the U.S. Marine Corps until retirement on disability. He writes a widely-read column, a weekly column, for active military, veterans and their families in a national newspaper. And again, this is under the name of Sergeant Shaft. Some of his decorations awards include the Purple Heart, Vietnam Service Medal and the U.S. President's Community Service Commendation. He is a lifetime member of both the Disabled American Veterans and The American Legion and also a member of many other VSO's.

We will then hear from Ms. Joy Ilem, a U.S. Army service-connected disabled veteran who is the National—Assistant National Legislative Director for DAV. Ms. Ilem's work to promote responsible legislation to assist disabled veterans and their families is well known to members of this committee. She previously worked as a National Appeals Officer with the DAV staff and the Board of Veterans Appeals.

We will then hear from Mr. Richard Fuller, who is the National Legislative Director of the Paralyzed Veterans of America. Mr. Fuller served for 8 years on the professional staff of the House Committee on Veterans' Affairs starting in 1979 and since worked in the field of public policy and government relations with PVA and several national medical and research societies.

So I want to welcome our panel and start with Mr. Miller. If you could proceed.

STATEMENTS OF THOMAS H. MILLER, EXECUTIVE DIRECTOR, BLINDED VETERANS ASSOCIATION; JOHN FALES, JR., PRESIDENT, BLINDED AMERICAN VETERANS FOUNDATION; AND JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF THOMAS H. MILLER

Mr. MILLER. Good morning, Mr. Chairman, good morning, Chairman Smith and Member Evans, and all the members of this distinguished committee. On behalf of the Blinded Veterans Association, I want to thank you and express our appreciation for the invitation to participate in this most important hearing this morning.

As you know, BVA has been advocating for a number of years that an oversight hearing be conducted into the blind rehabilitation services offered by the Department of Veterans Affairs. I especially want to thank Chairman Simmons for his request to GAO to do a critical analysis of services that are being provided and the manner in which they are being provided by VA for America's legally blind veterans.

In following up on the previous panel, I would just like to make a point that there are—although it emphasized very few eye casualties to the extent of legal blindness or total blindness returning from the Iraqi Freedom and Operation Enduring Freedom, several of those who have come back totally blind or near totally blind have also suffered amputations as well as brain injury and these individuals have been referred from DOD. And the ones I know specifically came through Walter Reed, ended up in the VA traumatic brain injury program in Minneapolis and one of those is already in a blind rehabilitation program now, the VA in Waco, TX.

We applaud the efforts to develop a seamless transition, the cooperation between DOD and VA. Clearly there is room for improvement, but many of these severely wounded veterans who are service personnel are being referred to very, very high quality excellent VA special disabilities programs and I think will ultimately benefit greatly as a result of this transition and cooperation that exists between the two departments.

I would like to just quickly make a few points and deviate somewhat from my prepared statement for this morning after listening to the first panel of VA experts. And I think the committee got a good sense of the dedication, the commitment and the high quality of personnel that are working within blind rehabilitation service across the system at all levels.

First of all, we would like to certainly concur with all of GAO's recommendations, the two related to the wait times and the inaccuracy of reporting wait times across the system and the need for greater leadership from the very top of VA on down. In that context, I would like to make one point very, very clear, that the program office and VA central office for blind rehabilitation has absolutely no line of authority over any elements of blind rehabilitation service delivery across the system.

As a consequence, it is very difficult when a blind center chief works for a hospital director and/or in the context of the network policy or procedures. BVA has long advocated for the need for national guidelines and standards to be developed that would be ad-

ministered and adhered to across the entire system. When the VA system was segmented into 22 separate veteran's integrated service networks, the ability to influence the delivery of service was dramatically reduced by the program office and central office.

Probably the most significant and negative impact of the network system was that reorganization was accompanied by a very broad-based decentralization of management decision-making authority. As I said, the program manager and central office has little ability to influence what happens at an individual medical center. Consequently, for any recommended changes that result from the GAO studies, clearly blind authority with the secretary, through the under secretary, through the deputy secretary, through the network managers and the facility managers and they must be held accountable for their compliance with any national standards or array of services that may be developed as policy for VA blind rehabilitation.

This leads me to the testimony of Ms. Bascetta this morning regarding the recommendations that the under secretary issue a policy directive establishing a standard of care that would require a broad array of both outpatient and inpatient blind rehabilitation services for legally blind veterans. This is something BVA has long advocated. We have passed numerous resolutions to this effect in our annual legislative priorities presented before the joint session of the House and Senate Committees on Veterans' Affairs and have documented this repeatedly.

We feel BVA is in an ideal position at this very moment to implement or to begin the implementation of the recommendation by GAO. Reference was made earlier in testimony to the Visual Impairment Advisory Board by Dr. Kussman. That board is an interdisciplinary board that has consisted of all elements of the Department of Veterans Affairs, Veterans Health Administration. BVA has been an active participant in that body. We have been an active participant on the executive council.

That group has submitted an executive decision memo to the under secretary that would recommend a policy that would prescribe a full continuum of vision rehabilitation care to be provided for veterans across the VA system. The idea behind this continuum of care is to get the veteran to the appropriate site at the appropriate time in the appropriate place and the appropriate level of care.

A companion piece and a very critical piece to implementation is the proposed recommended changes referred to earlier this morning in the VERA allocation model. That recommended change was more equitably fund or allocate resources through the networks and therefore hopefully to the local facilities to equitably, more equitably fund the delivery of outpatient services. We concur wholeheartedly with that recommendation and it is imperative that the under secretary sign off on both of these documents as expeditiously as possible.

There is one element of the proposed VERA change that is critical and probably the most controversial is that it would require special purpose funds be dedicated for the next 3 years, fiscal years, in order to bridge the current VERA model to the proposed

change in the model so that facilities could begin this transition and begin to support the delivery of outpatient services.

So it is essential that the under secretary approve the complete package and hopefully we believe this can be done in time to begin in fiscal year 2005 and that the continuum of care could be incorporated into a five year strategic plan for all the networks and for the facilities. And it must clearly be designated or delineated in the performance measures for both network and facility directors in compliance with this continuum of care approach and the provision of a broader array of outpatient and inpatient services.

Finally I would like to, in response to some of the testimony and the questions from the earlier panel and questions to the panel, while we have strongly supported the establishment and creation of more access to—and greater capacity for the delivery of outpatient services, we in no means want to in any way diminish the importance of the residential Blind Rehabilitation Center.

It is absolutely critical—as a graduate of a VA residential Blind Rehabilitation Center, I can't stress strongly enough how important that environment is to adjustment to and accepting vision loss, development of healthy attitudes about blindness and of course acquiring the necessary adaptive skills to help overcome the limitations of blindness.

With a continuum of care, there is going to be much greater responsibility placed on the Visual Impairment Services Team and their coordinators to do comprehensive assessments of each individual veteran to make some determination as to where—what is the most appropriate level of care needed by this individual to address their specific needs related to their degree of visual impairment and/or blindness.

For the young, newly blinded, suddenly traumatically blinded service personnel returning from Iraq or Afghanistan, there is no question in my mind, the residential blind rehabilitation is absolutely essential for them. I know it is difficult to leave home, to go to a residential blind center for an extended period of time and I know I did not look forward to that after 4 months in a military hospital returning home and then having to look forward to another long hospitalization in a VA facility for blind rehabilitation, but it was the best thing that ever happened to me and I am certain I wouldn't be sitting here talking to you today had I not had that opportunity and advantage of the outstanding services that are provided in all of our 10 blind rehab facilities.

Mr. Chairman, that concludes my statement and as always, I would be more than happy to answer any questions that I might.

[The prepared statement of Mr. Miller appears on p. 139.]

The CHAIRMAN. Mr. Miller, thank you so very much for your testimony and for your comprehensive written statement as well. We deeply appreciate it and for promoting and pushing for this oversight hearing. I would just make emphasize that, you made the point that if the goal of the GAO is to be achieved before the end of this year, there needs to be strong leadership from the highest levels of VHA, the BRS program office and all management elements in the VISN's.

I will commit to you that we will have another oversight hearing before the end of this year, because I assume good faith on the part

of the VA. They have made some very strong statements regarding implementation of the GAO recommendations, but just to do our part, I think we need to continue this hands on oversight. So before the end of this year, we will have another oversight hearing and you, obviously, and our other distinguished witnesses, like Mr. Fales, will be invited, as well.

John, if you could proceed.

STATEMENT OF JOHN FALES, JR.

Mr. FALES. Well, thank you very much, Mr. Chairman. Thank you so much for inviting me here to just about concur with everything that Tom Miller has said.

As you can see from my testimony, which hopefully you will submit for the record along with the attachments, you will see the strategic health groups and you will notice where spinal cord injury is, where prosthetics is and then you will see where the blind rehab program is located.

As Tom Miller just said, the director of blind rehab has no authority. The individuals also who—the team coordinators who used to report to the chief of staff now report, in most cases, to the social workers. We have—in addition to that, we have VISN directors and local medical center directors playing games manipulating the funds through VERA.

I pointed out in my testimony about a situation that is happening in Augusta, GA where, unfortunately, they are bringing individuals in for overnight so they could get the VERA money. This doesn't help the entire comprehensive blind rehabilitative program and that is mainly because there is no central control in the system. There is no standardization of programs.

It used to be that the comprehensive program, there used to be a psychologist, a voc rehab specialist, a social worker and nursing, doctor all within the blind rehab center. There used to be research, there used to be the testing. And this was done throughout the entire blind rehab system. Unfortunately, you have Palo Alto doing their own thing, you have West Haven doing their own thing and there isn't any control by the director of blind rehab.

You know, I would be remiss if I didn't mention the—thank Dr. Perlin. Recently they just established a new program where visual impaired vets will be able to get colonoscopies. They sent out a memo. I think I attached it to my statement.

And because of this policy, which was established in the Pittsburgh and then in Washington, DC, the former director of blind rehab went to the VA, got a colonoscopy and he found out he had colon cancer. And they operated on him and he is doing well, but from now on, they have the policy, and I would like to congratulate Dr. Perlin for taking that initiative and using it to fully take care of our blinded vets.

You know, I had an opportunity, like Tom, to go visit Walter Reed in Bethesda and visit some of the troops there. There are two individuals who were from Pittsburgh, a blinded vet plus one lost a leg and another had amputees. One went—they both went home, they weren't transferred to the blind—the VA blind rehab system because they don't have this program that they used to have called

ASMRO, which the individuals could be directly transferred to the VA blind rehab centers. I think they should reinstitute that.

We had—one of the blinded vets took almost a year before he was put on a retired list. Now there is a big difference between an active duty enlisted man and the compensation for him and what he would receive from the VA.

On the other hand, we have this other blinded vet who lost a leg and they put him on the active retired list; however, he was then put onto Tri-Care while he was still going back and forth to Walter Reed for some additional care except once he went on to Tri-Care, they wouldn't pay his travel or overnight stays. And finally the VA did—finally they did come and take care of the dollars, but here this individual, blinded vet, was getting all these bills from John Hopkins and Walter Reed and fortunately, the VA did take care of that.

I do want to highlight the VA in one other area and that is the audio prescription drugs. Chairman, I think I kind of showed it to you one time, but this is going to be—there is going to be sole-source contract, and let me just demonstrate this here for you.

[Device scans medicine label and gives oral instructions.]

Mr. FALES. Thank you for giving me the opportunity to appear before you today.

The CHAIRMAN. Yes, thank you very much.

Mr. FALES. I also have one for Chairman Simmons.

[The prepared statement of Mr. Fales, with attachments, appears on p. 145.]

The CHAIRMAN. I do thank you for that demonstration, which you have provided in the past, which is very helpful.

Ms. Ilem, if you could present your testimony.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you for the opportunity to present the views of the Disabled American Veterans on the collaborative efforts between the Department of Veterans Affairs and the Department of Defense in research and amputee care for veterans.

One of VA's primary missions is the medical and rehabilitative care of catastrophically disabled veterans. Over the past year, there has been increased concern whether VA is able to provide the necessary specialized care, including prosthetic services, to veterans returning from Iraq and Afghanistan who have suffered traumatic amputations. Focus has been placed on VA's and DOD's handling of these cases and the collaboration between the two departments as a wounded soldier transitions into veteran status and in many cases from one health care system to the other.

We understand DOD is providing the finest prosthetic items available to wounded soldiers and that everything possible is being done to help military personnel who have suffered these devastating injuries to regain their good health and to live full and active lives. It is also our understanding that VA is doing everything possible to coordinate with DOD to make this transition as seamless as possible and that Secretary Principi has put a high priority on caring for wounded veterans in need of VA and prosthetic and rehabilitation services.

We are pleased to hear this, but we have some concern about VA's funding for special disability programs and continuing care for previously wounded veterans who also have prosthetic needs. Providing essential health care services to our Nation's disabled veterans is a continuing cost of war. Last month the Senate included additional funding in the fiscal year 2005 defense appropriations bill for specialized amputee care, upgrading facilities and services at Walter Reed Medical Centers amputee center, and for research on prosthetic care, limb development and rehabilitation.

This is truly good news; however, we want Congress to ensure sufficient funding for the VA health care system as well and to maintain close oversight of VA's special disability programs including prosthetics. In many cases, VA will be the agency responsible for providing a lifetime of care for these seriously wounded men and women. Some veterans will need highly specialized prosthetic care to maintain their and replace their prosthesis. Others will need the full continuum of medical care services, including mental health services, to help cope with the severity of their disabilities.

Early on we were concerned whether VA would be able to meet these catastrophically disabled veterans needs given the new and very costly prosthetic items that were being provided by DOD. Additionally, we questioned if VA could continue to provide the same level of care for veterans who suffered traumatic amputations in previous wars and conflicts. These veterans deserve priority care as well and access to these items—if necessary, access to these new prosthetic devices.

Whether a veteran has been using VA prosthetic services for years or is a new user of this system, VA must ensure that new technology and/or the services of master prosthetists are available to these veterans based on their needs and VA must receive adequate funding for maintenance in issuing of these highly specialized items.

Sufficient funding is also necessary to prevent delays in orders of prosthetic items, to maintain their training initiatives directly related to the special disability programs and to have a certain number of skilled personnel available. Without question, VA should be a leader in the industry when it comes to conditions prevalent among veterans, especially war related injuries. Therefore, DAV recommends VA develop several centers of excellence to explore new technological advances for prosthetics and to promote research, education and new treatment and rehabilitation models for veterans with amputations.

VA should also take this opportunity to reevaluate and improve its prosthetic and rehabilitation programs and to launch new research studies into traumatic amputations, rehabilitation and prosthetics. Veteran focused research in these areas is especially important now and should be a top priority for VA.

VA special disability programs are essential for many of our Nation's most severely disabled veterans and therefore we must ensure they are not dismantled, diminished or compromised due to insufficient funding levels or for purely budgetary reasons. Especially during a period of war, it is critical that VA has the resources it needs to provide the specialized care now and in the fu-

ture to these veterans who have sacrificed their health and well-being in defense of our Nation.

Mr. Chairman, that concludes my statement, and I will be happy to answer any questions.

[The prepared statement of Ms. Ilem appears on p. 158.]

The CHAIRMAN. Thank you very much for your statement.

Mr. Miller, I want to ask you a question. You made a very strong statement, both orally and in your prepared testimony, about the importance of and the need for the comprehensive residential BRC's and you spoke to that very eloquently. We have ten, and two more proposed. Are 12 enough, in your view, and what do you think? Are they adequate? Are we looking at optimal? What would that be in a best case scenario?

Mr. MILLER. Yes, Mr. Smith, I think 12 will be more than sufficient, assuming a full continuum of care is implemented and those veterans who truly do not need to be in a residential environment for their rehabilitation have access to appropriate levels of service in their local community and closer to home.

In addition to the two proposed new blind centers in the CARES proposal that Secretary Principi signed off on earlier this year, two of the existing ten blind rehab centers, the one in West Palm Beach and the one in Waco, TX, currently are—have proposals to expand their big capacity over the next few years.

I think clearly there will be sufficient beds, but again, that is conditional on adequate levels of outpatient service so that—the culture of the VA blind rehab service over the years has been that blinded veterans have been forced to go to the residential blind center if they wanted to get blind rehabilitative care often only to get a new piece of equipment or some remedial training. These types of referrals could be handled very nicely in most local communities.

For those communities that don't have qualified providers or programs available, then of course the veteran would then still need to be referred to the residential blind center, but I think there are sufficient beds in the system, if they are used properly, for those who truly need the residential environment to successfully complete an episode of blind rehabilitation training.

The CHAIRMAN. Thank you very much. In earlier testimony, as you know, and all of you might want to respond to this, we heard that 27 VAMC's don't have VIST coordinators. Are you confident that that is on the mend, that it is going to be remedied? I think it is a self-evident question, but you might want, for the record, say if you believe they are needed? Mr. Fales?

Mr. FALES. I believe they are. You know, I agree with Tom as far as the outpatient, but I think we better be very careful when we deliver that service. One of the major problems for the blinded vets and the blind in general, is transportation, especially out west. There is very little public transportation and also, in many cases, they don't have—the VA doesn't have the funds to pay for it even if they had taxi fare or other transportations. The vans may not get there in time. And so when we look at the outpatient care, I think we better look at the transportation issue at the same time.

In addition, there are thousands and thousands of diabetics who are service connected, on the rolls. And as you know, diabetes is one of the major causes of blindness. So what I would like to see

is those VIST coordinators getting together with the medical center and then doing outreach to these diabetics and see if they are having difficulty and maybe we can stop—you know, do some preventative type of care and in addition, some remedial visual impairment care.

The CHAIRMAN. Thank you.

Mr. Strickland?

Mr. STRICKLAND. Thank you, Mr. Chairman.

Mr. Miller, your response to the chairman regarding the number of centers you think being sufficient or the number of beds being available, I am just curious. I have been told that there is a considerable waiting period of time for people to be able to be admitted into these centers. So can you speak to the issue of the waiting time versus the number of beds that will be available.

Mr. MILLER. Yes, sir. I think certainly waiting time is a critical issue. There has been some debate in blind rehabilitation for many, many years over the advisability of transferring a visually impaired or blinded military person directly from a military treatment facility to a VA Blind Rehabilitation Center.

I was released from a military treatment facility and was home for a period of three to 4 months before I was admitted to a blind rehab center. For me that worked well. Sitting around for three or 4 months got old really fast and while I didn't know for sure what blind rehab was going to do for me, I knew I had to do something because sitting in a rocking chair for the rest of my life wasn't a very viable option.

But I think if continuum care is available, the waiting times for the residential program will not be as long as they are. I think where veterans have access to appropriate levels of care closer to home, they are not going to be on waiting lists at the blind center waiting to get in. That should enable veterans who truly need that residential environment an opportunity to access the blind centers more quickly.

Another factor that is going to impact that, however, is fortunately, as has already been mentioned, there is very few legally blind casualties coming back from Iraq or Afghanistan, but those veterans when they go to a blind center are necessarily going to require a much longer program than what is currently reported in the blind centers today. The average length of stay is about 6 weeks.

When I went through the blind rehabilitation program in 1968, the average length of stay then was 18 weeks and I would submit to you that we needed every bit of that time. It was a very comprehensive, intensive program. It was pre-vocational training model because we had the bulk of our lives ahead of us and needed a lot more skills and for those of us who were totally blind, we couldn't rely on residual vision to help do some of the things that can be done today with all the optical visual devices that have developed over the years.

But so I think it is a combination of things. If the appropriate veterans are referred to the blind center and those who can benefit from care on an outpatient basis where it is available and accessible to them, I think that is going to relieve the long waiting list

and the excessive waiting times for admission to the residential program.

Mr. STRICKLAND. Thank you for your response. I would assume that things can be provided at these residential centers, as you used the word "comprehensive," that may not be available in more localized, less comprehensive facilities. But the question, you know, that I have I guess, if we only have 12 of these around the country, and it seems to me that someone, especially a newly blinded person through trauma or a war event, could best benefit from the kind of treatment that is provided in conjunction with family members. For example, a spouse or whatever.

And are there any provisions for say the spouse of the blinded veteran, especially the newly blinded veteran, if they are, you know, going to be there for several weeks or is this program only accessible to the patient or the veteran him or herself? I guess the question I am asking, are there any provisions for the family to participate in the kind of rehabilitation efforts that would take place with a newly blinded veteran?

Mr. MILLER. Yes, sir, there are. Not on a daily or weekly basis, but each of the Blind Rehabilitation Centers offers what they call a family program where they will bring a significant other, be it a spouse or a parent or whoever, that veteran may end up living with subsequent to their completion of the rehabilitation program is brought to the blind center for a period of up to a week, may have an opportunity to meet with all the instructors that were involved with the training of that individual, observe the veteran function in a variety of different capacities, whether it is in terms of orientation and mobility or in the kitchen or doing laundry or managing computer tasks or typing or whatever so that they have a much better understanding of what they can realistically expect and how they can reinforce training that has already been provided.

One of the dangers of having a family member there continuously is a tendency to not foster the development of the kind of independence that is most desirable, that each of us has to learn to be able to do as much as possible on our own without relying on sighted assistance from family members or friends or whoever.

Obviously there is some things that we definitely got to have sighted assistance for, but—so it is proven to be a more effective environment for that veteran not to be that closely linked with the family member on an ongoing basis, but clearly there is a need to involve the family member in the training at some level so they have a fuller appreciation of what they can expect realistically and what they can do to hopefully reinforce the training that the individual received.

Mr. STRICKLAND. Thank you, sir.

And thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Strickland.

And I want to again thank our panel for their insights and recommendations. As I said earlier, Mr. Miller, we will hold an additional oversight hearing before the end of the year and I think to see how well the VA is doing in implementing. They have agreed with the GAO recommendations, which is great, and there are a lot of good people over there I think who want to do the right thing

and are doing the right thing. So we will invite you back and our other distinguished witnesses as well at that point. Thank you so much.

I would like now to welcome our final panel to the committee. Dr. Kussman, we welcome you back to speak to the previous issue.

Mr. Frederick Downs, the Chief Consultant with the Prosthetic and Sensory Aid Service Strategic Healthcare Group Veterans Administration. Mr. Downs was in the U.S. Army from 1966 through 1969 where he served as a platoon leader in Vietnam. He was severely wounded losing his left arm above the elbow. Some of his decorations include the Silver Star, Bronze Start with "V" device for Valor, and four Purple Hearts. In 1994, Mr. Downs was the recipient of the Citation of a Layman for Distinguished Service, the highest award the American Medical Association bestows on a nonphysician. He is the author of three books.

We will then hear from Dr. Mindy Aisen, who became the Deputy Chief Research and Development Officer in May of 2003. She was appointed the Director of the VA Rehab R&D Service in September 1998 and maintained those duties until April 2004. She also served in several other important roles from January 2003 to March 2004. Dr. Aisen received her undergraduate degree from MIT and her medical degree from Columbia University College of Surgeons and Physicians. Dr. Aisen served as President of the Board of Directors of the American Society of Neurorehabilitation from 2001 to 2003 in addition to being a member of the board since 1994.

Mr. Bert Harman has, for 4 years, been the President and CEO of Otto Bock Healthcare, the leading supplier of orthotic and prosthetic devices to the prosthetic and orthotic industry and an important supplier of seating and positioning products to the rehabilitation segment of healthcare. For the previous 25 years, Mr. Harman held a variety of sales, marketing and business development and general management assignments, including 3 years of international experience as Managing Director of 3M Ecuador, South America.

And finally, Dr. Rory Cooper is the director of the VA Center of Excellence on Wheelchairs and Related Technology and serves on the editorial board of several prominent peer review journals in the fields of rehab and bioengineering. He is also chairman of the University of Pittsburgh's Department of Rehab Science and Technology. He is a member of the U.S. Health Care Finance Administration Medical Advisory Committee, the National Advisory Board on Medical Rehab Research, National Institute of Child Health and Human Development and the U.S. Secretary of Veterans Affairs Prosthetics and Special Disability Programs Advisory Committee. He is a 2002 recipient of the Olin E. Teague award for his work in helping disabled veterans.

Dr. Kussman, if you would begin.

STATEMENTS OF MICHAEL J. KUSSMAN, ACTING DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; FREDERICK DOWNS, JR., CHIEF CONSULTANT, PROSTHETIC AND SENSORY AIDS SERVICE, STRATEGIC HEALTHCARE GROUP, DEPARTMENT OF VETERANS AFFAIRS; BERT HARMAN, PRESIDENT AND CEO, OTTO BOCK HEALTHCARE; MINDY L. AISEN, DEPUTY CHIEF, RESEARCH AND DEVELOPMENT OFFICER, DEPARTMENT OF VETERANS AFFAIRS; AND RORY A. COOPER, DIRECTOR, CENTER OF EXCELLENCE ON WHEELCHAIRS AND ASSOCIATED REHABILITATION SCIENCE AND ENGINEERING, PITTSBURGH VA HEALTHCARE SYSTEM

STATEMENT OF MICHAEL J. KUSSMAN

Dr. KUSSMAN. Mr. Chairman and members of the committee, I think it is now good afternoon. I am pleased to testify today on the VA's collaboration with the Department of Defense in research amputee care for veterans of current and past conflicts. I will focus my remarks in the beginning on the VA's collaboration efforts with Walter Reed Army Medical Center Amputee Care Research.

VA's Prosthetic and Sensory Aids Service Strategic Health Care Group is our advocate for the core population of veterans with special needs for prosthesis and sensory aids. It provides specialized patient care by furnishing properly prescribed prosthetic equipment, sensory aids and devices in the most economical and timely manner possible. VA provides new and emerging technology as becomes available in the marketplace. Any product available in the marketplace is available to our veterans.

As new technology is rolled out, VA can prescribe to move them through a system of over 500 private contractors. As a veteran progresses through life, we refit, repair, adjust and replace the equipment provided to meet the veteran's changing needs. VA is fully prepared to provide the high tech prosthetic limbs that are now being provided by the Army to the amputees from the war. In fact, VA and Walter Reed have been working together since the beginning of Operation Iraqi Freedom to ensure that servicemembers and veterans receive whatever necessary. Moreover, we are excited about our increasing collaboration with the Defense Advance Research Projects Agency, DARPA.

I am pleased that Dr. Giroir is here today, was here today, to outline defined achievements of DARPA to improve the quality of life for amputees in assisting them to return to a normal life with official limbs that work as well as the ones they have lost.

Under guidance of the task force of the seamless transition of returning servicemembers, VA has assigned employees to Walter Reed and other MTF's across the country to assist in the transition of servicemembers to the VA system. The Department of the Army received some of the new technology directly from manufacturers' laboratories. In cases where the amputee is fitted with a limb that is not yet available to the general market, VA will pay the amputee's travel cost to enable the amputee to return to Walter Reed if he or she needs a repair or requests a new limb.

Often servicemembers use both health care systems as they travel home for convalescent leave or travel back to their units. VA offi-

cials also spend time at Walter Reed visiting with staff and patients and VA and Walter Reed staffs have participated in the conferences on amputees that each department has held.

The care we provide, however, is only part of the story. VA also has a robust prosthetic research program that focuses on providing the best care to all veterans with limb loss and enabling them to live complete and fulfilling lives. Current initiatives include collaboration with the Department of Defense, especially Walter Reed Army Medical Center, on 10 projects involving various aspects of the amputee care and outcomes. These efforts will evaluate existing technology and new potential surgical treatments, including tissue reengineering for residual limb lengthening and osio integration, a procedure that places a titanium lat in the bone.

In addition, VA and Walter Reed are developing a special database protocol to establish electronic data sharing that documents existing and perspective prosthetic rehabilitation in young, active amputees. This will optimize patient tracking and promote a seamless continuum of amputee patient care between VA and DOD. One critical area of focus is research to improve lower extremity prosthesis rehabilitation. Although the lower extremity amputees represent nearly 70 percent of limb loss patients admitted to Walter Reed, few studies exist investigating whether existing new technologies significantly improve overall function.

Several joint initiatives are seeking to fill this information gap. Let me briefly mention two devices being tested at the Kansas City VA, Walter Reed and the Rochester Mayo Clinic that are believed to be more effective than the previous prosthetics.

Investigators will examine the microprocessor controlled knee of the C–Leg. Currently all lower limb amputees returning from OIF and OEF receive this device. So it is vitally important to explore the limits of this new technology and to develop appropriate rehabilitation programs for its use. Researchers will also examine the low profile Vari-Flex foot to determine how the multi-axial function of the Vari-Flex foot supports better traction and foot control during a variety of activities in young, active amputees.

Mr. Chairman, VA has a long history and distinguished history of funding innovative and ground breaking projects that have benefitted amputee patients throughout the world. We look forward to a continued collaboration with the Department of Defense on this effort. Through the partnership we have forged, we have improved our ability to identify and serve returning servicemembers that have sustained serious injuries or illnesses while serving their country.

This concludes my statement, and I will be pleased to respond to any questions. Thank you.

The CHAIRMAN. Dr. Kussman, thank you very much for your testimony. Mr. Downs.

STATEMENT OF FREDERICK DOWNS, JR.

Mr. DOWNS. Thank you, sir. My testimony pretty well reflects what you heard today from the other groups. I would just like to add, in addition to that, as the chairman of a multi-disciplinary, strategic team on amputee care, we have in the VA, getting ready to move into a new stage. We want to be able to address the new

amputees coming back, but we also have to reevaluate what we have been doing with the older amputees, meaning myself I guess.

We have to ask questions, to determine. What kinds of limbs are people receiving. We have a better data system now and we are able to start comparing prescriptions. We have the C–Leg now. So let's look at our amputee clinic teams. We need to review the types of patients who are receiving the C–Leg and ask are we being aggressive enough in prescribing the C–Leg.

MyoElectric upper extremities. How good a job are we doing of presenting that to the older veterans. A lot of older veterans, like myself, are resistant to change, but we don't know perhaps how good those changes could be for us. So we need to explore more of those possibilities.

We have a lot of exciting opportunities coming up with the technology, our relationship with the prosthetists, the certified prosthetists, our certified labs, what we are doing to improve amputee care in the Veterans Administration. For the first time in a long time, we are having a tremendous push now within the Agency, starting at the Secretary's level, right on down to the laboratory level.

We have—for the first time ever in my office, we have a certified process prosthetist who works for me and his job is to oversee the National Prosthetic Orthotic program in the VA. We have an ongoing dialogue on a day to day basis as to what we are going to do to improve our labs, work to develop the centers of excellence, work closely with R&D and more importantly, implement those ideas, those products coming out of R&D. And those will be extremely important as we make that technology transfer. That is something that all of us look very much forward to. So I would be glad to answer any questions for you.

The CHAIRMAN. Thank you, Mr. Downs.

Regrettably, that annoying sound you heard, as I think you know, is the call to the floor. There are three votes pending, one 15-minute vote, which is already under way, and two 5-minute votes. So regrettably, we will have to take a brief recess. I would just point out that one of those votes is our COLA bill for service-connected disabled veterans. We previously debated that, and it was rolled until right now. So I apologize for this inconvenience, but we will reconvene as soon as those votes are over.

[Recess.]

Mr. SIMMONS [presiding]. The Veterans' Affairs Committee reconvenes after a break to vote, and we thank the witnesses for accommodating the sometimes difficult and disruptive schedule that we pursue here on Capitol Hill. It is my understanding that of the witnesses on Panel 4, Dr. Kussman has already testified, and that we have remaining Dr. Aisen and Mr. Downs. Mr. Downs has left. Excuse me. Mr. Harman and Dr. Cooper. It is my understanding that Mr. Harman would like to proceed at this point. Is that correct?

Mr. HARMAN. I would. Thank you, sir.

Mr. SIMMONS. You bet. Please proceed.

STATEMENT OF BERT HARMAN

Mr. HARMAN. Well, first, thank you for the opportunity to share a private sector perspective on collaboration among the Depart-

ment of Veterans Affairs, the Department of Defense and the industry on veteran amputee care and prosthetic research.

My name is Bert Harman, and I am the president and chief executive officer of North and South American operations for Otto Bock Healthcare, and I am located in Minneapolis. Otto Bock is widely known as the developer of the microprocessor- controlled C–Leg, arguably the most advanced prosthetic technology in use today and mentioned here several times. I am also appearing, however, on behalf of the entire prosthetic industry and the many committed providers and other manufacturers who stand ready to meet the challenge of ensuring optimal outcomes for military and veteran amputees.

I would like to make three points today in my testimony. First, the committee can and should be very pleased by the growing collaboration among the VA, the DOD and the private sector to meet prosthetic technology and care needs for the modern military and its veterans. Otto Bock is proud to be an active partner with the VA and DOD in this public-private collaboration that is essential to developing high quality prosthetics to benefit all persons with limb loss.

Second, though Otto Bock is the largest prosthetic manufacturer in the world, we are a relatively small privately held company with limited R&D resources. Expanded collaboration with the public sector, in my opinion, is essential, particularly in the area of clinical studies and assessments. For companies such as ours, to continue developing technologies that will significantly improve the lives, health and productivity of our military and veteran amputees, while also assisting Medicare beneficiaries and other private sector amputees, VA and DOD assistance, in our opinion, is essential.

And finally the reinvigoration of prosthetic care and research at the VA and DOD may be hindered by an insufficient number of experienced researchers in the areas of clinical and prosthetic research. This challenge exists in the public sector as well and we must do all that is possible, therefore, to further develop internal capacity and competency at the VA, remove any and all barriers to collaboration between the VA and the DOD so that existing assets may be leveraged and create a more streamlined, flexible mechanism for the VA to partner with the private sector to support innovative research and accelerate product development.

The human toil exacted by military operations in Afghanistan and Iraq has been widely reported particularly with respect to those men and women whose injuries have resulted in the loss of one or more limbs. We applaud the commitment shown by the leadership of both departments to swiftly address the needs of amputee patients by ensuring access to the latest and highest quality prosthetic technologies and care appropriate for their medical needs.

The current military's demand for prosthetic technology that will enable military servicemen and combat veterans to return to close to pre-injury levels of functionality is driving research and program development. This aggressive goal setting is precisely what is needed to further advance the science and standard of care within prosthetics.

The experience of Air Force Lieutenant Colonel Andrew Lourake underscores what is possible when a determined and driven indi-

vidual is provided with advanced prosthetic technology. Col. Lourake, an Air Force pilot in the 99th Air Lift Squadron, lost his leg above the knee in 2002 and was the first military serviceman fitted with a C–Leg. After multiple surgeries and hundreds of hours of physical therapy and retraining, Andrew Lourake was cleared last month by the Air Force surgeon general to return to active flight status within the military. It is an exceptional story.

Otto Bock has enjoyed a very strong relationship with the Walter Reed Amputee Care Center and is eager to expand these partnerships. We are convinced that strong, collaborative relationships among Walter Reed, the VA and the private sector will lead to next generation prosthetic technologies that enable these dedicated individuals to fully pursue their lives, be it civilian or military.

I commend the House of Representatives for its commitment to this effort. In particular, I want to recognize Representative Bill Young for championing $10 million through the DOD in fiscal year 2005 to support advanced prosthetic research to be administered by Walter Reed. The DOD-VA collaboration also extends to clinical studies. As an active participant with these departments in the development of clinical assessments, we have been very impressed, not only by the partnership itself, but also by the VA's responsiveness to emerging research opportunities.

From reassigning personnel to Walter Reed to coordinate research efforts to re-recruiting highly specialized talent from the Mayo Clinic into the VA to run prosthetic clinical studies, the VA has effectively responded to current, as well as anticipated needs.

In closing, the collaboration between the VA and DOD is working, but could be further enhanced. I urge the committee to fully support the DOD's—excuse me, the VA's renewed emphasis on amputee care and research through the fiscal year budgeting process. To further advance the standard of care and to improve patient outcomes, I recommend that the committee explore how additional product clinical research capacity and talent may be developed within the VA. I also suggest that a streamlined process for private sector collaborations and partnerships be explored so that the time from innovation to application may be greatly accelerated.

Otto Bock Healthcare, along with the entire prosthetic industry, is committed to enhancing its partnership with the VA and DOD to achieve optimal results for those men and women who have so bravely served our country. I know you share this goal and I appreciate your attention and the opportunity to testify today. Thank you.

[The prepared statement of Mr. Harman appears on p. 162.]

Mr. SIMMONS. Thank you very much, Mr. Harman. I appreciate your testimony.

And next, we look forward to hearing from Dr. Aisen.

STATEMENT OF MINDY L. AISEN

Dr. AISEN. Is this on? Okay. I want to thank you for your endurance for waiting for us.

So I work in the research office at the Department of Veterans Affairs.

Mr. SIMMONS. And we should thank Mr. Strickland for returning back, and he will be our official ranking member, even though he is on the far corner there.

Dr. AISEN. And just to review for people, the research appropriation in VA is a purely intramural appropriation. So we support research efforts in VA to work with veteran patients and only support VA employees conducting research. That doesn't mean that we don't do a lot of partnering, as you have heard about today, with the Department of Defense, also with the NSF, with DARPA, with the NIH (even occasionally) and obviously with private industry. Through our tech transfer program, we have cooperative research and development agreements and other mechanisms for partnering. We really appreciate the opportunities.

I heard a lot of things today. I heard a lot of things about low vision and blind care and I heard a lot of things about neural prostheses and innovative prostheses and innovative approaches to preserving limbs, and extending limbs, and osio integration. And there are just many, many questions that beg investigation that we are hoping to approach within VA research in collaboration with the clinical side of the house. And to my left is Dr. Rory Cooper who for a very long time, in addition to his many other duties, has been kind of the consumer report person of wheelchairs.

So that although people in rehab, particularly I think, rely on the private sector to learn about medical equipment necessary for giving best care to people with impairment and disability, you do need that objective assessment of what is out there commercially so that we can compare products and know what the very best is. It can't solely be commercially driven. And that is the nice balance I think that we have in VA and in having a federal research enterprise.

So that maybe I can pull together what has been said today to make a little bit of sense of it. DARPA, which is a very high risk, very sort of basic kind of research, produces a lot of materials and technologies that eventually can make their way to help veteran care. And we are hoping that we can serve as an incubator and as a clinical research testing site for a lot of their technologies.

Brett Giroir and I have met a number of times about robotic interventions, about new prosthetic opportunities, about retinal implants. And it is through DARPA and NSF collaborations that we have brought retinal prosthesis to the VA. And retinal prosthesis have the opportunity of turning the blind veteran into the low vision veteran simply by replacing retinal function, but also may have a therapeutic effect on the retina itself.

And we have two sites now engaged in doing this. One that is an NSF and VA funded site in Boston and one that is a private industry VA site in Atlanta. Our place in Atlanta also does work on measuring best outcomes for people in blind rehab so that we can have some data that can drive policy. They actually contributed to doing the gap analysis that was alluded to earlier and I think it is, you know, our view that cost is an issue.

We don't want to be the cheapest, we don't want to be the most expensive, we want to do the right thing. And I think underlying—a question that I thought was—provoked me a lot through the day was, what is best care. We know a lot about what intuition or compassion may tell us about counseling and peer counseling, which

are all good things, but we need to test these hypotheses so that we can know how much and who and when. And we are trying to address all those questions within the research office.

So just so I can kind of mention, with DARPA and NSF, we got our retinal implants, our cortical chips, better materials for osio integration so that these things don't corrode. We need the input from these very highly skilled technical engineering people and we also need a lot of input from the consumers and the veterans. And I think it was just a very good hearing today because you got a glimpse of what everybody felt they needed. And I see my red light is on. So I thank you for your time.

Mr. SIMMONS. Thank you very much, Dr. Aisen.

And now we will go to Dr. Cooper.

STATEMENT OF RORY A. COOPER

Mr. COOPER. Thank you, Mr. Chairman and members of the committee. I speak to you today in my role as a veteran with a spinal cord injury who has been a benefit—who has benefitted from research, and as a VA research scientist. For 24 years, I have been the user of multiple assistive devices and I am actually using a lot of our advanced research today, if you would like to see it, and have used a wheelchair as my primary means of mobility. I have also been a funded VA research scientist for nearly 15 years and director of the Human Engineering Research Laboratory since 1994, which is one of the VA's designated centers of excellence in rehabilitation, research and development.

I am going to confine my remarks to how ongoing research and development intersects with the promotion of full participation in the society of veterans with severe mobility impairments, which is our center's main concern. The increase in military deployments oversees has provided a steady stream of young veterans with disabilities. It is important to note that a large percentage of veteran wheelchair users are from special disability populations such as spinal cord injury and dysfunction, traumatic brain injury and amputation.

There are a number of other veterans who are using or will likely use wheelchairs in the future. The chances of acquiring a disability increase with age and people over 65 represent about 43 percent of individuals with severe disabilities. Over 35 percent of VA users are over 65 or older compared to only 17 percent in the general population.

While VA predicts that the total number of veterans is likely to decline by 19 percent between 1990 and 2020—this is without accounting for the war on terrorism and other hostilities—the number of older veterans from Vietnam and Korea conflicts was expected to climb sharply. VA has shifted focus from hospitalization to community integration. For veterans with disabilities, assistive technology is critical to promoting this effort.

While our center is focused on veterans, we would be remiss not to address the broader needs for wheelchairs. In the U.S., an estimated 2.2 million people currently use wheelchairs for their daily mobility; worldwide, an estimated 100 to 130 million people with disabilities need wheelchairs, but less than 10 percent own or have access to one. While these numbers are staggering, experts predict

that number of people who need wheelchairs will increase by 22 percent over the next 10 years.

One of the leading causes of disabilities in the world can be attributed to land mines, particularly in developing Nations, leading to over 26,000 people injured or killed by land mines worldwide each year. Given that major limb loss, spinal cord injury and traumatic brain injury affect a growing number of military personnel serving in Operation Enduring Freedom and Operation Iraqi Freedom and other foreign deployments, further research is particularly important.

There is an overwhelming need for wheelchairs and prosthetic limbs and the research and development required to make them safer, more effective and widely available. This was pointed out by the VHA Rehabilitation Strategic Healthcare Group who identified the following areas as being of particular importance: practitioner credentials, accreditation, device evaluation, device user training, patient education, clinical prescribing criteria, national contracts and access to new technologies.

Wheelchair-related research is a broad topic with many focused areas of investigation. The studies proposed in the studies that we have proposed involve remote monitoring, vibration exposure, clinical education to assistive technology. Recent deployments have also resulted in a large number of young, military aged American veterans with amputations, the largest number since Vietnam. Veterans of the Vietnam war were the last major influx of individuals who acquired traumatic or surgical amputations from injuries sustained during conflict deployment.

Since that time, the focus of prosthetic design has shifted away from deployment related traumatic amputations and moved towards older individuals who have required amputations due to peripheral vascular disease. Clearly, there is a need for deployment-related research and development, especially for veterans with traumatic limb loss.

The main reason I have been involved with research and development in the VA for the past 15 years is that I felt that the VA is a particularly favorable place for providing excellent prosthetics and assistive technology services. Among VA's advantages are the computerized patient record, including the national prosthetics patient database, and the veterans themselves who are a particularly rewarding group to work with and who participate in research more actively and with greater enthusiasm than the average person in the private sector. In addition, the VA has a long history of notable accomplishment and rehabilitation research and clinical service delivery often setting the standard for this field.

I would like to address our research—how our research benefits veterans from within the VA healthcare environment. I will limit my remarks to our programs in Pittsburgh; however, other VA medical centers have analogous stories. Our VA research program covers a wide spectrum of studies and development projects, from basic biomechanics through the development of new devices to clinical studies and new structures of service delivery. All of our studies are veteran-focused and many of our research and development concepts are directly inspired by veterans' needs.

For example, a fundamental driver for the high prevalence of upper extremity pain and joint degeneration is the improper selecting and fitting of manual wheelchairs. My colleagues, Drs. Michael Boninger and Alicia Koontz, were intimately involved in clinical practice guidelines with a consortium of organizations, including the Paralyzed Veterans of America, to reduce the incidence, if not prevent, repetitive strain injuries to the upper extremities. Many of the recommendations were based upon their work on biomechanics of manual wheelchair propulsion and modeling of the upper extremities.

These studies were able to show that the use of ultra-light weight wheelchairs fitted for the user placed less stress on the upper extremities during propulsion and reduced the incidence of pain and injury. In addition, it prompted the design of more ergonomically designed manual wheelchairs and components through the application of advanced engineering materials, design processes and manufacturing techniques. Manual wheelchairs today are nothing like the first wheelchair that I received 24 years ago. This is an example of how a problem faced by many veterans who use wheelchairs was investigated and led to new products and changes in clinical practice.

I mentioned the development of clinical practice guidelines earlier, but VA has also been a leader in the development and application of technical standards, especially for wheelchairs. Technical standards help to ensure minimum quality and allow the objective comparison of products or services. There is currently a suite of technical standards adopted by the Rehabilitation Engineering Assistive Technology Society of North America and the American National Standards Institute that the VA uses in its purchasing decisions. VA research and development has been, and continues to be, a cornerstone for clinical and technical standards development. These standards affect thousands of veterans who use wheelchairs, and millions of non-veterans with disabilities.

Mr. Chairman, I have tried to give a few examples of the spectrum of wheelchair and rehabilitation engineering research in Pittsburgh and to show you how it is integrated into VA medical care, which is our primary focus. I will be happy to answer any questions that you may have. Thank you.

[The prepared statement of Dr. Cooper appears on p. 171.]

Mr. SIMMONS. Thank you very much for the testimony. I thank everybody for their testimony. We have heard a lot this morning and we are now into the afternoon. And the question that I would like to ask is a somewhat general and perhaps even philosophical question. Mr. Harman has given us an interesting presentation on how science and technology has made tremendous breakthroughs and Dr. Aisen has raised the question of choices.

I served as a Senate staffer many years ago and used to see Senator Bob Dole on a regular basis. And two things were always apparent about Bob Dole. He had the Purple Heart button in his lapel, he always wore it, and he always carried a pencil in his right hand. He carried a pencil in his right hand because he couldn't shake hands with his right hand, as I recall, and that was his way of identifying that he had received grievous wounds during World War II. And yet at no point in his career that I am aware of did

he make the decision to take advantage of the newer technologies. So he chose, I guess to say, he chose to stick with the pencil.

Our colleague or my colleague, my comrade in arms, Mr. Downs, who was wounded in the Vietnam war, and welcome home. It is good to have you back.

Mr. DOWNS. It is good to be here.

Mr. SIMMONS. It is great to have you here. We thank God every day, don't we?

He has chosen a metal prosthesis, and yet just earlier today we had two young soldiers back from Iraq, one of whom was using a hand that has amazing properties and yet you have chosen not to use the hand. He chose to use the hand. We have had testimony today from Dr. Cooper who, I understand among other things, is a champion wheelchair racer. Is that true?

Mr. COOPER. At one time, yes.

Mr. SIMMONS. At one time. I will bet. Well, I used to be a runner at one time. Now I am just a jogger or a loafer I guess you could say. But a racer. In other words, you raced in these things.

Mr. COOPER. That is correct.

Mr. SIMMONS. I have had the experience of riding a Segway, which I am told was designed so people who are confined to wheelchairs actually have a chance to stand up and be vertical and be high and be eye to eye. So the Segway is an amazing piece of technology that may have some applications for those who currently use wheelchairs.

And so the essence of my question goes to the panel to answer in any way they wish, but in particular, I would focus on Dr. Cooper and Mr. Downs. How does choice factor in to your decisions to use the devices that you use and is the technology keeping up with what you want or have you decided that the level of technology you have is adequate for you even though there are more technological devices out there? How do veterans working with the DOD and the VA ultimately make these choices? How does that process work and is it working well?

Mr. DOWNS. Well, in my own case, when I started working with Walter Reed, both Walter Reed and myself wanted to—I wanted to try the MyoElectric arm, but I am so used to using the arm I have been using for 36 years, to me it is convenient. It is like a pair of shoes. I hate to get a new pair of shoes because you have to break them in. So it is like this: when it fits me right, it is just right.

I am going to get the MyoElectric arm just because I am curious and I want to do a comparison. However, one of the differences is that it takes a lot of training to put the electrodes on my stump and to go through the exercises so I learn how to control it properly. And that takes time. And so I haven't had the time to do it. And it is heavy. So I am sort of—I am happy where I am with it, but I do want to try it for curiosity, but it is nice to know in the VA I have the choice of doing it if I want.

When the C–Leg first came out, we were very suspicious that the technology could be that good. One of my employees, a Marines who lost his leg above the knee in Vietnam, decided to try it and see if it would work. We figured he was pretty cynical and if he liked it, then we might make a good decision on it. And he was amazed. It made such a difference in his function.

We started pushing the C–Leg throughout the VA system and it was relatively new. So we need to expand the effort to prescribe high tech prosthetics. Veterans have the choice and they come to us to ask for new devices. We see from our records that we are providing more and more high tech, especially things that make life more comfortable and functional. Not like the racing limb that we saw earlier, but the energy storing fact. The ongoing storing fact is an advance. It is good for just about all categories of amputees. Then variations in the technology, but we are providing a lot of newer technology.

The endoskeletal systems replace the exoskeletal systems for the most part. So yes, the choice is there. We try to make sure that the amputee teams are educated and providing information to the amputees, but we find a lot of the amputees get the information and come to us and ask for it too. So the choice is there and we want people to have that choice.

Mr. SIMMONS. Thank you very much.

Dr. Cooper, any thoughts on choice?

Mr. COOPER. Yes. I am a little different than Fred, I guess. I like to try what is newest. I guess that is being an engineer and a scientist. So—and also as you grow older, especially I think for wheelchair users, you want to maintain as much of your function and your ability to participate in the community and the newer technology allows that to happen. And so both from a professional and personal perspective, I am always looking for whatever new technology can help maintain or improve my function.

As far as choice for the veteran, my personal philosophy, and I think a philosophy that permeates much of the VA, is that the veteran should be part of the team in selecting their technology and that the role of the clinicians and the VA is to provide the veteran with options to inform them of what is available and how that might work for them and so that the veteran ultimately can make informed decisions and that the veteran should be, in the end, leading the process for what technology will work best for that individual.

And I work and use my wheelchair, you know, 16, 18 hours a day, 365 days a year. It is hard for a clinician, on one or a two hour visit, to make that decision without including me in that process. And I think that is true of most veterans. And I think the VA embraces that and understands that process.

Mr. SIMMONS. I appreciate that. I see I have got my red light. See, red lights apply to us as well. So I now yield——

Mr. RODRIGUEZ. I would like for the chairman to take time to allow the good Dr. Kussman to answer you, I think.

Mr. SIMMONS. Yes. He is looking eager. I reading you wrong?

Dr. AISEN. I think that clearly we always have to look at what the veteran wants when we do research, but I remember personally that I didn't think the Internet was all that exciting at first, you know, when DARPA first invented it or a former vice president invented or whoever invented it. And now I can't live without it and I think most of us can't. And when we brought osio integration to veterans at the winter games a couple of years ago, most people were horrified. They said, "I don't want anything like that."

But the more we looked at European experience, the more we realized there was something there and that people feel this is part of their body, they are able to perceive vibration and position. So we think this is something that begs investigation and we may—we need to make available to our veterans, at least learn how to make it possible for them to have it.

A couple of other things I wanted to mention. One is that Gail Reiber, one of our researchers, has been studying people who have had lower limb amputation and been living with them since World War II, since Korea, since Vietnam. And there is, of course—I mean, everybody observes this, but this is now documented, a very high rate of arthritis in the opposite limb and the low back. And so we can't just sit and be comfortable if we know that there are complications that can be avoided.

There is also the issue of people who have diabetes, lose a limb and never walk again so that technology could be very liberating for them too. And then finally, there was talk earlier about the DARPA chip in the monkey. I mean, once we can have—and those chips are going to be implanted in quadriplegics this summer up in New England so that they can perhaps learn to control an environment. Well if that chip can control an environment, that chip can contribute to a better prosthesis. So there is always something possibly better out there and I think that as comfortable as people may be, we are obligated to see what is possible for them.

Mr. SIMMONS. Yes, Dr. Kussman.

Dr. KUSSMAN. Mr. Chairman, I just wanted to say that looking at the C–Leg in particular, the data that we have is—and it is not perfect data, but we have, in 2003, purchased and worked with a veteran for a hundred and twenty-four-plus C–Legs in the VA.

So it is there and when it is appropriate—one of the things that we have talked about among ourselves and with Walter Reed is that if you look across the spectrum of amputees, you know, we are focusing on young people who are mobile and want the good ankle and the C–Leg and all those other things and that is critically important. But to look at our preponderance of amputees in the VA, our more geriatrics vascular types, and the C–Leg may not be the appropriate thing for them because it may not be of value.

So from a clinical perspective, you have to go on a case by case basis on what the individual wants and what is clinically appropriate for them because if giving them a C–Leg doesn't make them any better, in fact, some ways can be counterproductive for them and they might be like Fred, you know, they don't like anything new.

Mr. SIMMONS. Mr. Harman.

Mr. HARMAN. Mr. Chairman, if I may just add to that. The question of choice is a subjective thing, and I think this is really what we are talking about. And not all technology is appropriate in every situation. And the fundamental research that we are talking about doing, both at the DOD and the VA, is good, clear outcome studies that can point in the direction for good, clinical protocols. And then it would lead us to the appropriate product and the appropriate technology.

So—and that hasn't been done in our industry. Our industry has been focused in the private and public sector on basically applying

existing science and technology. And we really haven't spent the time on good clinical protocols and outcomes such as the pharmaceutical industry and other medical device industries. That is what is fundamentally missing and that is one of the requests that we have of the VA and DOD.

Mr. SIMMONS. I think that is a very good point, and I agree with you that other industries have done that very successfully. And so that represents some place for us to go in the future.

I have consumed a lot of time. Mr. Strickland, please.

Mr. STRICKLAND. Mr. Chairman, it was time well spent, I believe. Mr. Chairman, I have here a letter from Richard Fuller, who is the National Legislative Director of the Paralyzed Veterans of America. It is a letter that he had sent to Senator Stevens regarding appropriations for DARPA, and I was wondering if I would be able to submit that for the record.

Mr. SIMMONS. Absolutely. Without objection, and hearing none, so ordered.

[The provided material appears follows:]

April 27, 2004

The Honorable Ted Stevens, Chairman
Senate Appropriations Subcommittee on Defense
SD-119 Dirksen Senate Office Building
Washington, DC 20510

Dear Mr. Chairman:

On behalf of Paralyzed Veterans of America (PVA), all of whose members are veterans with spinal cord injury or dysfunction, I am writing to request your support in providing full funding for FY 2005 for the Human Assisted Neural Devices (HAND) program at the Defense Advanced Research Projects Agency (DARPA).

Neurological injuries and deficits are one of the most frequently occurring battlefield injuries faced by soldiers in combat today. In severe cases such as paraplegia and quadriplegia, these injuries leave many veterans and their loved ones hoping that research will one day develop ways for them to regain mobility, greater independence and improved quality of life.

The HAND program, formerly named the Brain-Machine Interface, has attracted a high level of public attention based on the success of its researchers at decoding brain signals from a monkey and using those signals to move robotic arms with brain power alone. The likelihood this technology will one day allow service personnel who incur severe battlefield neurological injuries to live richer and more productive lives in the future is closer than ever before. For this reason, we urge you to fund the HAND program at or above the $12 million amount requested in the President's Budget Request for FY 2005.

Based on initial reports from military action in Iraq and Afghanistan the good news is that head and body armor provided to our troops is working, increasing the survival rate for many. However, from all reports, the sustained wounds currently being treated are qualitatively different from those seen in past wars and potentially more complex requiring continued research in order to develop effective treatments and rehabilitation.

As we see increasing numbers of casualties, and new PVA members, return from the battlefield, we believe the Department of Defense has a clear responsibility through DARPA to advance this important research at the full requested funding level.

Should you have any questions regarding our position in this matter please do not hesitate to contact me at (202) 416-7669. Thank you for your consideration.

Sincerely,

Richard B. Fuller
National Legislative Director

Chartered by the Congress of the United States
801 Eighteenth Street, NW ★ Washington, DC 20006-3517
phone:(202) 872-1300 ★ tdd:(202) 416-7622 ★ fax:(202) 785-4452 ★ www.pva.org

Mr. STRICKLAND. Thank you, Mr. Chairman. I want to thank you for your testimony, and I want to thank you for what you are doing. To hear about the work to me is exciting because you wonder what else is out there. What more can be done. And I would just—I have got a concern, which I am going to share and this is my concern. The VA HUD bill is currently in committee and my understanding is that we have just had two attempts in that committee, in the conference committee, to increase funding. Both of those attempts were voted down.

In fiscal year 2004, for medical and prosthetic research, approximately $406 million was appropriated. That is for 2004. The VA budget request for 2005 for medical and prosthetic research is $385 million. That is $21 million less than was appropriated in 2004. And the committee staff tells me that the problem may be even greater than that. It may not be $21 million, it may be because of various accounting procedures. It may be as much as $50 million less for this research in 2005 than was appropriated in 2004.

And Dr. Kussman, I guess the question that I would ask you is how are you going to deal with that? How are you going to eat that kind of loss or deal with that kind of loss and still carry out, you know, this vital research that we all believe is so important?

Dr. KUSSMAN. I am not sure how to answer it because I was—I am not really—I wasn't as knowledgeable about that deficit that you are commenting on and certainly would have to go back and look at that issue. I know there is some budgetary issues that are going on, but I—certainly that would be a challenge for us.

Mr. STRICKLAND. Mr. Chairman, I am not going to ask another question and I—I mean, I know where you stand on these issues.

There is absolutely no doubt the chairman here is a champion for you and for what you do, but I am just disturbed that at a time when we are creating more and more people who may be in need of benefitting from this kind of research that—I mean, I just think it is ghastly. I think it is shameful. I don't know what word to find to apply to a decision to cut funds for this kind of vital work. It just seems appalling to me. I want to thank you for your testimony, for your information, your dedication and for your inspiration. Thank you very much.

Thank you, Mr. Chairman.

Mr. SIMMONS. And thank you, Mr. Strickland, for raising that issue for the record and I welcome the letter from the DVA. I am sure it will be very helpful to us. I thank Mr. Strickland for his kind words, but I will say that there are many fighters for the veterans in this committee, both sides of the aisle. Certainly our chairman Chris Smith, our ranking member Lane Evans, Mr. Rodriguez and I and others have made our voices heard on these subjects and we will continue to fight as hard for our veterans today and in the future as they have fought for us in the past.

I want to thank this panel in particular. We would have liked, if the table was large enough, to place them with some of the earlier panels, especially those that featured our soldiers from the Vietnam war and from the war in Iraq who are using some of the devices that we talked about, but unfortunately, the table is of limited size.

Your contributions to the committee are exceptional. We appreciate it. The testimony that you have provided today will be incorporated into our efforts to create better policies for the future and to work to fund those policies. And I thank you.

And if there are no other comments for the record, this hearing is now adjourned.

[Whereupon, at 1:39 p.m., the committee was adjourned.]

APPENDIX

STATEMENT OF LANE EVANS
RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS AFFAIRS

HEARING ON THE EVOLUTION OF VA-DOD COLLABORATION IN RESEARCH AND AMPUTEE CARE FOR VETERANS OF CURRENT AND PAST CONFLICTS, AND NEEDED REFORMS IN VA BLIND REHABILITATION SERVICES

JULY 22, 2004

Mr. Chairman, we have one of our most important hearings ahead of us. VA's specialized programs developed to treat the war wounds of veterans are often said to be its "reason for being." With new combat injuries occurring almost daily, coordinating these services with state-of-the-art military health care services and research is essential to ensure the best quality care.

We often say VA is at a turning point. For these programs developed to address service disabilities which have gone "full circle," since their establishment, it is literally true. VA programs created to serve the needs of young service members with acute traumatic injuries have evolved to serve the ongoing health issues of aging veterans who have survived with severe chronic injuries or who have acquired age-related conditions that can best be addressed through these specialized services. The programs must now be re-assessed to ensure that they once again meet the acute rehabilitation needs of a new generation of veterans with traumatic injuries.

Prosthetics may well serve the needs of older veterans who lose limbs due to diabetes, or other disorders associated with aging, but might not be state-of-the-art for younger veterans who have the expectation of fully restoring functionality. Likewise, with blinded veterans, VA has adapted its programs to meet the needs of aging veterans who have low-vision or who gradually lose vision due to disease. GAO reports that about 85% of these veterans have some residual sight. Few veterans have recently sought services due to traumatic injuries; few have presented to centers to adapt to total blindness; and, few suffer from the compound injuries associated with blast injuries, like the veterans of the current deployments are confronting and will continue to confront.

I think we will hear good news today regarding some important initiatives that are developing to address both of these critically important programs. VA, DOD, and the private sector will discuss some of the investments they are making in exciting new technologies that could revolutionize amputee care and may even have applications for veterans with neurological diseases or disorders, such as Parkinson's disease. I look forward to their testimony.

I am also pleased that dynamic leadership in both programs in VA and DOD is willing to look at new ways of delivering care and services to these seriously disabled veterans.

Yet we are still dogged by some of the problems of the past. Centralizing VA's prosthetics budget has helped to ensure that high-quality prosthetics are available on a more timely basis, but blind services have not enjoyed this sort of funding. VA networks without blind rehabilitation centers may too often rely upon cheaper, but not necessarily better, alternatives to provide care for blindness or low vision. Waiting times for blind services are entirely too long. Not enough outpatient services have become available to meet the evolving needs of the blinded veterans' population. There are concerns about the relative dearth in the training "pipeline" for specialized clinicians and researchers that can adequately serve veterans' needs for both of these programs.

We must also understand if these programs are appropriate for the veteran with a new traumatic injury, and, if not, how they need to be adapted to meet these needs.

Mr. Chairman, I believe we will hear some excellent testimony about these critical programs today and I will be pleased to hear from our witnesses.

Statement of Congresswoman Shelley Berkley
House Committee on Veterans' Affairs
Hearing on Amputee Care and Blind Rehabilitation Services
July 21, 2004

Thank you, Mr. Chairman. I am pleased that we are discussing how to better meet the needs of blind veterans, and disabled veterans who have suffered traumatic amputations.

Veterans across the nation lose their vision from age, diabetes, and other disease-related visual impairments. In Southern Nevada, 424 legally blind veterans receive care at the VA. Although Southern Nevada's VA has a Blind Rehabilitation Outpatient Specialist–1 of only 23 in the entire VA Healthcare System–and a Visual Impairment Service Team Coordinator, it is unable to provide all services to all blind veterans in need.

Because of inadequate services, up to 100 of these blind veterans in Southern Nevada are forced to travel over 400 miles to Arizona's Southwest Blind Rehabilitation Center. These veterans will spend 4 weeks to 6 months away from their family and friends to learn the skills necessary to live as independently as possible. The VA in Southern Nevada is optimistic that when the new medical complex is built, it will have the ability to expand services to include more local training services such as short-stay blind rehabilitation programs.

As military operations continue overseas in Iraq and Afghanistan, the new generation of veterans continues to grow. With this in mind, the VA must be prepared to help this new generation of veterans adjust, especially those who have been traumatically injured. The DoD has been primarily responsible for the soldiers who have suffered traumatic amputations and have provided them with state-of-the-art prosthetic care. However, any veteran with a prosthetic will need proper maintenance and replacement care. Currently, the Southern Nevada VA serves 21 veterans with amputated limbs, but must contract these services out. However, the new medical complex in Southern Nevada will be able to make artificial braces in-house, improving access to care for veterans with limb amputees.

The experiences of the blind veterans and veterans with amputated limbs in Southern Nevada highlight once again the great need for the new VA medical complex in Las Vegas. I look forward to hearing from the witnesses regarding our blind and disabled veterans. Thank you, Mr. Chairman.

STATEMENT OF CIRO D. RODRIGUEZ
RANKING DEMOCRATIC MEMBER
HEALTH SUBCOMMITTEE
COMMITTEE ON VETERANS AFFAIRS

HEARING ON THE EVOLUTION OF VA-DOD COLLABORATION IN RESEARCH AND AMPUTEE CARE FOR VETERANS OF CURRENT AND PAST CONFLICTS, AND NEEDED REFORMS IN VA BLIND REHABILITATION SERVICES

JULY 22, 2004

- Mr. Chairman, thank you for holding this important hearing.
- VA has long been considered at the forefront of rehabilitative care, particularly for disabilities associated with military service.
- This assumption is now being challenged as we face the needs of fresh combat injuries from the current deployments to Iraq and Afghanistan.
- Services and technologies are evolving to meet our newest veterans' needs and expectations.
- The good news is innovations in battlefield medicine and protective gear have made it possible for the members of our armed forces to survive assaults that would have previously ended their lives.
- In fact, service members are surviving with more severe and complex traumatic injuries than ever before.
- Blast injuries can cause a compounding array of problems including amputations, blindness, spinal cord injury, severe burns, traumatic brain injury, post-traumatic stress disorder and other mental health problems.
- We must ensure that there are comprehensive means of addressing these complicated problems.

- VA and DOD programs long ago established to meet the specialized rehabilitative needs of service-disabled veterans must now re-evaluate their services to prepare to meet these evolving needs.

- I am encouraged by much I have read and seen.

- We are told that VA and DOD are working more closely than ever to address these issues—and they will need to.

- Many of our witnesses will discuss how these rehabilitative programs must evolve to meet, not only the needs of new, recently injured veterans, but also veterans from past eras who continue to rely on them.

- Obstacles such as the availability of resources and shortages in the clinical staff and research talent pool that will make these programs work present formidable challenges.

- Mr. Chairman, we will hear a lot of enthusiasm and dedication from some of the new leaders in VA and DOD who are attempting to overcome these challenges.

- I am ready to work with you to ensure that we adequately meet the needs for any resources and legislative remedies that may be necessary to help them improve these vital programs.

The Honorable Michael H. Michaud
House Committee on Veterans Affairs
July 22, 2004

Thank you Mr. Chairman.

I am pleased we are meeting today to consider a number of important measures aimed at improving the quality of life of veterans and their families.

I want to thank Chairman Smith for recognizing the need to address research and care for veterans who have literally given their limbs for their country and those who suffer from other traumas such as blindness and the effects of traumatic brain injuries.

We must recognize that when this Nation sends its men and women into war, there are costs beyond those allocated for guns and bullets.

I had the opportunity to visit a number of our servicemembers who recently returned from Iraq and are now recovering at Walter Reed.

We should do everything in our power to provide the best possible medical care for these brave individuals who have given so much for our country.

The lives of our servicemembers, especially those who are here today have been profoundly changed as the result of their injuries.

We must be sure that VA has the personnel and financial resources to adequately address their health care needs.

I want to particularly thank our wounded servicemembers for being here today and for helping to inform our debate on these important issues.

Mr. Chairman, we have a responsibility to care for the men and women in uniform, not only while they are in harm's way, but also upon their return.

Thank you for your leadership on these matters.

Thank you Mr. Chairman.

OPENING STATEMENT
Senator Bob Graham
Ranking Member
Committee on Veterans' Affairs
United States Senate

Hearing on Needed Reforms in VA Blind Rehabilitation Services
July 22, 2004

Thank you, Chairman Smith and Ranking Member Evans, for holding this hearing today. I am pleased that we have finally begun to make some progress on providing timely rehabilitation services to blinded veterans.

The Department of Veterans Affairs (VA)'s Blind Rehabilitation Centers (BRCs) are regional inpatient centers designed to provide comprehensive, high-quality care to meet a wide-range of rehabilitation needs of blinded veterans. Recent estimates by VA show that approximately 157,000 veterans are legally blind, 44,000 of which are enrolled in the VA health care system. VA also reported that 2,100 of these veterans received treatment at a BRC.

I note with great pride that one of these BRCs is located at the West Palm Beach VA Medical Center (VAMC) in my own state of Florida. The West Palm Beach VAMC currently has approximately 70,000 enrolled veterans, and its phenomenal BRC is the referral center for all of the blind and visually impaired veterans in Florida seeking rehabilitation through VA. At this center, specially trained staff provide an array of services designed to maximize the independence of the veterans it treats. BRC staff assist veterans in making an emotional and behavioral adjustment to blindness through individual counseling sessions and group therapy meetings. In addition, the Center provides orientation and mobility training, as well as a variety of skill courses designed to help blinded veterans achieve a realistic level of independence.

Unfortunately, the success of the BRCs has led to overwhelming – and unacceptable – waiting times for blinded veterans to get care. In order to alleviate this problem, VA established the Blind Rehabilitation Outpatient Specialist Program (BROS) in 2000. This program was meant to reduce the backlog for services by providing rehabilitation training to meet the limited needs of veterans who are not candidates for the BRC program and by providing services that will enhance the effectiveness of the BRC. While BROS has addressed a vital need, the waiting list for veterans seeking services at BRCs continues to grow.

I have been concerned about the waiting times blinded veterans face, as well as the accuracy of VA's data. Last year, I asked GAO to study VA's BRC program, focusing particularly on three aspects: what the actual average waiting times are for those seeking services at a BRC, also determining which specific regions have experienced the most rapid increase in waiting times; the clinical makeup of the patients on the waiting list; and recommendations as to viable actions that should be taken to reduce the backlog on the BRC waiting list.

I would like to thank GAO for fulfilling my request and for providing their report, titled:

"VA Needs to Improve Accuracy of Reported Wait Times for Blind Rehabilitation Services." In its study, GAO made two very significant findings. First, it found that the average length of time VA reported veterans were waiting for admission to a BRC was inaccurate. This miscalculation resulted from the fact that some of the data used to determine the wait times was incomplete or incorrect. Second, GAO discovered that the BRCs used different procedures for their calculations, also leading to the inaccurate waiting times.

In order to correct these serious deficiencies, GAO has advised that VA instruct both the program office to develop more specific instructions for calculating wait times and the BRCs to adhere to these instructions by developing procedures to compile complete and accurate information on the waiting times. I am pleased with these recommendations as an important first step in correcting the problems the BRCs face. However, we must remain diligent in our efforts if we are to assure that blinded veterans receive the quality of care they have earned.

I would be remiss if I did not take this opportunity to also thank the Blinded Veterans Association. Without its tremendous work and dedication to improving the lives of blinded veterans, we may never have made the strides we have in this important field.

Thank you.

United States Government Accountability Office

GAO

Testimony
Before the Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 9:30 a.m. EDT
Thursday, July 22, 2004

VA HEALTH CARE

More Outpatient Rehabilitation Services for Blind Veterans Could Better Meet Their Needs

Statement of Cynthia A. Bascetta
Director, Health Care—Veterans' Health and Benefits Issues

GAO-04-996T

July 22, 2004

GAO
Accountability · Integrity · Reliability

Highlights

Highlights of GAO-04-996T, a report to the Committee on Veterans' Affairs, House of Representatives

VA HEALTH CARE

More Outpatient Rehabilitation Services for Blind Veterans Could Better Meet Their Needs

Why GAO Did This Study

In fiscal year 2003, the Department of Veterans Affairs (VA) estimated that about 157,000 veterans were legally blind, and about 44,000 of these veterans were enrolled in VA health care. The Chairman of the Subcommittee on Health, House Veterans' Affairs Committee, and the Ranking Minority Member, Senate Veterans' Affairs Committee expressed concerns about VA's rehabilitation services for blind veterans. GAO reviewed (1) the availability of VA outpatient blind rehabilitation services, (2) whether legally blind veterans benefit from VA and non-VA outpatient services, and (3) what factors affect VA's ability to increase veterans' access to blind rehabilitation outpatient services. GAO reviewed VA's blind rehabilitation policies; interviewed officials from VA, the Blinded Veterans Association, state and private nonprofit agencies, and visited five Blind Rehabilitation Centers (BRC).

What GAO Recommends

GAO recommends that the Secretary of Veterans Affairs direct the Under Secretary for Health to issue, as soon as possible in fiscal year 2005, a uniform standard of care policy that ensures that a broad range of inpatient and outpatient blind rehabilitation services are more widely available to legally blind veterans. In commenting on a draft of this testimony, VA concurred with our recommendation.

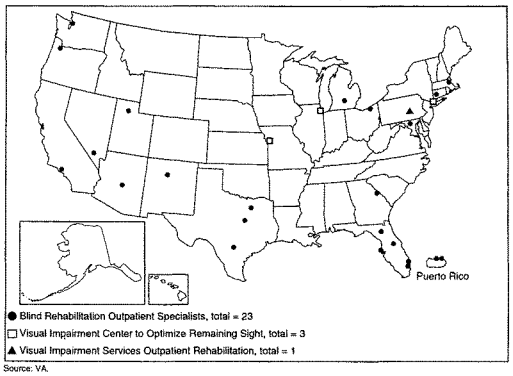
www.gao.gov/cgi-bin/getrpt?GAO-04-996T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101

What GAO Found

VA provides three types of blind rehabilitation outpatient training services. These services, which are available at a small number of VA locations, range from short-term programs provided in VA facilities to services provided in the veteran's own home. They are Visual Impairment Services Outpatient Rehabilitation, Visual Impairment Center to Optimize Remaining Sight, and Blind Rehabilitation Outpatient Specialists.

Locations of VA Outpatient Blind Rehabilitation Services, May 2004



Source: VA.

VA reported to GAO that some legally blind veterans could benefit from increased access to outpatient blind rehabilitation services. When VA reviewed all of the veterans who, as of March 31, 2004, were on the waiting list for admission to the five BRCs GAO visited, VA officials reported that 315 out of 1,501 of them, or 21 percent, could potentially be better served through access to outpatient blind rehabilitation services, if such services were available.

GAO also identified two factors that may affect the expansion of VA's outpatient blind rehabilitation services. The first involves VA's longstanding position that training for legally blind veterans is best provided in a comprehensive inpatient setting. The second reported factor is VA's method of allocating funds for medical care. VA is currently working to develop an allocation amount that would better reflect the cost of providing blind rehabilitation services on an outpatient basis.

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the health care rehabilitation services the Department of Veterans Affairs (VA) provides to legally blind veterans. In fiscal year 2003, VA estimated that about 157,000 veterans were legally blind,[1] and about 44,000 of these veterans were enrolled in VA health care. Since the 1940s, the demographics of VA's blind veteran population have changed from young veterans totally blind as a result of traumatic injury to primarily older veterans whose legal blindness is caused by age-related eye diseases.

You expressed concern that VA has not updated its delivery of care options for blind rehabilitation programs by offering, in addition to inpatient services, a range of outpatient services closer to where veterans live.[2] To determine how VA serves the needs of legally blind veterans and what role outpatient training services could play, we reviewed (1) the availability of VA outpatient blind rehabilitation services, (2) whether legally blind veterans benefit from VA and non-VA outpatient services, and (3) what factors affect VA's ability to increase veterans' access to blind rehabilitation outpatient services.

To address these issues, we met with officials from VA's Rehabilitative Strategic Health Care Group, including the Blind Rehabilitation Service Program Office (program office). We also met with VA's directors for ophthalmology and optometry. We reviewed applicable policies and procedures regarding VA's blind rehabilitation services, its strategic plan for blind rehabilitation, and its planning documents for special disability populations. To determine what blind rehabilitation services were available to veterans, we visited five medical centers offering blind rehabilitation services and met with Blind Rehabilitation Center (BRC) officials as well as case managers and rehabilitation specialists who work

[1]VA defines "legal blindness" as when the patient's best-corrected central visual acuity, with ordinary glasses or contact lenses, is 20/200 or less in the better eye (measured by the Snellen Visual Acuity Chart), or when the field of useful vision is 20 degrees or less in the better eye. For example, a legally blind person can read only the big "E" on the eye chart or sees as if looking through a paper towel tube.

[2]This work was requested by the Chairman, Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives and the Ranking Minority Member, Committee on Veterans' Affairs, United States Senate.

with legally blind veterans.[3] We asked BRC officials and case managers to evaluate veterans on the waiting lists for admission to these BRCs as of March 31, 2004, to identify those who could potentially be better served through access to outpatient blind rehabilitation services, if such services were available. We also interviewed case managers who were located at medical centers without a BRC and representatives of the Blinded Veterans Association to gain their perspectives on the types of care that would benefit legally blind veterans. In addition, we met with officials from state and private nonprofit agencies in Arizona, Illinois, and Washington to learn about the blind rehabilitation programs they offer older citizens.[4] Our review was conducted from September 2003 through July 2004 in accordance with generally accepted government auditing standards.

In summary, VA provides three types of blind rehabilitation outpatient training services, but they are available only in a few VA locations. These services range from short-term programs provided in VA facilities to services provided in the veteran's own home. VA also believes that some legally blind veterans could benefit from increased access to outpatient blind rehabilitation services. In fact, VA officials reported to us that 21 percent of veterans on the waiting lists for admission to the five BRCs we visited could potentially be better served through access to outpatient blind rehabilitation services, if such services were available. Finally, two factors affect the expansion of VA's outpatient blind rehabilitation services. The first involves VA's long-standing position that training for legally blind veterans should be provided in a comprehensive inpatient setting. This delivery model has not kept pace with VA's overall health care strategy that reduces its reliance on inpatient care and emphasizes more outpatient care. The second reported factor affecting the use of outpatient blind rehabilitation services is its method of allocating funds for medical care. VA's Visual Impairment Advisory Board (VIAB) believes that the funds allocated for basic outpatient care for legally blind veterans do not cover the cost of providing blind rehabilitation outpatient services. The VIAB is currently working with VA's Office of Finance and Allocation

[3]We visited the BRCs located in Tucson, Arizona; West Palm Beach, Florida; Augusta, Georgia; Hines, Illinois; and American Lake, Washington. These BRCs were selected based on differences in geographic location and the number of beds available at the BRC.

[4]We selected these states because they were in the same geographic location as three of the BRCs we visited.

Resource Center[5] to develop an allocation amount that would better reflect the cost of providing blind rehabilitation services on an outpatient basis, which could provide an incentive to expand this care. We are recommending that VA take action to ensure that a broad range of inpatient and outpatient blind rehabilitation services is more widely available to legally blind veterans.

Background

In 1944, President Franklin D. Roosevelt made a commitment that no servicemen blinded in combat in World War II would be returned to their homes without adequate training to meet the problems imposed by their blindness, according to VA. From 1944 to 1947, the Army and Navy provided this rehabilitation training. In 1947, responsibility for this training was transferred to VA, and in 1948, VA opened its first BRC to provide comprehensive inpatient care to legally blind veterans.

In 1956, blind rehabilitation services were expanded to include veterans whose legal blindness was not service-connected. Because of this expansion, the demographics of VA's blind veteran population shifted toward predominately older veterans whose legal blindness was caused by age-related eye diseases. Expanded eligibility also caused an increase in demand for services. VA responded to this demand by opening 9 additional BRCs in the United States and Puerto Rico for a total of 10 facilities with 241 authorized beds. (See table 1.) As of May 5 2004, VA reported that there were 2,127 legally blind veterans waiting for admission to BRCs.[6]

[5]The Allocation Resource Center is responsible for developing, implementing, and maintaining management information systems that provide data for the Veterans Health Administration's budget process.

[6]See U.S. General Accounting Office, *VA Needs to Improve Accuracy of Reported Wait Times for Blind Rehabilitation Services*, GAO-04-949 (Washington, D.C.: July 22, 2004).

Table 1: Location of VA's Blind Rehabilitation Centers, the Year Each Was Opened, and the Number of Authorized and Staffed Beds, as of May 2004

		Beds*	
Location	**Year Opened**	**Authorized**	**Staffed**
American Lake, Washington	1971	15	12
Augusta, Georgia	1996	15	15
Birmingham, Alabama	1982	32	32
Hines, Illinois	1948	34	34
Palo Alto, California	1967	32	27
San Juan, Puerto Rico	1986	12	11
Tucson, Arizona	1994	34	27
Waco, Texas	1974	15	15
West Haven, Connecticut	1969	34	27
West Palm Beach, Florida	2000	18	18
Total		**241**	**218**

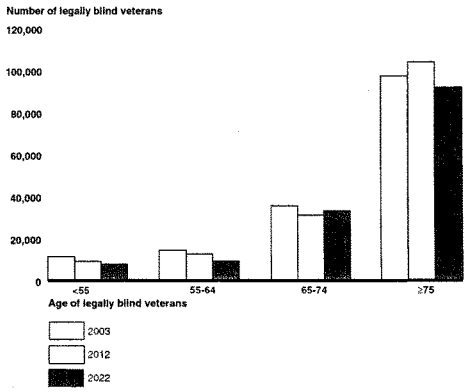
Source: VA.

*Authorized beds are the total bed capacity of the BRC. Staffed beds are the beds available for admission of patients. According to VA's Capacity Report for 2003, the number of staffed beds may be less than authorized beds because the local medical center may have eliminated staff positions, imposed a hiring freeze, or experienced difficulties in recruiting qualified personnel.

In fiscal year 2003, VA estimated that about 157,000 veterans were legally blind,[7] with more than 60 percent age 75 or older. About 44,000 legally blind veterans were enrolled in VA health care. VA estimated that through 2022, the number of legally blind veterans would remain stable. (See fig. 1.)

[7]All legally blind veterans are given priority 4 status and currently are eligible to enroll in VA health care.

Figure 1: Estimated Age Distribution of Legally Blind Veterans, Fiscal Years 2003, 2012, and 2022

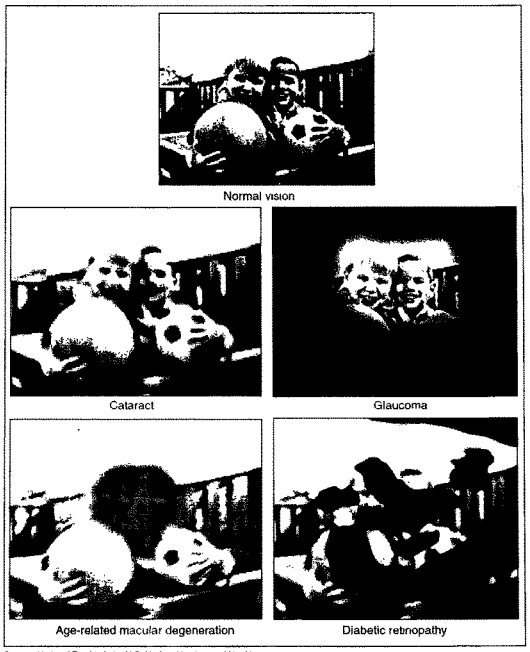


Source: Atlanta VA Rehabilitation Research and Development Center.

The National Institutes of Health (NIH) considers the increase in age-related eye diseases to be an emerging major public health problem. According to NIH, the four leading diseases that cause age-related legal blindness are cataract, glaucoma, macular degeneration, and diabetic retinopathy, each affecting vision differently. (See fig. 2 for illustrations of how each disease affects vision.) Cataract is a clouding of the eye's normally clear lens. Most cataracts appear with advancing age, and by age 80, more than half of all Americans develop them. Glaucoma causes gradual damage to the optic nerve—the nerve to the eye—that results in decreasing peripheral vision. It is estimated that as many as 4 million Americans have glaucoma. Macular degeneration results in the loss of central visual clarity and contrast sensitivity. It is the most common cause of legal blindness in older Americans and rarely affects those under the age of 60. Diabetic retinopathy is a common complication of diabetes impairing vision over time. It results in the loss of visual clarity, peripheral vision, and color and contrast sensitivity. It also increases the eye's

sensitivity to glare. Nearly half of all diabetics will develop some degree of diabetic retinopathy, and the risk increases with veterans' age and the length of time they have had diabetes.

Figure 2: Vision and Vision Loss Due to Age-Related Eye Diseases



Source: National Eye Institute, U.S. National Institutes of Health.

To assist legally blind veterans, VA established Visual Impairment Services Team (VIST) coordinators who act as case managers and are responsible for coordinating all medical services for these veterans, including obtaining medical examinations and arranging for blind rehabilitation services. There are about 170 VIST coordinators, who are located at VA medical centers that have at least 100 enrolled legally blind veterans. VIST coordinators are also responsible for certain administrative services such as reviewing the veteran's compensation and pension benefits. Almost all of VA's blind rehabilitation services for veterans are provided through comprehensive inpatient care at BRCs, where veterans are trained to use their remaining vision[8] and other senses, as well as adaptive devices such as canes, to help compensate for impaired vision. VA offers both basic and computer training. (See table 2 for examples of the types of skills taught during basic and computer training.)

[8]About 85 percent of those who are legally blind have some usable vision.

Table 2: Examples of Training Courses Offered at Blind Rehabilitation Centers

Basic training	Examples of skills taught
Visual skills	• Maximizing remaining vision through the use of alternative scanning or viewing techniques • Using magnification devices or closed circuit televisions to read or write
Orientation and mobility	• Moving around the home • Traveling through different environments • Using adaptive devices, such as telescopic devices for reading street signs
Living skills	• Cooking and eating • Doing laundry or changing light bulbs • Typing or keyboarding
Manual skills	• Using hand and power tools • Problem solving and organization of work
Leisure skills	• Going to sporting events • Playing golf or fishing • Developing a hobby, such as woodworking
Adjustment counseling	• Using counseling, therapy, and social interaction with others who have similar visual impairments to learn to adjust to blindness
Computer training	**Examples of skills taught**
Computer skills	• Operating a computer • Searching the Internet • Sending, receiving, and reading e-mail

Source: VA Blind Rehabilitation Service.

In fiscal years 2002 and 2003, VA spent over $56 million each year for inpatient training at BRCs. During this same time period, VA spent less than $5 million each year to provide outpatient rehabilitation training for legally blind veterans.

Blind Rehabilitation Outpatient Services Are Available in Few VA Locations

VA offers three types of blind rehabilitation outpatient services to legally blind veterans,[9] but these services are available in few VA locations. The three types of services include Visual Impairment Services Outpatient Rehabilitation (VISOR), Visual Impairment Center to Optimize Remaining Sight (VICTORS), and Blind Rehabilitation Outpatient Specialists (BROS). The services range from short-term outpatient programs provided in VA facilities to home-based services. Figure 3 identifies the locations throughout the United States and Puerto Rico where these services are offered.[10]

[9]Some VA low vision eye clinics also provide limited outpatient rehabilitation training to legally blind veterans whose remaining vision can be enhanced through the use of magnification devices. However, while VA has overall workload data for its eye clinics, it cannot disaggregate the data to identify how much low vision training is provided to legally blind veterans.

[10]All of VA's outpatient programs also treat low vision veterans in addition to those veterans who are legally blind. VA defines low vision as when the patient has significant uncorrectable visual impairments of 20/70 up to, but not including, 20/200.

Figure 3: Locations of VA Outpatient Blind Rehabilitation Services, May 2004

Source: VA.

VISOR

VISOR is a 10-day outpatient program located at the VA medical center in Lebanon, Pennsylvania, that offers training in the use of low vision equipment, basic orientation and mobility, and living skills. Serving veterans in the surrounding 13-county area, it is primarily for veterans who can independently perform activities of daily living and who require only limited training in visual skills and orientation and mobility, such as traveling within and outside their homes. According to a VISOR official, the program is meant to provide training to veterans while they wait for

admission to a BRC or to veterans who do not want to attend a BRC. Veterans who participate in this program are housed in hoptel beds[11] within the medical facility. In fiscal year 2003, 54 veterans attended the VISOR program; about 20 to 30 percent of these veterans were legally blind. According to a VISOR official, there is no waiting list for this program and the local medical center provides the necessary funding for it.

VICTORS Services

VICTORS is a 3- to 7-day outpatient program for veterans in good health whose vision loss affects their ability to perform activities of daily living, such as personal grooming and reading mail. The program provides the veterans with a specialized low vision eye examination, prescriptions for and training in the use of low vision equipment, and counseling. There are three VICTORS programs located in VA medical centers in Kansas City, Missouri; Chicago, Illinois; and Northport, New York. Veterans are housed in hoptel beds within the medical facility or in nearby hotels. In fiscal year 2003, VICTORS served over 900 veterans; about 25 to 30 percent of these veterans were legally blind. According to VICTORS officials, the wait time for admission to VICTORS varied from about 55 to about 170 days. The medical center where the program is located funds the services.

BROS Services

BROS are blind rehabilitation outpatient instructors who provide a variety of short-term services to veterans in their homes and at VA facilities. BROS train veterans prior to and following their participation in BRC programs, as well as veterans who cannot or do not choose to attend a BRC. BROS training addresses veterans' immediate needs, especially those involving safety issues such as reading prescriptions or simple cooking. There are 23 BROS throughout VA's health care system, with 7 located in the VA network that covers Florida and Puerto Rico. In fiscal year 2003, BROS trained about 2,700 veterans, almost all of whom were legally blind. Wait time for BROS services varied from about 14 to 28 days according to

[11]A hoptel is temporary lodging where no medical care is provided.

the BROS we interviewed. BROS are funded by the medical centers where they are located.[12]

Outpatient Services Provide Opportunities to Benefit Veterans

VA officials who provide services to legally blind veterans told us that some veterans could benefit from increased access to outpatient blind rehabilitation services. We obtained this information by asking VA to review all of the veterans who, as of March 31, 2004, were on the waiting lists for admission to the five BRCs we visited and to determine whether outpatient services could meet their needs. VA officials reported that 315 out of 1,501 of these veterans, or 21 percent, could potentially be better served through access to outpatient blind rehabilitation services, if such services were available. The types of veterans VA believes could potentially benefit from outpatient services include those who are very elderly or lack the physical stamina to participate in a comprehensive 28- to 42-day BRC program and those who have medical needs that cannot be provided by the BRC. For example, some BRCs are unable to accept patients requiring kidney dialysis. In addition, some veterans do not want to leave their families for long periods of time[13] and some legally blind veterans are primary caretakers for their spouses and are unable to leave their homes. VA officials also told us that veterans in good health who can independently perform activities of daily living and require only limited or specialized training could also be served effectively on an outpatient basis.

A VA study concluded that there is a need for increased outpatient services for legally blind veterans. In 1999, VA convened a Blind Rehabilitation Gold Ribbon Panel to study concerns about the growing number of legally blind veterans. The panel examined how VA historically provided blind rehabilitation services and recommended that VA transition from its primarily inpatient model of care to one that included both

[12]In connection with VA's fiscal year appropriations for 1995, the Senate Committee on Appropriations had recommended including $5 million for blind rehabilitation services to alleviate the lengthy waiting lists for such services. The conference committee agreed. *See* S. Rep. No. 103-311 (1994), H. Conf. Rep. No. 103-715 (1994). In addition to the BROS, these funds were also used to establish a BRC in Augusta, Georgia, and additional staff positions for VIST coordinators and computer specialists.

[13]A 2003 study of 150 veterans located in the southeastern United States who were recommended for BRC training by their VIST coordinators but who did not attend, found that 59 percent cited a reluctance to leave home for an extended period as an important reason for non-participation. Williams, M., *Help-Seeking Behavior as a Predictor of Participation in Department of Veterans Affairs-Sponsored Visual Impairment Rehabilitation.* A Dissertation (Decatur, GA.; 2003).

inpatient and outpatient services. In 2000, VA established the VIAB to implement the panel's recommendations. The VIAB drafted guidance for a uniform standard of care policy for visually impaired veterans throughout VA's health care system. This guidance outlined a continuum of care to provide a range of services from basic low vision to comprehensive inpatient rehabilitation training, including use of more outpatient services from both VA and non-VA sources. In January 2004, a final draft of the uniform standard of care policy was forwarded to VA's Health Systems Committee for approval. The committee believed additional information was needed for its approval and requested additional analysis that compared currently available blind rehabilitation services with anticipated needs. VA plans to complete this analysis in the first quarter of fiscal year 2005 and then resubmit the uniform standard of care policy and the additional analysis to the Health Systems Committee. VA officials were unable to provide a timeframe for the Health Systems Committee's approval.

Some VIST coordinators have already provided outpatient services to legally blind veterans by referring them to state and private blind rehabilitation services. For example, in Florida a VIST coordinator referred veterans to the Lighthouse for the Blind for computer training at its outpatient facility if they did not live near and did not want to travel to the BRC. A VIST coordinator in Oklahoma arranged contractor-provided computer training in the veteran's home for veterans with a 20 percent or more service-connected disability. The coordinator issued the computer equipment to a local contractor; the contractor then set up the equipment in the veteran's home and provided the training. Another VIST coordinator in North Carolina referred all legally blind veterans to state service agencies, including veterans waiting for admission to a BRC. Each county in that state had a social worker for the blind that referred its citizens to independent living programs for in-home training in orientation and mobility and living skills. The state provided this training at no charge to the veteran and VA paid for the equipment.

Recently, VA has begun to shift computer training from inpatient settings at BRCs to private sector outpatient settings. VA's goal was to remove from the BRC waiting list by July 30, 2004, those veterans seeking admission to a BRC only for computer training. In spring 2004, VA issued instructions stating that the prosthetic budget of each medical center, which already paid for computer equipment for legally blind veterans,

would now pay for computer training.[14] Additionally, the Blind Rehabilitation Service Program Office asked BRCs to identify all the veterans waiting for admission for computer training and refer them back to their VIST coordinator for local computer training. If BRC and VIST coordinator staff determined that local computer training was not available or appropriate for a veteran, they were to provide an explanation to the program office. On May 5, 2004, 674 veterans were waiting for admission to a BRC for computer training. As of July 1, 2004, 520 veterans were removed from the BRC waiting list because arrangements were made for them to receive computer training from non-VA sources or they no longer wanted the training.

Factors that Affect Expansion of Blind Rehabilitation Outpatient Services

There are two factors that affect VA's expansion of outpatient services systemwide. One factor is the agency's long-standing belief that rehabilitation training for legally blind veterans can be best provided in a comprehensive inpatient setting. The second reported factor is VA's method of allocating funds for blind rehabilitation outpatient services, which provides local medical center management discretion to provide funds for them.

Some VA officials told us that one factor affecting veterans' access to outpatient care has been the agency's traditional focus on providing comprehensive inpatient training at BRCs. VA has historically considered the BRCs to be an exemplary model of care, and since 1948 BRCs have been the primary source of care for legally blind veterans. However, this delivery model has not kept pace with VA's overall health care strategy that reduces reliance on inpatient care and emphasizes outpatient care. VA's continued reliance on inpatient blind rehabilitation care is evident in its recent decision to build two additional BRCs in Long Beach, California, and Biloxi, Mississippi.[15] We have, however, observed some recent changes that may affect this reliance on inpatient services. For example, VA has new leadership in its blind rehabilitation program that has expressed an interest in providing a broad range of inpatient and outpatient services to meet the training needs of legally blind veterans. Further, as previously

[14]According to VA officials, the funds allocated for prosthetics maybe used only for prosthetic care—e.g. purchase of prosthetic items and veteran training in the use of these items.

[15]See Department of Veterans Affairs Capital Asset Realignment for Enhanced Services (CARES): *Secretary of Veterans Affairs CARES Decisions* (Washington D.C.; May 2004).

discussed, the VIAB's draft continuum of care policy recommends a full range of blind rehabilitation services, emphasizing more outpatient care, including VICTORS, VISOR, and BROS.

VA blind rehabilitation officials also told us that they believe changes to VA's resource allocation method could provide an incentive to expand blind rehabilitation services on an outpatient basis. The VIAB believes that the funds allocated for basic outpatient care for legally blind veterans do not cover the cost of providing blind rehabilitation services. Veterans Integrated Service Networks (networks)[16] are allocated funds to provide basic outpatient care for veterans, which they then allocate to the medical centers in their regions. Both the networks and the medical centers have the discretion to prioritize the use of these funds for blind rehabilitation services or any other medical care. Some networks and medical centers have made outpatient blind rehabilitation training a priority and use these funds to provide outpatient services. For example, the network that covers Florida and Puerto Rico has used its allocations to fund seven BROS that are located throughout the region to provide outpatient blind rehabilitation services to legally blind veterans in their own homes or at VA facilities. Currently, the VIAB is working with VA's Office of Finance and Allocation Resource Center to develop an allocation amount that would better reflect the cost of providing blind rehabilitation services on an outpatient basis, which could in turn, provide an incentive for networks and medical centers to expand outpatient rehabilitation services for legally blind veterans.

Conclusions

Many legally blind veterans have some vision, which frequently can be enhanced with optical low vision devices and training that includes learning to perform everyday activities such as cooking, reading prescription bottles, doing laundry, and paying bills. Since the 1940s, VA's preferred method of providing training to these veterans has been through inpatient services offered by BRCs. Because of its predisposition toward inpatient care, VA has developed little capacity to provide this care on an outpatient basis uniformly throughout the country. For the last 10 years, VA has been transitioning its overall health care system from a delivery model based primarily on inpatient care to one incorporating more outpatient care. Outpatient services for legally blind veterans, however, have lagged behind this trend. Recently, VA drafted a uniform standard of

[16]VA has organized its medical facilities into 21 regional health care networks.

care policy that recommends a full range of blind rehabilitation services, emphasizing more outpatient care, including more services provided by VISOR, VICTORS, and BROS type programs. Making inpatient and outpatient blind rehabilitation training services available to meet the needs of legally blind veterans will help ensure that these veterans are provided with options to receive the right type of care, at the right time, in the right place.

Recommendations

We are recommending that the Secretary of Veterans Affairs direct the Under Secretary for Health to issue, as soon as possible in fiscal year 2005, a uniform standard of care policy that ensures that a broad range of inpatient and outpatient blind rehabilitation services are more widely available to legally blind veterans.

Agency Comments

We provided a draft of this testimony to VA for comment. In oral comments, an official in VA's Office of the Deputy Under Secretary for Health informed us that VA concurred with our recommendation.

Mr. Chairman, this concludes my prepared remarks. I will be glad to answer any questions you or other Members of the Committee may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact Cynthia A. Bascetta at (202) 512-7101. Michael T. Blair, Jr., Cherie Starck, Cynthia Forbes, and Janet Overton also contributed to this statement.

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STATEMENT OF
THE HONORABLE MICHAEL J. KUSSMAN, MD
ACTING DEPUTY UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

JULY 22, 2004

Mr. Chairman and Members of the Committee:

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

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

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

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

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

Amputee Care

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

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

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

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

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

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

Prosthetics Research

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

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

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

Research in Collaboration with WRAMC

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

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

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

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

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

Additional Initiatives in Prosthetics Research

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

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

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

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

VA Blind Rehabilitation Program

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

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

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

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

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

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

Program Challenges

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

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

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

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

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

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

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

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

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

Improvements in Blind Rehabilitation

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

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

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

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

CARES and Blind Rehabilitation

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

Conclusion

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

Statement of
Penny L. Schuckers, MSW
Chief
Eastern Blind Rehabilitation Center
Before the
Committee on Veterans' Affairs
U.S. House of Representatives
July 22, 2004

Mr. Chairman and Members of the Committee:

It is an honor to speak with you today in my role as Chief of the Eastern Blind Rehabilitation Center, which is housed at the West Haven Campus of the Connecticut VA Healthcare System.

In 1969, the Eastern Blind Rehabilitation Center (EBRC) became the second VA Blind Center to serve blinded veterans. Today, our 34-bed EBRC serves 16 states and 6 VISNs in its catchment area. We have 27 on-board blind rehabilitation instructors, many of them cross-trained, and full-time nursing coverage. We reorganized the EBRC eight years ago from skill-specific teams into interdisciplinary treatment teams to improve continuity of care and better utilize time and staff. Last year we served 258 inpatients at the EBRC.

We have three Blind Rehabilitation Outpatient Specialists (BROS) stationed in Boston, West Haven, and Baltimore, who provide local outpatient blind rehabilitation training to veterans in our catchment area. Our Regional Consultant coordinates and oversees service delivery of our 42 full and part-time Visual Impairment Service Team (VIST) Coordinators, who identify blinded veterans and serve as case managers for this population. We pride ourselves in our dedicated staff, strong programs, and strong leadership in providing excellence of care for blinded veterans, in the most appropriate modes possible. Last week at the EBRC, we celebrated our 35th anniversary with some of those veterans. Our history has been one of steady improvements and enhancements to services for vision-impaired veterans.

Through early 1970s, the EBRC served a veteran population that included many young, totally blinded Vietnam veterans. Low Vision programs, electronic aids, and computers were all but non-existent or experimental. The standard length of stay was four months. Mobility, Braille, adjustment, and pre-vocational counseling took the bulk of the time. By the late 1970's, the EBRC veteran population, technology, and blind rehabilitation began to change. Vietnam veterans returned for refresher courses and to attempt state-of-the-art technology, such as the now defunct Sonic Guide for mobility. Low Vision used the first Closed Circuit Televisions (CCTVs). Our researcher worked with a private inventor named Kurzweil to develop an experimental, room-sized machine, which recognized and spoke written text. Its miniaturized descendents reside in most of today's screen-reading and voice-activated computer technology. In the 1980s, more specialized optical aids were available in Low Vision, and training increased. Braille was taught for labeling, not reading, and new cassette recorders were used for note taking.

In the 1990s, our Mobility program modified techniques for wheelchair and mobility-challenged veterans, and our Living Skills program increased touch-typing instruction. This better prepared the many veterans who wanted to continue on to the Computer Access Training (CAT) Program. The average age of our blinded veterans continued to increase, and more female veterans appeared. Most were blinded due to diseases related to aging, such as diabetic retinopathy. More had severe physical impairments and many exhibited decreased memory or cognitive functioning. We increased nursing staff to ensure 24/7 skilled coverage. Electronic or computerized aids for the blind increased, and the EBRC began to evaluate and prescribe the most promising of the devices. By 1993, we created a department devoted solely to this specialty.

In 2000, the EBRC became the first Blind Center in the United States to receive full accreditation from the Council for Accreditation of Rehabilitation Facilities (CARF). We also earned full accreditation, with no recommendations, again in 2003.

In the past three years, we have reduced our average daily cost by almost $2,000. Our average length of stay at the EBRC is five weeks, and our wait list is now down to an average of 125 days for our Regular Program. Through a series of

initiatives, including out-sourcing CAT for qualified applicants, the wait time for admission for our CAT Program has been reduced from 443 days two years ago to its current 149 days.

Our CAT staff is evaluating a digital recorder that will record instruction and download it directly into a computer. One of our CAT staff is experimenting with a technique to telecommute with a student; the potential is great for future instruction of veterans who might stay at home for this training. The same student has also learned to communicate with his daughter living in Israel by using voice e-mail on his adapted computer.

In the past three years, the EBRC has experienced an unprecedented shift in its veteran population. Never before have we experienced the age disparity of our inpatient population. Many veterans are now in their 80's and 90's, but we are also seeing the youngest in 25 years, many of them recent active duty veterans blinded by unusual accidental causes, rather than actual military conflict. As a result, our inpatient programs have again become more individualized, and our lengths of stay have varied depending on patient needs. Our staff is challenged to provide rehabilitation training to both old and young veterans, who have extremely differing needs and abilities.

We have refocused our local outpatient treatment to improve service delivery. In 2001, the EBRC created an Outpatient Treatment Team, which included the VIST Coordinator and BROS, and added a staff Optometrist and Chief. We shortened outpatient waits and treatment length by assigning a Low Vision specialist to patients who only needed Low Vision evaluation and training. Some veterans are tracked directly into outpatient Low Vision training, some into more expanded BROS training to obviate the need for inpatient training, and some for admission into the EBRC. This has improved wait times and case closure for the BROS veterans. We also now "fast-track" some veterans in an intense, one-week training curriculum to expedite training in mobility, low vision, and rehabilitation. Currently the team is exploring a 1-2 week modified day program that would allow veterans to participate in the group atmosphere of the inpatient program, which often facilitates adjustment skills and improved morale.

We are also proud of our participation in the initial development and follow-up of research projects conducted by the Atlanta Rehabilitation Research and Development

Department. These two historic projects developed criteria to evaluate the effectiveness of blind rehabilitation training and to create benchmarks in various VA and non-VA settings. Beginning in 1997, the EBRC began using these criteria to evaluate our student population and our program in three major areas: demographics, patient satisfaction, and change in functional independence following rehabilitation. One example of changes we have made from application of the criteria involves a modification to our training curriculum based on results of the Atlanta Functional Change Scores. Seeing a drop in our scores in Low Vision tasks in 1999, the EBRC modified and increased its training in mid-distance viewing tasks, and in 2001, ambitiously began a staff cross-training initiative in Low Vision where staffing and training hours were inadequate. Our scores in these areas improved noticeably. Our cross-training now has expanded to other skill areas. We now have five cross-trained staff in Low Vision, five in Manual Skills, and two in Living Skills, as well as five staff who have dual degrees in Orientation and Mobility, and Blind Rehabilitation Teaching.

Quality, veteran choice, continuity of care, and increased independence for each blinded veteran continue to be our foundation and guide our future. At the EBRC, we will continue to explore and evaluate training alternatives and best practices for our ever-changing veteran population. Mr. Chairman, this concludes my statement, and I will now be happy to answer any questions you might have.

Statement of
Nancy J. Strohm, LCSW, CLVT
Visual Impairment Services Team Coordinator
VA Medical Center, Lebanon, PA
Before the
Committee on Veterans' Affairs
U.S. House of Representatives

July 22, 2004

Mr. Chairman and Members of the Committee:

I am a licensed clinical social worker with a certification in Low Vision Rehabilitation. I have worked in the field of blind rehabilitation since 1995, when I was selected to implement the full time Visual Impairment Services Team (VIST) Program at the VA Medical Center, Lebanon, PA.

Vision loss is a condition that affects every aspect of a person's life. A VIST Coordinator is tasked with identifying veterans who are visually impaired, assessing their needs, providing education, developing a plan for rehabilitation, implementing the plan through referral to an agency that provides direct services, and following up with the veteran yearly to determine if there are new needs. Within VISN 4, veterans with needs that can best be met at a thorough and intensive rehabilitation program, and are willing to participate, are referred to the Eastern Blind Rehabilitation Center at the VA Connecticut Health Care System, West Haven. During the nine years that I have been VIST Coordinator, I have witnessed veterans discharged to their families, homes and communities to reclaim roles that they had abandoned when blindness became unnecessarily debilitating. Among the veterans whom I referred, they were well satisfied.

However, approximately six years ago, I noticed that fewer veterans, many of them in advanced life stages, were not willing to participate in inpatient blind rehabilitation. Most of these veterans were suffering from age related maculopathy, commonly known as macular degeneration, a progressive eye disease that affects use of central vision. Despite my best presentation of the positive trade-offs of a VA rehabilitation program, they did not perceive themselves as "bad enough" to warrant this type of treatment. Common reasons

for resistance included family caregiver roles, length of stay, and fear of traveling alone. Yet they still wanted to read and write, resume hobbies, take care of their daily needs, and travel safely within their communities. Their needs could not be met locally by the VIST program or through community or state agencies in a timely manner.

In the late summer of 1998, the leadership of the Blinded Veterans Association (BVA) of PA, Inc. contacted me. For nearly a decade, these veterans had been interested in expanded services for visually impaired veterans in the Lebanon area. They specifically requested an inpatient center like the one in West Haven. I referred them to the CEO at Lebanon, who listened to their concerns and then asked me to write a proposal. I was subsequently asked to develop an outpatient program that would meet the needs of veterans who were unable or unwilling to participate in a traditional inpatient program.

I reviewed services provided by community and private agencies via the internet and contacted the Carroll Center in Boston, MA, to learn more about their day program for senior citizens. A blind rehabilitation therapist from the Maine Commission for the Blind as well as faculty at the Pennsylvania College of Optometry acted as consultants. Within a short period of time, the BVA of PA, Inc., the Pennsylvania State Veterans Commission, and the VISN leadership supported the Visual Impairment Services Outpatient Rehabilitation Program, better known as VISOR.

The VISOR Program is the treatment component of the VIST Program at the Lebanon VA Medical Center. Because every veteran has unique needs and circumstances, there are three separate treatment modalities within the VISOR Program that serve veterans who are legally blind or visually impaired. They include the VISOR Outpatient Clinic, the VISOR Home Care Program, and the VISOR HOPTEL Program, a residential ten-day outpatient program for veterans who are legally blind.

The VISOR Team consists of five professionally trained blind rehabilitation specialists in the core areas of low vision, rehabilitation teaching (independent activities of daily living/communications/manual skills), and orientation and

mobility. Some members of the VISOR Team are competent in the fields of recreation and social work as well. Trained staff addresses special needs for using adaptive equipment to manage diabetes and overcoming the emotional turmoil related to sight loss for both veteran and family.

The three-part VISOR model ensures that veterans receive the right care, at the right time, in the right place. The type of care each veteran receives is dependent upon an individualized treatment plan using input from the VISOR team, optometrists in the low vision clinic, the veteran, and the veteran's family. Training with optical and non-optical aids issued through Prosthetics Service to help veterans overcome difficulties with everyday activities such as reading newsprint, writing, financial management, traveling safely in the home or community, grocery shopping, home maintenance, and participating in leisure time activities can all be accomplished on an as needed basis at a pace that is right for each veteran.

The VISOR Outpatient Clinic has thus far served 333 veterans during this fiscal year. When warranted, the therapist can provide services in the home as well. One hundred home care visits have been provided this fiscal year. The outpatient clinic and the home care program complement the VISOR HOPTEL Program (described below), and are available between VISOR HOPTEL Programs, which is in session for ten days, ten times per year.

Veterans must be legally blind and capable of self-care to participate in the VISOR HOPTEL Program. Other factors considered for participation in the program include stamina, ability to learn in a fast paced group environment, and the feasibility to leave the home environment. The VISOR HOPTEL Program begins on Monday at noon, with family involvement, and ends on Wednesday of the following week with a half-day family program. During the ten-day VISOR HOPTEL Program, rehabilitation takes place throughout the weekend in order to ensure that skills learned are continuously reinforced. Additionally, veterans are provided with the opportunity to worship and visit with family during this time.

The goal of the VISOR HOPTEL Program is to help the veteran and family return to activities that they enjoyed prior to visual impairment. A typical day

begins with group therapy and ends at approximately 4:30 p.m. with adaptive leisure activities. In between, veterans are provided with education and skill training in core blind rehabilitation areas. A combination of group activities, one-to-one instructions, and independent assignments to build confidence are included in the VISOR HOPTEL curriculum. A VIST support group, held on the ninth day of the VISOR HOPTEL Program, allows current participants to access support from previous graduates and helps them transition to an ongoing support group. A family support group is run simultaneously.

Assessments by the VISOR team are completed in the VISOR Outpatient Clinic prior to the onset of the program. Education and training begins in the VISOR Outpatient Clinic during the veteran's first contact with the VISOR Team. Veterans who are referred by other VIST Coordinators throughout the VISN are assessed at their respective medical centers. A low vision exam by a VA optometrist is an essential part of treatment planning. Approval to participate, based on physical findings, is provided by primary care. A home assessment by a member of the VISOR team provides valuable insight into the veteran's ability to function in his/her home and neighborhood. A field visit within two weeks of the conclusion of the program ensures that skills taught at the VISOR HOPTEL Program transfer back to the home environment.

A typical veteran who participates in the VISOR HOPTEL Program has been diagnosed with age-related macular degeneration and sometimes other age related diseases such as diabetic retinopathy, glaucoma and cataracts. Since July 2000, the VISOR HOPTEL Program has rehabilitated 170 veterans, nine of whom are female. The median age during the past four years was 74. Two-thirds of the veterans ranged from that age to age 90.

The VISOR Team has provided data to the Blind Rehabilitation Services (BRS) Outcomes Project in order to compare functional outcomes of this model to the more traditional VA Blind Rehabilitation Centers. Data collected from the third quarter of FY 2001 through FY 2003 suggest that the VISOR HOPTEL Program is an efficacious model for the veterans whom we serve. We are proud of the large percentage of veterans who are able to read a magazine or

newspaper article, pay their own bills, assemble or measure something, communicate in writing, and orient themselves to a familiar environment following rehabilitation via the VISOR HOPTEL model.

Patient satisfaction has been measured for the VISOR HOPTEL portion of the VISOR Program and has been 100% both on the internal satisfaction survey and on the BRS Outcomes Project survey. On the BRS survey, 100% of all veterans indicated that they would recommend this program to other veterans. These reports are congruent with the comments made by veterans and families through letters sent to our medical center. Comments include:

"This program gave us all new hope."

"Thank you for giving me back 'a life'."

"It gave us a sense of security and mobility."

"I have been able to do jobs (home repairs) that I wouldn't think of doing before."

"The staff and their program uplifted my spirits and gave me confidence that I could still do some of the things if I only tried."

"Thank you for giving our father back to us."

"Your program has helped in so many little ways to help Dad maintain some of his independence."

Mr. Chairman and members of the committee, I have attempted to provide you with an understanding of the VISOR Program and the variety of interventions on the continuum of care that are necessary for veterans who are visually impaired to achieve independence, restore confidence, resume roles, and lead a quality life. I would be pleased to answer questions that you may have. Thank you.

NOT FOR PUBLICATION UNTIL RELEASED BY THE COMMITTEE

Statement by

Dr. Brett Giroir

Deputy Director, Defense Sciences Office
Defense Advanced Research Projects Agency

Submitted to the

Committee on Veterans' Affairs
United States House of Representatives

July 22, 2004

NOT FOR PUBLICATION UNTIL RELEASED BY THE COMMITTEE

Mr. Chairman, Committee Members and staff: I am Dr. Brett Giroir, Deputy Director of the Defense Sciences Office (DSO) of the Defense Advanced Research Projects Agency (DARPA). I am pleased to appear before you today to discuss DARPA's vision for the future of amputee care, a vision we are proud to be pursuing collaboratively with the Walter Reed Army Medical Center (WRAMC) and the Department of Veterans Affairs (VA).

Our vision is simple but bold: to drastically improve the quality of life for amputees by transforming current limb prostheses into biologically integrated, fully functional limb replacements that have normal sensory abilities. Our goal is for amputees to return to a normal life, with no limits whatsoever, with artificial limbs that work as well as the ones they have lost. DARPA's vision includes not only regaining fine motor control, such as the ability to type on a keyboard or play a musical instrument, but also the ability to sense an artificial limb's position without looking at it, and to actually "feel" precisely what the artificial limb is touching.

A major caveat is in order at this point. We are in the early stages of this research and it will take considerable time to fulfill the vision completely. But the only way to achieve the vision is to move towards it.

Let me begin by saying a few words about DARPA and the Defense Sciences Office.

DARPA is a research agency within the Office of the Secretary of Defense with a special mission: to maintain the technological superiority of the U.S. military and prevent technological surprise from harming our national security. DARPA does this by sponsoring high risk, high-payoff research that bridges the gap between fundamental discoveries and their military use. As a result of this mission, DARPA has a tradition of sponsoring research that a first glance seems like science fiction, but that eventually becomes everyday fact. The most widely known examples of this are the Internet and stealth technology.

Within DARPA, my office, the Defense Sciences Office, is focused on fundamental research in the areas of physics, material science, mathematics and, more recently, what we have termed the "Bio-Revolution" – a broad effort to harness insights from biology to make U.S. warfighters and their equipment safer, stronger, and more effective. Our vision for amputee care came directly out of this work.

Specifically, our vision stemmed directly from two of our programs. The first program, called Fundamental Research at the Biology: Information Science: and Microsystems Interface (BIO-Interfaces) established interdisciplinary research teams that combined biology, information science, and microsystems with the specific goal of developing novel computational tools to study biological systems ranging from single cells to the entire brain. In fact, Dr. John Donoghue, the lead neuroscientist at the new VA Center of Excellence at the Providence VA Medical Center, has received support from the BIO-Interfaces Program since 2001.

The second program, Human Assisted Neural Devices (HAND), has also been extremely successful. You may have seen some articles in the press about this last year. In this program, researchers supported by DARPA have demonstrated the ability to capture, process, and decode the electrical signals from thousands of individual nerve cells within the brain. What this means is that it is possible to decode brain signals in order to control the actions of an external device. Let me give you an example.

A monkey was trained to use a joystick to move a computer cursor while its brain cell activity was monitored. Eventually, the joystick was disconnected and even removed, and the monkey soon realized that it was able to control the cursor simply by using its brain directly, without the action of arm muscles or nerves. Perhaps more importantly, we discovered that the monkey had also learned how to use the decoding device to do what it wanted. In a sense, the monkey's brain turned the equipment into an extension of the monkey, a new limb of sorts, if you will.

Viewing these results, an number of our researchers saw the promise for disabled people. What if improved decoding of neural signals, combined with the brain's incredible plasticity and learning capability, meant that we could build devices, including prosthetics, that people could control just as naturally as they control their own limbs?

It soon became apparent that the DARPA BIO-Interfaces and HAND programs, as well as other DARPA programs on wound healing, sensors, information processing, multifunctional materials, and novel power sources could enable revolutionary new prosthetics. Realizing this, DARPA reached out to our colleagues at WRAMC and the VA.

We expect our relationship with the VA to be analogous to the relationships we have with the Military Services for most of our work. We focus on the high risk research needed for a

breakthrough, which, if successful, will radically alter people's concepts of what is possible. When we do succeed, we always identify what we call a "transition partner" in the Services, an organization to perform the final phases of design, engineering, and when applicable, clinical development and testing. For amputee care, we are working with the VA and WRAMC in this same model. DARPA invests and develop high risk, high payoff technologies, many of which will be useful for prostheses as well as other military applications. These technologies will be transitioned through the VA Centers of Excellence for design integration, and clinical development and testing. DARPA and the VA Health System have an ongoing two-way collaboration.

DARPA also has a special relationship with WRAMC, where there is a growing clinical population of young, otherwise healthy amputees, who will be living with their disabilities for the next 5 or 6 decades. We visited these soldiers and they have provided our inspiration, and indeed fueled our passion, for this work.

So, our vision is clear. We will develop artificial limbs that will respond to an amputee's intent to move them just like a natural limb would. These artificial limbs must be biologically integrated and provide the patient with a clear sense of where the limbs are in space – that is, their position relative to the rest of the body. Moreover, the limbs must be able to transmit feeling and sensation back to the patient just as a normal limbs do.

To achieve our vision of prostheses that function like normal limbs, a tremendous amount of cutting edge research will be required in many disciplines, including neuroscience, microelectronics, control systems, materials, actuators, and power supplies. Ongoing examples are:

- First, we will continue to optimize our ability to detect and decode brain signals so that a patient can exert fine motor control over a prosthesis. Equally important, we will develop methods for a prosthesis to sense the environment, and then communicate that sensation back into the brain, so that the patient can actually sense where the prosthetic is and precisely what it is feeling. We also need to find ways to train people to use these new devices, to use the plasticity of the brain to make the prosthesis seem like a natural extension of the body. It is clear that this training will need to start as soon as the patient

is physically able, in order to maximize the brain's ability to adapt and control its new appendage.

- We will continue to develop improved control architectures that combine centralized general control originating in the brain with local control based on sensors embedded within the prosthesis. Some of these architectures might benefit from elements that mimic reflex responses, so there could be simple actions that do not need to be directed by the brain.

- We need microelectromechanical (MEMS) devices both to sense and act on a fine scale. We will continue to develop a variety of lightweight, infection-proof materials to build the devices and provide an interface with the body that is much more comfortable and compatible than existing materials. We will also continue our work on novel materials that could serve as actuators by contracting much like our muscles do. And, our development of compact, lightweight, highly efficient power supplies, such as fuel cells, that can provide the energy needed to operate the prosthesis for prolonged periods of time without recharging will be a major input.

We have an on-going, robust working relationship with WRAMC and the VA. We have started projects at WRAMC that to lay the groundwork for the future. First, we are improving the collection and access to data on amputations and wound healing so that military clinicians and researchers can provide even better care to their patients. Second, we are developing and implementing a new training program for the control of prostheses based on virtual reality simulations. Not only do we expect to greatly expedite this rather arduous aspect of rehabilitation, but also make it far more interesting to new patients who must perform this training, repeatedly, day after day.

We have formed a number of working groups both inside of DARPA, as well as with the VA, WRAMC, and the academic and industrial communities to assure that our approach will yield the desired results. We have also hired a critical care neurologist, an Army Colonel who served in Afghanistan, to be the lead program manager of our HAND program.

There is a great deal of enthusiasm, and indeed passion, for this research inside DARPA. After personally visiting and interacting with our wounded soldiers, how could we experience anything

but a heartfelt desire to make an important and lasting contribution? I fully expect that our current efforts will coalesce into a significant and growing research thrust for DARPA in the coming years – a thrust which we are primed to implement with our colleagues at WRAMC and the VA.

With that I'll be glad to take your questions.

RECORD VERSION

STATEMENT BY

LTC PAUL F. PASQUINA
MEDICAL DIRECTOR FOR THE U.S. ARMY AMPUTEE PATIENT CARE PROGRAM

BEFORE THE

VETERANS AFFAIRS COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES

SECOND SESSION, 108TH CONGRESS

ON THE VA-DOD COLLABORATION IN RESEARCH AND AMPUTEE CARE

JULY 22, 2004

NOT FOR PUBLICATION
UNTIL RELEASED BY
THE HOUSE VETERANS AFFAIRS COMMITTEE

Chairman Smith and Members of the Committee, I am LTC Paul F. Pasquina, M.D., the Chief of Physical Medicine and Rehabilitation and Medical Director of the Amputee Program at Walter Reed Army Medical Center. It is with great pleasure that I appear before this Committee to discuss the care of our Armed Forces Members.

Amputee Clinical Care Background Information

Providing optimal care requires the development of a well functioning and coordinated multidisciplinary team. Experience at WRAMC has supported the creation of a dedicated Amputee Inpatient Service as well as a separate Outpatient Amputee Clinic under the management of Physical Medicine & Rehabilitation (PM&R). Following a rehabilitation model, the physiatrist functions as the primary care provider for the amputee, coordinating the recommendations and interventions of multiple medical and surgical subspecialists, therapists, nurses, prosthetists, psychologists, and social workers. This not only assures that holistic care is provided, but also helps to improve the quality and standardization of care across a healthcare system. Critical elements to the functioning of the team include: strong leadership, clear designation of duties and responsibilities, an ongoing educational program, and most of all, communication.

The ongoing educational program must be all encompassing, while at the same time target individual disciplines. This is facilitated by identifying key leaders within each service (PM&R, nursing, orthopedics, prosthetics, occupational and physical therapy, and psychology). It is the responsibility of these leaders to identify the educational needs of their services and then the responsibility of the program to ensure these educational needs are met. This can be facilitated in a cost-effective way by bringing in

outside experts or partnering with existing national organizations such as the Department of Veterans Affairs (VA), the Defense Advanced Research Projects Agency (DARPA), public and private universities, as well as private companies and foundations. Issues of a cross-disciplinary nature such as pain and wound management, psychological adjustment, etc. should be presented in a forum where all disciplines are present to facilitate inter-disciplinary discussion.

In order to facilitate communication and patient flow through the medical system at WRAMC the following flowchart was established (see figure).

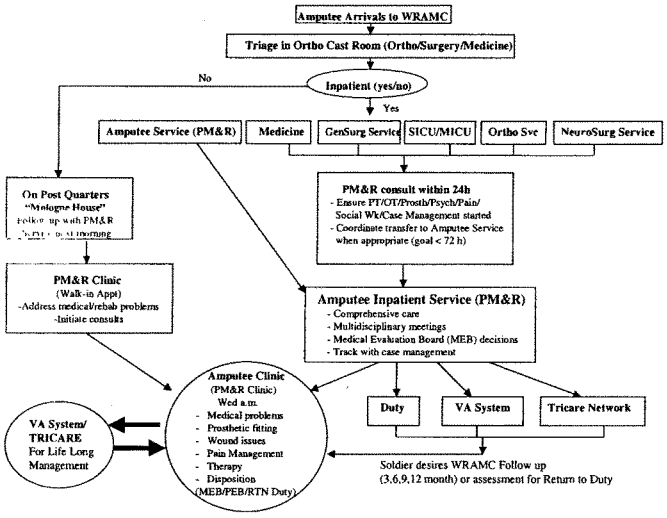

Figure: Patient flow for combat amputees at Walter Reed Army Medical Center (WRAMC). MICU = medical intensive care unit, PEB = Physical Evaluation Board, PM&R = Physical Medicine & Rehabilitation, RTN = return, and SICU = surgical intensive care unit.

In addition to creating an amputee care program model to help streamline and standardize patient care, our experience over the past year managing young traumatic combat amputees has brought to light many critical elements and lessons learned. We continue to discover ways to integrate advances in technology and medicine to optimize care and hopefully positively influence rapid recovery and long-term quality of life. Examples of these critical elements are discussed in the following sections.

Pain Management:

Over the past several years, new Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, as well as the recognition of Pain Medicine as a distinct medical subspecialty by the Accreditation Council for Graduate Medical Education (ACGME), has not only sensitized the entire nation on a patient's right to pain management but has also lead to advances within the field. At WRAMC, extensive groundwork had already been accomplished prior to OIF/OEF to ensure that proper pain management systems were in place.

Nurses, physicians, and therapists all play critical roles in ensuring recognition of pain problems and optimizing care. Research supports the importance of effective pain control to allow a patient to participate in therapy, as well as in reducing long-term pain complications, such as residual limb and phantom limb pain. Our experience has shown that adequate pain control in most combat amputees requires a multi-modal medication approach. Nearly

every patient is provided a patient controlled anesthesia (PCA) pump during the perioperative period and then quickly converted to long-acting opioids after his or her definitive surgery is performed. Short-acting opioids are also used for breakthrough pain or pre-medication prior to therapy. Most patients are also prescribed an anticonvulsant (gabapentin, oxcarbazepine, lamotrigine), a Tricyclic Antidepressant (Nortriptyline, Amitriptyline, Desiprimine), and a Nonsteroidal Anti-inflammatory agent (NSAID-typically one that is COX-2 selective, given the number and nature of comorbidities as well as frequent concurrent use of anticoagulation medication). We have found quetiapine fumarate to be a very effective sleep aid, especially in cases when the soldier reports trouble with nightmares. In addition to pharmacological management, we have found physical agent modalities (ice, heat), desensitization and transcutaneous electrical nerve stimulation (TENS) units helpful. Perhaps most effective, however, has been the support of the Regional Anesthesia Team. The placement of peripheral infusion catheters to the brachial, lumbo-sacral plexus, or sciatic nerves has had a dramatic positive effect on pain control, reduction in medication use, and participation in therapy.

Medical Management:

As mentioned earlier, most combat amputees face multiple comorbidities and greater risk for secondary complications. Traumatic amputees are at increased risk for development of deep venous thrombosis (DVT) both in their intact and residual limb. For prophylaxis all patients are started on low molecular

weight heparin (Enoxaparin), unless contraindicated. We have also noticed that a high percentage of combat amputees develop heterotopic ossification (HO). Whether this correlates with the nature of injury (typically, from a blast), the patient's age, or perhaps the presence of comorbid head injury is unclear. The secondary effects of HO, may lead to significant pain and trouble with prosthetic fitting.

We have initiated the use of COX-2 selective NSAIDs on all patients, unless contraindicated, for both prophylaxis and treatment of HO. Our experience had shown that in this patient population, signs of secondary complications such as DVT or HO, are typically very subtle and may first present with only mild low-grade fever, therefore medical vigilance is imperative. Because of the high incidence of comorbid head injury, it is important that the medical staff have experience in managing patients with cognitive deficits. For posttraumatic seizure prophylaxis and treatment, we have found levetiracetam very effective. Finally, because of the high incidence of multi-trauma and blood loss, combat amputees have benefited from the use of Epoetin to stimulate red blood cell production. This treatment not only helps healing but also promotes more energy during rehabilitation.

Surgical Considerations:

Standardizing surgical approaches to amputation is challenging, especially for combat casualties whose wounds are not only extensive but also are

contaminated with dirt, bacteria, and shrapnel. Most require comanagement by multiple surgical subspecialties (orthopedics, vascular, plastics, neurosurgery); therefore good communication between these services is essential. Limb-salvage decisions remain complex and should be made in conjunction with the patient, as well as the entire medical and rehabilitation team. Tools such as the Mangled Extremity Severity Score (MESS) are helpful in facilitating these decisions. In addition to anatomic and physiologic factors, one should not lose sight of anticipated functional outcome, especially for this generally young and active patient population, who are eager to return to high level sporting activities. Similar considerations must be made when deciding on amputation length and level. It is critical that the rehabilitation team, especially the Prosthetist, be involved in these decisions preoperatively to ensure optimal length for prosthetic fitting and function.

Advances in Prosthetics:

It is our belief that the technological advances in prosthetic design and fit not only significantly improve patient satisfaction and function, but also facilitate progression in rehabilitation.

- *Upper Extremity Amputees*:

Because of the complex nature of combat wounds, prosthetic fitting is often delayed to allow time for graft healing. Comorbid fractures, nerve plexus injuries, or soft tissue defects often prohibit the use of body powered prostheses

and suspension harnesses or cables. During the immediate postoperative period, we focus our attention on identifying myoelectric control sites.

Occupational therapists work closely with the patients using electronic sensors over remaining intact muscles. These sensors capture electromyographic (EMG) signals that trigger audio and video feedback to the patient and therapist. These signals are also used to operate video games, which creates a friendly and therapeutic competitive environment for the patients and leads to quick mastering of certain skills. Once these skills are acquired, patients progress rapidly to operating myoelectric prostheses as soon as their limb is cleared for fitting. Body-powered prostheses are introduced later, as their comorbid injuries permit. Advanced prosthetic components such as the Utah Arm 3™ allow simultaneous operation and control of the elbow and terminal device. The addition of a wrist control unit allows more useful upper extremity functioning. While the SensorHand™ SPEED allows a faster and more responsive opening and closing terminal device, as well as the ability to maintain constant grip force, because of built-in sensors within the fingertips. These sensors provide feedback to a microprocessor, which automatically tightens the grip to prevent objects from slipping out of the hand.

- *Lower-Limb Amputees:*

We have found that the Computer Aided Design and Manufacture (CAD/CAM) equipment has significantly improved our ability to provide

prostheses for traumatic lower-limb amputees. The computerized system allows the fabrication of a custom-made socket in a fraction of the time needed for traditional casting. The shorter fabrication time is especially helpful in caring for the combat amputee, whose residual limbs have complex scar and suture lines and experience significant rapid volume changes. We have also found that advances in lower-limb prosthetic components, such as microprocessor knees and dynamic response feet, not only enhance function but also promote a more rapid progression through rehabilitation.

The ability to program microprocessor knees to provide more or less stance and/or swing control assists advancement from early weight-bearing to initial ambulation and, eventually, to stair and obstacle negotiation, without having to change prosthetic components or alignment. We have also found that during initial ambulation, patients perform well with multiaxial feet and vertical compression pylons, however, as their confidence and activities increase they perform better with lighter-weight feet that have vertical compression features built into the keel of the foot itself. Our 3-D motion analysis gait laboratory provides useful functional measures during the early phases of fitting to aid with prosthetic alignment and choice of components, as well as feedback to the patients and therapists on specific items to work on during therapy sessions.

The Role of Graduate Medical Education (GME):

Experience throughout OEF/OIF has demonstrated the critical impact that GME has had in providing the finest care to those wounded in combat. Ongoing

educational programs that include military-unique curriculum help military facilities stay current with state of the art medicine, surgical and rehabilitation approaches to care. Of note, WRAMC operates the only PM&R Residency Program in the Department of Defense (DoD). This has greatly enhanced incorporating fundamental rehabilitation principles to the care of the combat amputee. Lastly the presence of a vital and active research program at WRAMC has helped to bring cutting-edge interventions to this group of patients.

Peer & Psycho-Social Support Programs:

An extremely important aspect of a comprehensive program includes professional psychological and amputee peer support. We have formed partnerships with the VA and Amputee Coalition of America (ACA) to find and train outstanding individuals who volunteer their time to support combat casualties returning from war. It is ideal if these volunteers have military experience. They not only provide emotional support but also provide valuable feedback to the rehabilitation team as to how a patient is progressing both physically and emotionally. In addition they are helpful in facilitating guidance through the military medical disability system. Events such a the National Disabled Veterans Winter Sports Clinic (sponsored by the VA) and those sponsored by the ACA, Disabled Sports U.S.A., and numerous other private and public organizations help to introduce patients to the variety of sports and recreational activities available for individuals with disabilities. Support to family members is an equally important aspect of the program. WRAMC successfully

established a Family Assistance Center (FAC) within the hospital to meet this need. Social workers and nurse case managers are critical members of the team, coordinating continued care, discharge planning, equipment purchases, etc.

Military Medical Disability System:

Navigation through the military medical disability system is complicated. A single amputee service promotes communication and standardization. Physicians have to be well educated and experienced in writing medical evaluation boards. In addition, a Physical Evaluation Board Liaison Office (PEBLO) counselor should be assigned to each patient during his or her inpatient stay. VA counselors are also necessary to ensure each patient is aware of his or her eligible benefits. Educational programs need to be tailored to the soldiers' needs, especially those with head injury, hearing or vision loss.

Optimal disposition of patients is often complicated by the frequent geographical challenges created when the patient's duty station, home of record, and nearest military or VA medical facility are not located near each other. In these situations, medical follow-up must be coordinated through the TRICARE military healthcare system. Unfortunately standards and availability of health care services vary in both the private and public sectors across the United States. Through partnerships between the DoD and the VA, WRAMC is hopeful to be able to continue and follow these combat amputees in order to ensure the best long-term care.

Conclusion:

Over the past decade, a cultural shift has occurred within the military, giving individuals with limb-loss the opportunity to stay on active-duty service. Advances in medical, surgical and rehabilitative care, as well as prosthetic design, should help individuals achieve this goal. Whether or not the soldier desires, or has the ability, to remain on active duty service, WRAMC is committed to helping all combat amputees reach their maximal function and return to the highest possible quality of life.

PASSBACK

STATEMENT BY

MR. CHARLES SCOVILLE
PROGRAM MANAGER FOR THE U.S. ARMY AMPUTEE PATIENT CARE PROGRAM

BEFORE THE

VETERANS AFFAIRS COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES

SECOND SESSION, 108TH CONGRESS

ON VA-DOD COLLABORATION IN RESEARCH AND AMPUTEE CARE

JULY 22, 2004

NOT FOR PUBLICATION
UNTIL RELEASED BY
THE HOUSE VETERANS AFFAIRS COMMITTEE

Chairman Smith and Members of the Committee, I am Charles Scoville, The Program Manager for The U.S. Army Amputee Patient Care Program. Thank you for inviting me to appear before your committee today to discuss the care of our Service Members and Veterans' who have lost a limb. The Global War on Terrorism is causing a surge in combat injuries involving amputations of major limbs. Over 144 service members have lost one or more limbs as a direct result of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) (120 Army, 20 Marine, 2 Navy and 2 Air Force). Approximately 85% sustained a single limb amputation while 15% have lost multiple limbs. The Walter Reed Army Medical Center (WRAMC) has provided care for 120 military personnel and 1 civilian. Thirty-five percent of all amputations from OIF/OEF involve the loss of an upper-extremity, as compared to approximately 5% in the civilian sector. This presents a unique population for the integrated care within the Department of Veteran's Affairs (VA) and Department of Defense (DoD) health care systems.

During WWI 1.2 % of all wounded in action (WIA) sustained a major limb amputation, in WWII the rate remained the same 1.2 %, and in the Korean War 1.4% of all WIA sustained a major limb amputation. During the current conflict, amputations account for 2.4% of all WIA. This may be due to an increased survival rate secondary to the effectiveness of the protective vests. During WWII and the Korean War injuries to the torso accounted for 15% of all injuries, during OIF they account for only 7% of all injuries.

In December of 2001, projecting the potential for a large number of amputee patients, LTG Peake, then Surgeon General of the United States Army, directed the development of an amputee patient care program. This program addresses the entire spectrum of amputee patient care from time of injury on the battlefield through the evacuation process to the CONUS facilities that will care for these service members and through the integration of care within the VA's Health Care System. It also includes the training of deploying surgeons in the "Extremity War Trauma Surgery Course" a 6-hour training program that addresses the management of the unique aspects of wounding patterns created by blasts. The amputee patient care program also includes the training in advanced prosthetics and rehabilitation methodologies to the allied health care providers who will work with these patients as they return to the various Medical Treatment Facilities across the nation.

The combat injured amputee in many ways presents a unique patient population that the military and VA's health care systems are specifically prepared to address. Amputations caused by blast injuries present a more complex wounding pattern and are more difficult to treat than amputations resulting from disease or other trauma. Blast injuries may involve loss or injury of multiple limbs, head trauma, injury to eyesight, etc. In addition, military amputees are typically young, healthy individuals who maintained a high state of physical fitness before injury. They have a higher propensity for returning to their pre-injury levels of

physical activity. Reaching these goals requires advanced prosthetic equipment and higher levels of training.

Appropriate amputee patient care demands highly specialized care from an experienced, multi-disciplinary team of surgeons, prosthetists, physical and occupational therapists, psychologists, psychiatrists, nurses, social workers, nutritionists, and other specialists. The VA has worked very closely with the DoD and the Army Amputee Patient Care Program to meet the needs of our patients. VA's Social Workers, Benefits Counselors, Vocational Education and Rehabilitation Counselors and Researchers have been detailed to WRAMC in support of the care of our amputee patients, as well as all other soldiers who are patients in our hospital and facing the transition of care into the VA' s Health Care System.

Our mission is to rehabilitate military amputee patients to the highest possible level of physical function so that the loss of a limb does not prevent them from returning to our active duty forces. Likewise, if they elect not to return to the active duty forces, they are able to make that decision based upon factors other than the loss of a limb, and they are functioning at a level where they can carry on a full, active and productive life.

Military amputee care requires solid research and application of technological advances in a well-coordinated effort between the DoD, VA, and civilian

counterparts. There have been several recent advances in prosthetics that have been integral to the return of our patients to the highest levels of activity. For above elbow amputees, the Utah3 Arm permits simultaneous motion of the elbow and hand or elbow and wrist. This is coupled with the SensorSpeed Hand, a device that has sensors in the fingertips that detects if an object is present and will maintain a steady pressure on the object so that it is not dropped or crushed without requiring the individual to consciously monitor the object. This myoelectric hand is also several times faster than other devices currently available, and is fast enough to permit our patients to be able to throw and catch with their prosthetic hand. For the above knee amputee, the C-Leg, which has a computer chip in the knee that monitors motion 50 times a second, and hydraulically assists in ambulation, greatly aids in their ambulation. While the US Military is among the first to receive many of these devices, the VA has also made these devices available for their patients, where appropriate. Also, the VA and the DoD have worked closely together to ensure that the patients have access to necessary maintenance and services for these prosthetic devices, regardless of their geographical location.

As advances in prosthetics and treatment approaches become available it is imperative that we develop sound, scientific rationale for utilization of these devices and approaches. The amputee patient care program at WRAMC is one focal point for DoD and VA researchers working collaboratively to develop common methodologies to advance rehabilitation programs and prosthetic

capabilities. The VA has detailed researchers to this facility to closely coordinate our efforts in determining best practices, evaluating the cost-effectiveness, and advancing the care of our amputee patients. Also integral to this program is the dissemination of this information through publications in referenced journals and presentations at national and international conferences, to effect changes that will benefit all amputee patients.

The return of our amputee patients to a full and productive life involves a commitment and partnership by the DoD and the VA. Both the Clinical and the Research arms of the VHA have been tremendous in their cooperation with our amputee patient care program staff. They have facilitated care for the Active Duty service member while home on convalescent leave, shared their expertise through conferences and Quality Enhancement Research Initiative (QUERI) Workshops, and worked side-by-side with our health care providers to assist our patients as they continue their care through the DoD and VA health care systems. Because of this continual interaction between the VA and DoD, the patients leaving WRAMC may be confident that the care they receive as they transition into the VA's Health Care System will be the same world-leading level regardless of where they travel.

To facilitate both the research and clinical aspects related to amputee patient care, the US Army has worked in collaboration with the VA to develop an amputee patient registry. This database is currently available to designated

health care providers within the WRAMC Health Care System on the Intranet. This database incorporated many of the outcomes measures identified by the VA as significant for long-term patient management, and has data entry tables specific to both VA and DoD requirements. We are currently completing the administrative requirements to provide access via a secure internet link and mechanisms of access for the VA Health Care System are currently being finalized.

Mr. Chairman and members of the committee, thank you for your continued commitment and support to the quality care for our Armed Forces Service Members.

BLINDED VETERANS ASSOCIATION (BVA) TESTIMONY ON GAO REPORT 04-949 Before the U. S. House of Representatives Committee On Veterans Affairs July 22, 2004 Presented by Thomas H. Miller, BVA Executive Director

Mr. Chairman and members of this distinguished Committee, on behalf of the Blinded Veterans Association (BVA), I want to express our sincere appreciation to you for conducting this hearing to address what we believe to be very serious problems with VA Blind Rehabilitation Service (BRS) and the manner in which BRS delivers blind rehabilitation services to America's blinded veterans. Before commenting specifically on "GAO Report 04-949 VA Health Care: VA Needs To Improve The Accuracy Of Reported Wait Times For Blind Rehabilitation Services," I especially wish to thank Chairman Simmons and Senator Graham for requesting that GAO determine the accuracy of reported average wait times for admission to one of the ten VA Blind Rehabilitation Centers (BRCs). As you know, BVA has expressed strong concern for a number of years over the rapidly growing waiting lists and particularly the unconscionably long wait times to access the VA BRC program. I must say that the GAO report reveals nothing that BVA did not already know. Hopefully its findings reinforce our arguments for substantial changes in the leadership and culture within BRS, the manner in which these essential services are delivered and the critical need for more stringent accountability at all levels of BRS.

Mr. Chairman, BVA wholeheartedly concurs with the two principal recommendations made by GAO regarding the reported accuracy of wait times for admission to blind rehabilitation services. In our view, it is absolutely critical that the Secretary of Veterans Affairs as well as the Under Secretary for Health take an active leadership role if the necessary changes are to be fully implemented. VA BRS has existed for 56 years and has long been recognized as the premier provider of comprehensive residential blind rehabilitation services. Unquestionably, BVA continues to believe that this reputation remains intact. The reputation certainly has been challenged, however, as a result of the decentralized decision-making authority system of health care management currently in place, as well as the manner in which resources are distributed to the Veterans Integrated Service Networks (VISNs) and ultimately to the facility level. Further compromising these practices, as it relates to the delivery of blind rehabilitation services, has been the insufficient budget the Veterans Health Administration (VHA) has received in recent years.

Background

Mr. Chairman, there are a few fundamental concepts that must be clarified in order to fully appreciate the concerns BVA has over wait times and length of wait lists. In its report, GAO describes VA blind rehabilitation Services as the means by which legally blind veteran acquires the skills necessary to maximize his/her independent functioning. The report goes on to say that VA provides these services almost exclusively in residential BRCs. While we

certainly do not disagree with this description, we believe it does not go far enough in emphasizing the importance of the residential program. The reader of this report could be left with the impression that the BRC is not the most effective model for service delivery. It is absolutely essential to understand that the overarching purpose of the comprehensive residential BRC program is to assist the severely visually impaired veteran with acceptance of and adjustment to vision loss. Without question, acquisition of essential adaptive skills is an integral piece of the process, but not the end in and of itself. Unless these veterans are able to accept themselves as people who are blind, they will never fully utilize acquired skills or strive for independence. It has been clearly demonstrated over the past 56 years that the comprehensive residential training environment facilitates the process of acceptance, adjustment, and skill acquisition. Any criticism BVA may have for long wait times or lists should in no way be construed as minimizing the importance of or need for the comprehensive residential BRCs.

The other fundamental reality is the increased prevalence of severe visual impairment and blindness associated with aging. It is well documented that aging is the single best predictor of visual impairment and blindness. Given the aging of our veteran population, it is not surprising that the numbers of visually impaired and blind veterans are growing just as rapidly. It follows that there will be an increased demand for VA blind rehabilitation services. Access to essential services is the crucial issue and, regardless of the accuracy of wait time reporting, there is no question that those times will be long, given the numbers of veterans applying for these vital services.

In response to specific findings of GAO contained in the report, BVA is appalled that VA BRCs appear to be unable to accurately and consistently report wait times. There appears to be no excuse for failure to uniformly comply with relatively clear policy from the BRS Program Office in VACO as to how to determine wait times. This is not "Rocket Science". This pitiful failure demonstrates BVA's long-standing concerns over lack of leadership, oversight, and accountability. Until Dr. Lucille Beck was appointed Chief Consultant for the Rehabilitation Strategic Healthcare Group (SHG), a significant void existed in terms of leadership from the program office. Her dynamic leadership has clearly resulted in substantial progress to enhance timely access to appropriate models of service delivery.

Mr. Chairman, in fairness and as partial explanation for the failures in leadership, the program office has absolutely no "line authority" over the BRCs in the field. It is extremely difficult for the Director of BRS to be held responsible for the system-wide program in the absence of line authority. Undeniably, this is the real test of leadership (the ability to influence subordinates and all levels of management to do the right thing).

The next level of responsibility within BRS consists of positions classified as Regional Consultants. There is one such position stationed at each of the five large BRCs. Two of the five positions are currently vacant, and one of the two vacancies is currently open to applicants. These are unusual positions in that those occupying them, according to the position description, spend 75 percent of their time as the representative of the Director of BRS in the field. Unfortunately, however, these individuals have no real authority and are easily ignored when making recommendations during site visits at VA facilities within their areas of responsibility. If desperately needed oversight by the VACO Program Office is to be accomplished, the Regional Consultant positions must be strengthened.

The two other essential professional positions intimately involved in the delivery of comprehensive services to America's blinded veterans are the Visual Impairment Service

Team (VIST) Coordinators and Blind Rehabilitation Outpatient Specialists (BROS). Here again, the Director of BRS has no line authority. Mr. Chairman, if VA is to provide uniform, appropriate and timely service, the classification and recruitment authority for key positions within the special disabilities programs must be re-centralized and the Program Director must, at the very least, have concurrence on the selection of any BRC Chief, Regional Consultant, Full-Time VIST Coordinator or BROS.

Finally, if wait times are to be consistently and accurately reported, accountability must be enforced. Since the program office has no line authority, accountability must begin with the Under Secretary for Health (USH) and move through the Deputy Under Secretary for Operations and Management, to the VISN Directors, and ultimately to the local Facility Directors. Clearly, that is the chain of command responsible for the performance of the Chiefs of the BRCs, full-time VIST Coordinators, and BROS. BVA fully concurs that clear policies and procedures must be established and implemented regarding the accurate reporting of wait times. Without accountability, however, compliance, as demonstrated by the GAO study, will not occur.

Additional Factors Affecting Wait Times

Mr. Chairman, BVA also offers some additional factors that have a direct impact on wait times. These factors must be addressed if significant improvements are to be realized. Without a doubt, BRS must become more accurate in reporting the length of time required to enter BRCs. Unfortunately, however, the GAO report does not shed light on what the real wait times are. No doubt, given the increased demand for service mentioned above, they are quite long. We submit, Mr. Chairman, that these lengthy wait times may not be necessary. There are several contributing factors that GAO did not address in its study of the accuracy of wait time reporting.

First, we question whether all of the veterans being referred to the BRC, and currently on waiting lists, truly need the residential program. Many have had previous training in a BRC and are only referred back in order to obtain a particular piece of adaptive equipment, or receive some remedial training. We contend that many of those individuals could have their needs met through greater utilization of local resources, both within VA as well as outside the system.

Second, to this end, BRS has already taken aggressive steps to refer blinded veterans to qualified local resources, where they exist, for Computer Access Training (CAT). Until this month, these veterans were being forced to attend one of the BRCs in order to receive this training or any necessary upgrades in equipment. We applaud this initiative and believe it will substantially reduce the wait lists and times, freeing up residential beds currently dedicated to the CAT program. Because of the increased demand for CAT training, residential beds previously dedicated to the basic adjustment to blindness program were being shifted to the CAT program. Consequently, the wait for the residential program was made longer. In our view, the basic program must have priority for these beds.

A third factor affecting wait times has been the inability of BRCs to operate all the authorized beds due to staffing shortages. Several BRCs with vacancies in blind rehabilitation specialist positions have not been allowed to fill those vacancies and have therefore not been able to operate all their beds. Admitting a visually impaired or blinded veteran into a BRC without sufficient staff to provide essential instruction only makes an individual's

rehabilitation program unnecessarily longer, thus increasing wait times for those still on the waiting lists. BVA is very concerned that, in an effort to keep the wait lists and times down, facility managers place increasing demands on BRC staff to shorten the length of stay for each veteran in the program. Quality will certainly suffer if veterans are not provided sufficient time in the program to a) make the appropriate adjustment to their vision loss, and b) obtain proficiency with the newly acquired adaptive skills.

The fourth factor that could have a substantial impact on wait times is the influx of casualties from Iraq and Afghanistan. Fortunately, the numbers are small at this time but, given the level and nature of the insurgency, eye casualties may increase. Newly visually impaired and blinded servicemen/women will definitely require the basic comprehensive residential program. As you can imagine, adjustment issues for young individuals, blinded traumatically, are significant. There is no question that the therapeutic environment provided by the comprehensive residential BRC is absolutely crucial if these veterans are to successfully adjust to their visual impairments. In order for these individuals to complete a beneficial course in blind rehabilitation training, the length of the program will necessarily be much longer than the average length of stay currently reported by the BRCs. The needs of a young, suddenly traumatically blinded person are much more extensive than those of elderly, medically compromised veterans possessing residual vision that can be improved with the prescription of and training with optical low vision aids. For example, Mr. Chairman, when I underwent my own blind rehabilitation training following med evacuation from Vietnam, the average length of stay in a BRC at that time was eighteen weeks. I submit that we needed every bit of that time. The average is now approximately six weeks. Therefore, the longer the program, the more slowly the beds are turned over and those on the waiting lists must wait longer. Pressure by network and facility managers to reduce length of stay must not be tolerated.

Mr. Chairman, BVA believes that a partial solution to wait times is assuring that visually impaired and blinded veterans are referred to the most appropriate level of rehabilitative care to meet individual needs. This solution may or may not involve the BRC.

This partial solution relates to the BVA response to the second portion of the GAO report on VA BRS. Again, Mr. Chairman, we concur wholeheartedly with the GAO recommendation that the USH issue a standard of care policy for VA to provide a broad array of inpatient and outpatient vision rehabilitation care for legally blind veterans across the entire system.

On a positive note, VA BRS has recently forwarded two proposals for approval by the USH that BVA believes will change the prevailing culture of BRS and substantially improve access to quality blinds rehabilitation services. Specifically, there are three initiatives BVA strongly supports that we believe will assist in achieving the goal of increased timely access to essential services.

First, the Visual Impairment Advisory Board (VIAB), a multi-disciplinary group appointed by Dr. Thomas Garthwaite (USH at the time), was charged with exploring more effective methods of integrating BRS into the network system of health care delivery. BVA has been an active member of VIAB and is represented on its executive council. VIAB has forwarded to the Health Committee of the National Leadership Board (NLB) a comprehensive recommendation calling for VA to provide a full continuum of vision rehabilitation care across the entire VA Healthcare system. The Health Committee received the proposal favorably and requested that a GAP analysis be conducted to determine what resources

currently exist within VA ands what resources will be necessary to fulfill the requirement to provide the full continuum. The Gap Analysis has just been completed and is being carefully reviewed by VIAB prior to submission to the Health Committee. Mr. Chairman, BVA believes it is imperative that the NLB and the USH expeditiously approve this proposal and mandate the implementation of the full continuum. We also believe that the proposal should be included in network strategic plans as well as in the performance measures for Network and Facility Directors. As mentioned above, accountability will be absolutely essential if the implementation is to be successfully achieved as a National System Priority. Of course, the initiative will also satisfy the GAO recommendation.

A second initiative, which BVA believes is an essential companion to the Continuum of Vision Rehabilitation care, is modification of the Veterans Equitable Resource Allocation (VERA) model of resource allocation to the Networks. Under the current VERA methodology, there is no incentive for facility managers to develop capacity for the delivery of outpatient blind rehabilitation services, or for that matter to contract for such services in the local community. Over the years, the BRS culture has trained facility managers to refer all legally blinded veterans to the BRC for training. We contend that, for a variety of valid reasons, many veterans are either unable to leave home for an extended period to receive these services, or in fact do not require the residential environment of the BRC to obtain necessary services. This is particularly true for our older veterans who now have spouses that are either disabled or have serious medical conditions. These conditions often obligate the blinded veteran to remain home as the primary caregiver. Working closely with the Chief Financial Office of VHA, BRS has submitted a proposed change in VERA that, in our view, would more equitably allocate funds for the provision of services, both inpatient and outpatient, for the legally blind veteran population enrolled in the VA Healthcare system. Again, this proposal has been referred to the Finance Committee of the NLB. We urge expeditious approval by the NLB and the USH. The new allocation should enable and provide incentives for local facilities to successfully comply with the provision of a full continuum of vision rehabilitation care. Contained within the proposal is an element that may prove controversial. In order for the recommended change in VERA for legally blind veterans to be fully implemented in Fiscal Year 2005, funding must be provided through Special Purpose funds for the first three years before the change can stand on its own. We urge this committee to strongly encourage the USH to provide such Special Purpose funds.

The third initiative that will assist in reducing both wait times and lists is expansion of the current bed capacity in BRCs. This initiative is currently under consideration at two facilities: the BRC at the West Palm Beach, Florida, VA Medical Center and the BRC at the Waco, Texas, VAMC. Additionally, the CARES plan approved by Secretary Principi earlier this year calls for establishing two more comprehensive residential BRCs to be constructed at the VAMCs in Biloxi, Mississippi and Long Beach, California.

Ultimately, however, BVA believes that expansion of VA's capacity to provide vision rehabilitation services on an outpatient basis is the real solution to wait times and lists. To their credit, some facilities have already recognized this reality on their own and have taken steps to provide more services through outpatient models of service delivery. The bottom line is that all of the GAO recommendations for improving vision rehabilitation services for legally blinded veterans can be implemented through approval of the two VIAB proposals by the USH. Such approval will set in motion VA's increased and enhanced capacity to provide the appropriate vision rehabilitation services in the right place at the right time.

Mr. Chairman, if the goal recommended by GAO is to be achieved, there will need to be strong leadership from the highest levels of VHA, the BRS Program Office, and all management elements in the VISNs. BVA is encouraged by the selection of a new, dynamic leader for the BRS Program Office. We hope and pray that he fully recovers from his recent medical problem. Additionally, we believe a dramatic change in BRS culture is required for these new proposals to succeed.

Finally, Mr. Chairman, I wish to express our sincere appreciation for your invitation to participate in this hearing this morning. We are especially grateful that Chairman Simmons and Senator Graham have requested that GAO examine the long wait times involved in receiving VA blind rehabilitation services. As always, I would be pleased to respond to any questions you or the Committee members might have

BAVF

Blinded American Veterans Foundation
P.O.Box 65900
Washington, D.C. 20035-5900
www. bavf.org
e-mail: email@bavf.org

Statement of John Fales, Jr.
President
Blinded American Veterans Foundation (BAVF)

U.S. House of Representatives
House Committee on Veterans' Affairs

Hearing on The Evolution of VA-DOD Collaboration in Research and Amputee Care For Veterans of Current and Past Conflicts, and Needed Reform In Blind Rehabilitation Services

Mr. Chairman and Distinguished Members, thank you for holding this important hearing. I welcome this opportunity as President of the Blinded American Veterans Foundation (BAVF), to give you my personal views both as a blinded veteran and also as a visitor to our wounded at the Walter Reed Army and Bethesda Naval Medical Centers.

I have attached a copy of the organizational chart (Attachment #1), Patient Care Services, Strategic Healthcare Groups, which vividly shows the diminished priority that the VA puts on blind rehabilitation. As you can see from the chart, within the past decade VA decentralization has resulted in the deterioration of the VA's renowned Blind Rehabilitation Centers (BRC) programs.

In order to reverse this deterioration of the esteemed blind rehabilitation programs, we must regain the ability to retain uniformity in quality training nationwide plus oversight capability by restoring CENTRALIZATION of this vital program. Amateurs, newcomers not attuned in the field of rehabilitation and those who think they can save public money with their so called new ideas are actually going back to the practices of the past that

have consistently failed for decades. Years of decentralization have devastated the VA Blind Rehabilitation Service (BRS) by reckless local micro-management.

Blind Rehabilitation Services have been severely diluted as rehabilitation teaching positions in BRC's have been abolished, frozen or deferred. Several vacant Visual Impairment Service Team (VIST) Coordinators and other BRC positions have been offered to unqualified individuals or targeted for abolishment. Frequently personnel standards utilized in selection of critical BRS positions have been ignored by local Medical Centers. Several local Medical Centers have considerably diminished the value and level of services provided to blinded veterans by assigning VIST Coordinators to other collateral duties. The lines of supervision of the various BRS components, at the local level, are varied, confusing and lack professional expertise in providing adequate oversight and guidance. The level of blind rehabilitation training and services offered to blinded veterans and their families, nationally, including the determination of prosthetic aids issued, depends unfortunately on local management's level of budgetary support for the program.

There is a very strong need for a balance system of oversight and establishment of lines of supervision within all components of BRS from local to VA Central Office level insuring accountability and maintenance of national standards. Within the new decentralized structure, there is a deep sense that centralized guidance is not needed, wanted or required. Each Veterans Integrated Service Network (VISN), each hospital, attempts to function independently with different governing philosophies, goals, and priorities, while operating under mounting pressures created by shrinking resources. Within such an environment, it is highly improbable that all twenty-two VISN's will adequately provide or properly manage BRS without a check and balance system under guidance from VA Headquarters. The uniformity and equity of programs for blind veterans is at great risk under the current system. There is no oversight or unifying force for this small, but highly visible program.

Local management teams within VISN's and Medical Centers do not possess the professional expertise to strategically plan blind rehabilitation services nor can they provide strong oversight and peer review to the blind rehabilitation specialists scattered in the field. Currently the three components of the Blind Rehabilitation Service delivery system have no common lines of reporting, or authority, or accountability, for their performance. The Director of Blind Rehabilitation in the Central Office has no significant authority in the running of the Blind Rehabilitation Service Programs or the control of their standards at the local level.

We need immediate and viable corrective measures to restore CENTRALIZATION of BRS. CENTRALIZATION was the reason for the success of the program for blinded veterans in the past. I strongly believe the CENTRALIZATION of the Blind Rehabilitation Program is the best insurance we can give our blinded veterans.

Recently, BAVF Secretary, Dr. Dennis Wyant, visited the West Palm Beach Medical Center, Florida and made some observations and recommendations (Attachment # 2). One observation he made regarding the West Palm Beach BRC was that the waiting time is more than one year for blinded veterans waiting to receive rehabilitation training. This, unfortunately, is consistent with all of the VA BRCs.

I have recently learned of a very serious situation at the Augusta, Georgia VA Medical Center. This Center has initiated a one – five day rehabilitation program. Two additional beds have been identified for blind rehabilitation without additional staff to be located on Ward 1C (Dementia Ward). This was done to expedite the minimum length of stay to cash in on the inpatient Veterans Equitable Resource Allocation (VERA) Reimbursement. The staff responsible for this ward has no expertise in dealing with blind individuals. Recently, a local female veteran was admitted for a one day assessment for Job Access With Speed (JAWS).

Another local veteran was admitted to one of these beds for a one day stay for a complete computer upgrade. This veteran received computer training a couple of years ago. It is evident that these two admissions are based on manipulating the VERA system.

I have had the opportunity to visit our wounded heroes at Walter Reed and Bethesda Medical Centers. Although they are being well treated, there is a breakdown for the severely wounded as they transfer from active duty military (Tri-care) to VA medical centers. There used to be a program at military hospitals called Armed Services Medical Relocation Office (ASMRO), which coordinated the transfer of active duty blind to VA Medical Centers. This program, however, is non-existent today, creating a breakdown in communication between the armed forces and VA Medical Centers. This breakdown in communication is detrimental to these wounded heroes not only medically, but financially as well on their quest to lead fully productive lives.

Mr. Chairman, I would be remiss if I did not highlight two positive developments within the VA Medical system. In a memorandum (Attachment #3) VISN Directors are directed to immediately make sure that they inform veterans with low-vision that a colonoscopy is available as a screening method of choice for colorectal cancer. In addition, the VA will be issuing a sole source contract to institute the audio prescription drug program throughout the VA medical system.

Mr. Chairman, thank you for the opportunity to appear before this committee. I will be pleased to answer any questions you or your colleagues may have.

Attachments:
#1 Chart – Patient Care Services
#2 Dr. Dennis Wyant's observations and recommendations (7 pages)
#3 Memorandum from Department of Veterans Affairs

ATTACHMENT #1

Patient Care Services
Strategic Healthcare Groups

Office of Patient Care Services (11)
Michael Kussman, M.D. (Acting), Chief PCS Officer
Madhulika Agarwal, M.D. (Acting), Deputy Chief PCS Officer

Medical/Surgical Services SHG (111)
Madhulika Agarwal, M.D. (Acting)
Chief Consultant

- Medical Service
- Surgical Service
- Anesthesia Service
- Neurology Service
- Organ Transplantation
- Chaplain Service
- Nutrition & Food Service
- Eye Care
- Dental Care
- Foot Care
- Health Promotion & Disease Prevention

Prosthetic & Sensory Aids Services SHG (113)
Frederick Downs, Jr.
Chief Consultant

- Assistive Aids
- Prosthetic/Orthotics
- Surgical

Geriatrics & Extended Care SHG (114)
James F. Burris, M.D.
Chief Consultant

- Community-Based Long Term Care
- Nursing Home Care
- Geriatric Care
- Residential Rehab Care
- Cross-Cutting Functions

Diagnostic Services SHG (115)
Charles Anderson, M.D.
Chief Consultant

- General Diagnostics Services
- Invasive Procedures
- Therapeutic Services
- PACS/Tele-imaging
- Women's Program Services
- Accreditation/Inspection

Mental Health SHG (116)
Mark Shelhorse, M.D. (Acting)
Chief Consultant

- Serious Mental Illness
- PTSD
- Addictive Disorders
- Homelessness
- Psychosocial Rehabilitation
- Geropsychiatry

Rehabilitation SHG (117)
Lucille Beck, Ph.D.
Chief Consultant

- Blind Rehabilitation
- Audiology/Speech Pathology
- National Recreation Therapy Programs
- Physical Medicine & Rehabilitation
- Traumatic Brain Injury Rehabilitation

Pharmacy SHG (119)
Michael Valentino, R.Ph., MHSA
Chief Consultant

- Pharmacy Benefits Management
- VISN Support and Virtual Relationship with other Strategic Healthcare Groups

Office of Care Coordination (11CC)
Adam Darkins, M.D.
Chief Consultant

- Telemedicine
- Social Work Service

Forensic Medicine SHG (11F)
Michael P. Hughes (Acting)
Chief Consultant

- Compensation & Pension
- Tort Claim Review
- Smoking Related Illnesses
- Medical/Legal Issues

Spinal Cord Injury/Disorders SHG (11S)
Margaret Hammond, M.D.
Chief Consultant

- Spinal Cord Injury/Disorders

MJRyerson 7/04

ATTACHMENT # 1

09 June 2004

Mr. John Fales, President
Blinded American Veterans Foundation
P. O. Box 65900
Washington D.C. 20035-5900

Dear John:

As a result of information and questions posed to you by blinded veterans of Florida, Blind Rehabilitation professionals throughout the system, and veterans' organizations, you requested that I visit the West Palm Beach V A Medical Center [WPB VAMC] and Blind Rehabilitation Center [BRC].

I was asked to look at 1. quality and timeliness of Visual Impairment Services [VIS] for outpatient blinded veterans and 2. quality and timeliness of services for blinded veterans who either plan to or have used the services at the BRC

As you requested, I reviewed specialized services ranging from 'script talk' in the pharmacy to colonoscopy screening for VIS outpatients.

Finally, you asked that I review the effects of personnel and disciplinary procedures. This was by far, the most uncomfortable and difficult task. Nevertheless, I will include my observations on the issues.

Attached is a summary sheet on the site visit, issues, recommendations, and additional comments.

Thank you for the opportunity to serve blinded veterans.

Yours truly,

Dennis R Wyant, EdD
National Secretary

Attachments: (2)

Site Visit Summary

I'd like to extend my thanks for the cooperation of Dr Perlin, Ms Miller, Dr Beck, Mr Lewis, and VISN-8 Director, Dr. Elwood Headley for helping make the site visit a pleasant and positive experience. Mr Ed Seiler's, Medical Center Director, hospitality was much appreciated.

The WPB VAMC is a large, clean, and extremely busy facility. The management team takes great pride in it. Mr Seiler is diligent in meeting the 30-day goal of initial appointments for primary care.

I was equally impressed by the management and operations at WPB BRC. Both Mr. Getz, Chief and Ms Garrity, Program Coordinator, seem to be a great team in providing blinded veterans with among the best blind rehabilitation programs in the world.

However, as good as the Medical Center and BRC are, there are issues. Nine recommendations are included that, in my opinion, will improve service to blinded veterans.

The large blinded veterans population in Florida and in particular in the WPB VAMC catchments area will continue to be challenging without additional resources.

In preparation for my site visit, I was pleased to see that a new modular 30-bed BRC is being designed and perhaps even funded this year. This project is supported at the highest levels of the VA and the station management. Please keep your stakeholders informed on the progress of this project.

There were several 'best practices' observed for blinded veterans. Hopefully these will continue, however, my focus will be devoted to short term recommendations that will affect the quality and timeliness of service to blinded veterans.

It was my observation that there are personnel and disciplinary practices and actions that may interfere with employees' feeling empowered. This restricts innovation because employees can be overcautious and concerned that the perception by management outside of BRC will be negative if any initiatives are not successful.

Since I am not a Title 5 or 38 subject matter expert on personnel issues, including reprisals, I was hesitant to delve too deeply into this topic. In fairness to all, I didn't get the opportunity to discuss this with Mr Seiler, the Director, or employees affected.

Attached are issues, recommendations, and comments as a result of information obtained prior to my visit and from my observations during my site visit.

Site visit to West Palm V A M C and B R C

1. The waiting time for Blinded Veterans who plan to attend the WPBRC
   A. This is a major issue. The waiting time is over one year. However, the highlight of my visit preparation time and actual site visit was to learn that a new, 30 bed modular BRC is in the planning stages. If this new facility is adequately staffed, it will go a long way to solve the complaint from stakeholders currently on the waiting list.

Recommendation: Move quickly to build the 30-bed facility while there is national and VISN-8 support. Once approved and funded, I would initiate a major P R effort. It is a win-win effort: blinded veterans will be pleased and the WPB VAMC will be praised.

   B. In February 2004, Dr Beck, VHA, VACO while touring the VAMC-BRC was told that additional optometrists would be coming on board. This hasn't happened almost four months later and becomes more important as Dr Lee who is currently providing this service will be going on maternity leave shortly. It is my observation that Dr Lee is pulled in many different directions, dividing time between BRC, VIS and primary care. This makes scheduling difficult which in turn may delay needed services. For example, a newly referred blinded veteran would have to wait eight- ten weeks for a low vision exam by the VIS team. It is one of the few areas where the facility is missing its 30-day goal of seeing a new patient. I know I was told that hiring additional optometrists is planned but not yet executed.

Recommendation: Make this hiring action a priority. While Dr Lee is on maternity leave, you might follow through with your plan to hire some contract optometrists. Both actions are needed if you plan to continue priority service for blinded veterans in a timely fashion.

C. The mixes of staff that are professional Blind Rehabilitation Specialists [BRS] contribute to the waiting list, that is, blinded veterans must wait for service. At other BRCs in the VA, they have found a 1:1 ratio, that is BRS to blinded veteran, is a 'best practice'. This was verified in my discussions with other BRCs. In my preparation, I noticed a letter from C O to Dr Headley, VISN Director, (29January 2004) that WPB-BRC only had 13 professionals for 15 beds. Now, the Center has expanded to 17 beds but only 13 BRS are in place.

Recommendation: A Q I Task Team be established to compare WPB BRC Blind Rehabilitation staffing with other VA-BRCs with the plan to assess which ratio model gives the VA the most "bang for the buck" and the best service to blinded veterans.

D. The WPB BRC and VIS Coordinator and Blind Rehabilitation Outreach Specialists [BROS] throughout VISN-8 are on the fast track to identify local resources for Computer Assisted Training Service [CATS] to assist blinded veterans with computer training. This will save the V A funds and make additional spots available for blinded veterans who need initial blind rehabilitation training at the WPB BRC.

Recommendation: Continue your current efforts. You are to be commended for this effort.

E. Since the Birmingham BRC has a shorter waiting time to serve the blinded veterans in their catchments area, they were contacted to assess their ability to assist WPB BRC on a short term basis. Mr. Sands, Chief of Birmingham's BRC said he would do his best to assist the blinded veterans of Florida. I was told by Mr. Getz, Chief at WPB BRC that currently, some of their candidates travel for

training from northern Florida to Birmingham or Augusta for their training.

Recommendation: Until you expand your BRC and receive additional staffing, you might design a referral system from central FL (Orlando – Tampa) to Birmingham so that some blinded veterans would receive training sooner in the event of unexpected cancellations or as openings become available.

2. Do the Blinded Veterans of WPB VAMC receive timely and quality outpatient VIS services?

   A. Ms Jenson, VIST Coordinator has over 600 blinded veterans on her roles. Her job, if done properly is more than a full time job. Recently, she was detailed to WPB-RC which helped them but eliminated outpatient program services for the blinded veteran. At the BVA state convention, it was reported by blinded veterans in the area that the monthly support meeting was cancelled. It was difficult to get in touch with VIS or get a timely reply about whether prosthetics, pharmacy, or other VIS issues needing the intervention of the VIS Coordinator. The veteran population would indicate that 2,500 blinded veterans live in the area and are eligible for VIS services. I believe VA projections show that 3,500 blinded veterans live in the catchments area. If an extensive outreach to blinded veterans was conducted, the workload could quadruple.

Recommendation; The VIS Coordinator should not be detailed to Blind Centers as long as the described workload and timelines exist. It simply means that a larger number of local outpatient blinded veterans go un-served or under-served.

   B. There may be a timeliness issue with prosthetics and sensory aid delivery on those items not in stock. Examples of these items include software updates for JAWS and ZOOM TEXT, or renewal of anti-virus packages such as Norton or McAfee. Mr Rouch,Chief of Prosthetics, states there had been a problem in the past but it has been resolved. However, blinded veterans in the area disagree.

Recommendation: A Q I Task Team perform a review covering all orders for items not routinely maintained in station inventory for blinded veterans for a 90-day period.

C. The Blind Rehabilitation Outreach Specialist [BROS] is usually thought of serving outpatients and working in conjunction with the VIS Coordinator. However, at West Palm, it appears the service is a hybrid practice serving the Blind Center Inpatient and West Palm Blinded Veteran Outpatient services. I was impressed with the dedication of the two BROS. Their key boarding and touch typing outreach programs are a best practice because they keep the blinded veteran motivated as well as eventually reducing the time required in computer training. Both BROS felt comfortable with being assigned to the BRCs

Recommendation: BROS are outreach specialists. Each VIS catchments area should use BROS for this purpose; therefore minimizing the use of them for inpatient activity at the BRC and maximizing their outreach effort and identifying local resources to assist blinded veterans. In the big picture, this reduces work at the BRC as well.

3. Personnel and disciplinary actions can be complicated issues to analyze. The issues observed at the BRC are consistent with what I heard from CO contacts and Blind Center Chiefs (I didn't discuss with WPB BRC Chief John Getz) The local blinded veterans and VIST Coordinator throughout VISN-8 report that employees with good past records are now subject to more micro management and harsher disciplinary actions than in the past. Since time didn't permit I did not have the opportunity to talk with either Mr Seiler or employees affected concerning the issues. However, if what I heard was true, there have been three or four situations where suspension was an initial step in the disciplinary process. In my 20-years as a Director for the VA, I only used a suspension as the last step before dismissal. My style may differ perhaps because of my rehabilitation and counseling background. I would first use verbal counseling and training; and if necessary, move to written letters of counseling, reprimands or admonishments; saving suspension and removal

for the most serious infractions. Hopefully these differences can be worked out between the Director's office and the employee in a manner appropriate, fair, and equitable for all. While on my site visit, I was asked to meet with members of veterans organizations, disabled employees, and representatives of advocacy groups representing VAMC employees. All of these individuals requested that they remain anonymous due to their concerns about reprisals. These meetings took place off-station during non-duty hours. There were no BRC employees involved in these meetings. However, it is rumored that BRC employees share similar concerns.

Recommendation: A comprehensive VACO survey team review ongoing personnel issues, disciplinary actions, and if fear of reprisals is reality or perception. The expertise of the team should include not only subject matter experts in personnel issues but EEO, reasonable accommodation, and the interface between union and management.

ATTACHMENT #3

Department of Veterans Affairs

Memorandum

Date: July 8, 2004

From: Deputy Under Secretary for Health (10A)
Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Colon Cancer Screening for Visually Impaired Patients

To: VISN Directors (10N1-23)

1. Colon cancer screening is one of several preventative measures recommended by the Health Promotion and Disease Prevention Program in VHA. Colon cancer screening using fecal occult blood testing (FOBT) cards is the most commonly used screening method in VA. This process requires good vision and is not suitable for patients with severe visual impairment.

2. Therefore, it is imperative that this quality of care issue be addressed immediately. It is recommended that all providers be informed through a local policy or directive that veterans with low vision, who are unable to complete FOBT, be offered colonoscopy as the screening method of choice for colorectal cancer. The veteran may accept or reject the choice for an alternative screening method, such as FOBT or flexible sigmoidoscopy, based on personal and family preference for the different screening modalities.

3. Each VISN should inform Odette Levesque(10NC) via email of its plans to address this very important issue by COB July 30, 2004. If you have additional questions on this issue, please contact Thakor G. Patel, MD in the Office of Patient Care Services, VACO, at (202) 273-8490.

Michael J. Kussman, MD, MS, MACP

Laura J. Miller

VA FORM MAR 1989 2105

STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JULY 22, 2004

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to present the views of the Disabled American Veterans (DAV) and its Auxiliary, on the evolution of collaboration between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) in research and amputee care for veterans of current and past conflicts, and needed reforms in VA blind rehabilitation services.

The Veterans Health Administration (VHA) is the largest direct provider of health care services in the United States and offers specialized care that is world renowned to veterans with amputations, spinal cord injury, blindness, posttraumatic stress disorder, and brain injury. Access to high quality, timely health care services is essential for many DAV members, especially those who have suffered severe or catastrophic disabilities as a result of their military service. Therefore, preservation of VA's specialized disability programs is of the utmost importance to DAV and our members.

VA Prosthetic Services

One of VA's primary missions is the medical and rehabilitative care of catastrophically disabled veterans. Over the past year, there has been increased concern whether VA is able to provide the necessary specialized care, including prosthetic services, to veterans returning from Iraq and Afghanistan who have suffered traumatic amputations. The focus has been on VA's and DoD's handling of these cases, and collaboration between the two Departments as the wounded soldier transitions into veteran status and, in many cases, from one health care system to the other.

Several newspaper articles have been written about returning soldiers who have been severely wounded and are now undergoing extensive rehabilitation at Walter Reed Army Medical Center and other military installations. There are reports that DoD is providing the finest prosthetic items available to wounded soldiers and that everything possible is being done to help military personnel who have suffered these devastating injuries to regain their good health and live full and active lives.

Congress has been supportive as well. The *New York Times* article, "Redefining the Front Lines in Reversing War's Toll" stated that, "[i]t is not an inexpensive proposition, reflecting a cost of war that is less apparent than money spent for supplies and ammunition."

The article noted that, since 2001, Congress has provided Walter Reed an additional $6.6 million in funding to cover the costs of treating returning wounded veterans, many who need very lengthy specialized care for their injuries. The prosthetic items purchased by Walter Reed, according to the article, can cost over $150,000 each. DoD is apparently fitting new amputees with high tech items such as the $85,000 myoelectric arm, which is powered by a lithium battery and approximates hand movements through electrical impulses when remaining muscles in the arm are flexed, and the c-leg, a technologically advanced prosthetic leg with a computer-chip costing on average $50,000 each. Some of the other prosthetic items provided by DoD are not even available yet in the private sector. According to the *New York Times* article, a state-of-the-art prosthetic lab at Walter Reed houses technicians that help fine-tune the newly provided prosthetic items. Computer programs and magnetic resonance imaging are then used to custom fit the devices to the affected limb to achieve a perfect and comfortable fit.

We could not agree more that providing essential health care services to our nation's disabled veterans is a continuing cost of war. Recently, the Senate included provisions in the fiscal year 2005 Defense Appropriations bill to further increase funding for specialized health services for wounded troops from Iraq and Afghanistan. Key sections in the measure include $18.4 million for specialized care of amputees, $9.4 million for upgrading facilities and services at Walter Reed Medical Center's Amputee Center, and an additional $9 million was designated for research on prosthetic care, limb development, and rehabilitation.

In many cases, the next step for the wounded soldier is discharge from the military and transition into veteran status. It is our understanding that VA is doing everything possible to coordinate with DoD to make this transition as seamless as possible. It appears that much of the cooperation between the two Departments has been accomplished through informal networks. We encourage VA, through these relationships, to formalize and expand transition programs to ensure injured soldiers receive a full continuum of care without experiencing bureaucratic red tape. We were informed that VA Secretary Anthony J. Principi has put a high priority on care for wounded veterans returning from Iraq and Afghanistan, and that VA is prepared to handle the specialized needs of veterans seeking VA prosthetic and rehabilitation services. We are pleased to hear this, but we have some concern about funding for these specialized programs and continuing care for previously wounded veterans who also have prosthetic needs.

Initially, DAV believes full funding for veterans' health care is essential to ensure timely, quality health care services are provided to eligible veterans. Currently, VA's prosthetic department is funded under a centralized budget. We support the continuation of centralized funding for VA's prosthetic service to ensure that VA is able to meet the needs of disabled veterans with catastrophic disabilities. Right now there is strong support for our troops, especially those who have been severely wounded, and a renewed interest in what is being done to ensure these men and women get the health care services they need. We are pleased that additional funding has been proposed for specialized amputee care and rehabilitation in the fiscal year 2005 Defense Appropriations bill. However, we want Congress to provide sufficient funding for the entire VA health care system as well, and maintain close oversight of VA's special disability programs, including prosthetics. In many cases, VA will be the agency responsible for providing a lifetime of care for these seriously wounded veterans. Some veterans will need specialized prosthetic care to properly maintain or replace their prosthesis; others will

need a full continuum of health cares services, including mental health services to cope with the severity of their disability.

We are concerned if VA is fully prepared to meet these catastrophically disabled veterans' needs, given the new and very costly prosthetic items that are being provided by DoD. Additionally, we question if VA can continue to provide the same level of care for veterans who suffered traumatic amputations in previous wars and conflicts. These veterans deserve priority care as well, and, if necessary, access to new prosthetic devices. DAV members who have received specialized services from VA for limb loss have complained that it is frequently difficult to find a good prosthetist or one that will accept VA's reimbursement rate for making a new prosthetic limb. Our members tell us that there is a very unique relationship that must exist between a prosthetist and amputee patient. The prosthetist must be flexible and willing to listen to the veteran and consider his or her personal needs. There must be a level of trust and confidence that the prosthetist is qualified and able make an item that is tailored to the veteran's needs; one that is both comfortable and fully functional. Ultimately, all service-connected veterans with amputations deserve to have cutting edge, top quality prosthetic items that provide the highest level of function.

Whether a veteran has been using VA prosthetic services for years or is a new user of the system, VHA must ensure that new technology and/or the services of master prosthetists are available to veterans based on their needs. VA should reach out to veterans with amputations who are current users of the system and inform them about the newest and most advanced prosthetic items available. Many older veterans may not be aware of the technological advances that have been made recently that could make them more functional and greatly enhance their quality of life. Likewise, VA must receive adequate funding for maintenance and issuing of these specialized items. Sufficient funding is also necessary to prevent delays in orders of prosthetic items, properly maintain training programs for physical medicine and rehabilitation programs directly related to special disabilities, and maintain a sufficient number of skilled personnel. Additionally, all VA prosthetic labs should be certified to ensure quality. Finally, VHA must guarantee consistent application of prosthetic devices and proper application of national VHA prosthetic policies and procedures.

Without question, VA should be a leader in the industry when it comes to conditions prevalent among veterans, especially war related injuries. DAV strongly supports research programs focused on veterans health concerns, particularly those related to aging and disability. Therefore, DAV recommends VA develop several centers of excellence to explore new technological advances for prosthetics, promote research, education, and new treatment and rehabilitation models for veterans with amputations. VA should also take this opportunity to reevaluate and improve its rehabilitation services with a focus on traumatic amputations resulting from combat-related injuries. Likewise, VA has a unique opportunity at this time to launch new research studies in prosthetics. Veteran-focused research in this area is especially important now and should be a top priority for VA.

In closing on this section, we strongly believe that decisions about VA's prosthetic services should be patient oriented, not budget driven. Disabled veterans should be allowed to collaborate with clinicians and participate in the selection process of choosing a personalized

prosthetic item to ensure they maintain their freedom of choice and to maximize their independence and facilitate their lifestyle.

VA Blind Rehabilitation Service

VA's Blind Rehabilitation Service (BRS) is known worldwide for its excellence in providing comprehensive blind rehabilitation services to our nation's blinded veterans. However, to remain on the cutting edge, VA must rededicate itself to the excellence of these specialized programs for blinded veterans.

The DAV, along with the other co-authors of *The Independent Budget* (IB), American Veterans (AMVETS), Paralyzed Veterans of America, and the Veterans of Foreign Wars, identified several deficiencies in VA's Blind Rehabilitation Service and recommended improvements. Initially, we noted that many blind rehabilitation centers are unable to operate all of their beds due to reductions in staffing levels causing blinded veterans to wait longer for needed services. VA must restore bed capacity in all blind rehabilitation centers to the level that existed at the time of passage of Public Law 104-262. Currently, there is an insufficient number of key personnel trained to meet the specialized needs of blinded veterans, specifically visual impairment services team coordinators and blind rehabilitation outpatient specialists. Staff in these positions provide essential services, including comprehensive assessments for entry into residential blind rehabilitation centers, and in-home blind rehabilitation training. The latter is especially important given VA's shift to outpatient care services, focus on alternative health care delivery models and a rapidly aging veteran population in need of blind rehabilitation services as a result of age-related diseases. To meet the changing needs of this specialized population, VA must constantly reevaluate its programs and ensure appropriate staffing levels of all blind rehabilitation specialists based on need.

The IB also called for additional funding for research into alternative models of care for blind rehabilitation services, but cautioned that other service delivery models should be thoroughly tested and validated prior to dismantling existing programs. Likewise, if needed, VA should expand capacity to provide computer access evaluation and training for blinded veterans by contracting with qualified local providers when and where they are available.

VA's specialized disability programs are essential for many of our nation's most severely disabled veterans; therefore, we must ensure they are not dismantled, diminished or compromised due to insufficient staffing levels or for purely budgetary reasons. To maintain and continue the success of these highly specialized programs it will require oversight by Congress, veterans, veterans service organizations, and other interested parties. During a period of war, it is critical that VA has the resources it needs to provide specialized care now and in the future to veterans who have sacrificed their health and well-being in defense of our nation.

Again, we thank the Committee for holding this hearing today and providing DAV the opportunity to express our views on these important issues.

House Committee on Veterans Affairs

Hearing on the Department of Veterans' Affairs Prosthetic Rehabilitation and Research Programs

Thursday, July 22, 2004

9:30 a.m.

Testimony of

Mr. Bert Harman

President and CEO, Otto Bock HealthCare GmbH

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7/19/2004 6:03:04 PM

Chairman Smith, Ranking Member Evans, and distinguished members of the Subcommittee: thank you for the opportunity to share a private sector perspective on collaboration among the Department of Veterans' Affairs, the Department of Defense, and industry on veteran amputee care and prosthetic research.

My name is Bert Harman and I am the President and Chief Executive Officer of North and South American operations for Otto Bock Healthcare, located in Minneapolis, MN. With over 80 years of experience and a presence in 140 countries worldwide, and with design and manufacturing operations in Florida, Minnesota, and Utah, Otto Bock is the global leader in developing and manufacturing innovative prosthetic technologies and devices. Our aim is to offer persons with limb loss technological solutions to maximize functionality, enhance productivity and ensure restored independence. Otto Bock is widely known currently as the developer of the microprocessor controlled C-Leg, arguably the most advanced prosthetic technology in use today. I am also appearing on behalf of the orthotic and prosthetic industry, and the many committed providers and companies who stand ready to meet the challenge of ensuring optimal outcomes for military and veteran amputees. Collectively, our industry continues to push the limits of technology and patient care and is eager to maintain, and grow, current collaborations with the DoD and the VA.

I would like to make the following three points in my testimony today:

- The Committee can be very pleased by the growing collaboration among the VA and the DoD, and also the private sector, to provide care and rehabilitation to servicemen and women whose injuries

have resulted in the loss of one or more limbs. Historically, the needs of the military have helped to drive advances in prosthetic technology developed by the private sector, and Otto Bock is proud to be a partner with the VA and DoD to meet the needs of the modern military and veterans. This public-private collaboration is essential to developing high-quality prosthetics to serve all persons with limb loss.

- While Otto Bock is the largest prosthetic manufacturer in the world, we are a relatively small, privately held company with limited research resources. Expanded collaboration with the private sector is essential, particularly in the area of clinical studies and assessments, to continued development of technologies that will significantly improve the lives, health, and productivity of our military and veteran amputees, while also assisting Medicare beneficiaries and other amputees outside of the VA and DoD systems.
- The reinvigoration of prosthetic care and research at the VA and the DoD will serve to further underscore significant deficiencies among medical and scientific communities in the area of clinical and prosthetic research. Simply stated, there currently are too few researchers within the DoD and the VA and the private sector as well, with interest and experience in the field to adequately address

the challenges that we face in dramatically advancing prosthetic care and technology. The amputee population in the U.S. is approximately 1.2 million people. As such they represent a very needy, but, from the business perspective, a very small market. Bringing next generation technologies to this patient population is challenged by the economics of the relatively small scale of the industry. We must do all that is possible, therefore, to ensure that the current renewed focus on amputee care is fully leveraged, including: providing the VA with the necessary support so that internal capacity and competence may be further developed; ensuring that any and all barriers to collaborations between the VA and the DoD are removed so that existing assets may be complimented; and creating a more streamlined, flexible mechanism for the VA to partner with and support innovative research and accelerate product development in conjunction with the private sector.

The human toll exacted by military operations in Afghanistan and Iraq has been widely reported, particularly with respect to those men and women whose injuries have resulted in the loss of one or more limbs. DoD swiftly and effectively addressed the medical rehabilitation and prosthetic care needs of military personnel, and formed an innovative partnership with the VA to transition active duty personnel to VA care and rehabilitation. We applaud the commitment shown by the leadership of both

Departments to ensure that amputees injured in Afghanistan and Iraq are provided with the latest and highest quality prosthetic technologies and care appropriate for their medical needs, and available in the market.

Traumatic amputation is an unfortunate consequence of military engagement. Historically, the increased demand for prosthetic rehabilitation during and following times of war has also driven innovation. For example, hydraulic technology developed for military applications during World War II was adapted for use in prosthetic knee components, and continue in use today. The Vietnam era spawned considerable prosthetic advances, including the development of modern, modular prosthetic components, resulting in greatly expanded technology options, along with the eventual departure from the use of wood in the fabrication of prosthetic limbs.

Currently, the modern military's demands for prosthetic technology that will enable military servicemen and combat veterans to return to close to pre-injury levels of functionality are driving research and program development. DoD's approach to view injured military personnel as "tactical athletes" has set the rehabilitation bar extremely high. This aggressive goal setting is precisely what is needed to further advance the state of science and standard of care in prosthetics.

Otto Bock has enjoyed a very strong relationship with the Amputee Care Center at the Walter Reed Army Medical Center and stands prepared to expand its collaboration. We are convinced that collaborative partnerships among Walter Reed, the VA and the private sector, if fully supported, will enable the best and most current technologies, from

other business segments, to be integrated into next generation prosthetic technologies in order to enable these dedicated individuals to pursue their lives – military or civilian.

Investments must be made to further adapt these existing technologies, and develop *new* advancements to meet the demands of military and veteran applications. I want to thank the House of Representatives for its commitment to this pressing need, and in particular I want to recognize Representative Bill Young for championing $10 million in FY 05 support -- above and beyond the support provided for direct patient care and operations of the Amputee Care Center -- for advanced prosthetic research to be administered by Walter Reed.

The DoD/VA collaboration also extends to clinical studies. As an active participant with Walter Reed and the VA in the development of clinical assessments, we have been very impressed by the partnership between the two agencies, and in particular the aggressive response by the VA to allocating necessary resources to begin meeting the demands in this area. For example, while staff of the Amputee Care Center at Walter Reed was focused, appropriately, on patient care, VA personnel identified and supported a VA researcher to be located at Walter Reed to coordinate clinical research studies. Additionally, while specific expertise was needed to coordinate lower-limb clinical and technology assessments, the VA effectively recruited a highly respected researcher in the field from the Mayo Clinic to lead and oversee this work.

Good, solid clinical studies are essential to ensuring that any technology is suitable for specific populations and applications. Clinical research on amputee populations is also an area where the challenges of a small, dispersed, patient population

have limited the rate of treatment advances in the category. For example, for some highly specialized therapies of the upper extremities, there are only a few hundred patients in the whole country with a need for prosthetic assistance. Without the assistance of the VA and DoD, it would be virtually impossible to execute and direct clinical research on this patient population by any private company. But the VA and DoD, with access to focused patient populations are in a better position than anyone in the world to assist in the conducting of the basic research needed to improve their lives. Advanced technologies such as the C-Leg, which initially was believed to benefit primarily active amputees, are beginning to demonstrate promising benefits for the moderately active patient and even for aging veteran amputees as well. Microprocessor controlled knee components, for example, provide greater confidence in descending stairs and inclines, and in navigating uneven terrain. These could contribute to fewer falls and resultant injuries among the aging amputee population.

Additionally, these advanced prosthetic devices offer reduced energy consumption during ambulation, encouraging aging veterans to be more active. For veterans with chronic conditions such as diabetes and cardiovascular disease, higher levels of physical activity will help to dramatically reduce devastating and costly secondary complications. But executing good clinical research to document exactly which care pathways to follow is an expensive proposition, one which the prosthetic industry is embracing. But due to its small size, the prosthetic industry is doing so on a timeline far slower than is desirable to meet the growing needs for both the military, veteran or civilian amputee population. The VA has recognized this and is actively

collaborating with us on further clinical research in this promising area of amputee treatment.

A further example of VA collaboration is the clinical testing that is planned to assess the benefit of vacuum assisted socket systems. This research activity will evaluate these technologies and seek to determine the effect of vacuum pressure resulting in improved circulation, on patients' residual limbs health. Otto Bock is very encouraged by the commitment by the VA and the DoD to work with the private sector to gain the benefit of the industry's experience and recommendations to address these challenging issues, while at the same time further contributing to our own knowledge base.

In closing, the collaboration between the VA and the DoD is working. This partnership can be enhanced even more, in order to have the optimal, dramatic, long-term effect on amputee patient care that we all hope it will. I urge the Committee to fully support the efforts of the VA and its renewed emphasis on amputee care and research through the FY05 budget process. To further advance the standard of care in prosthetics, and to improve patient outcomes, I recommend that the committee explore how additional prosthetic clinical research capacity and talent may be developed within the VA. I also suggest that a streamlined process for private sector collaborations and partnerships be explored so that the time from innovation to application may be greatly accelerated.

Otto Bock Healthcare, along with the entire prosthetic industry, is committed to enhancing its partnership with the VA and DoD to achieve optimal results for those men

and women who have so bravely served our country. I know you share this goal, and appreciate your attention and the opportunity to testify before you today.

Thank you.

Statement of
Rory A. Cooper, Ph.D.
Senior Career Research Scientist and
Director, Center of Excellence for Wheelchairs and Associated Rehabilitation Engineering
VA Pittsburgh Healthcare System
Before the
Committee on Veterans' Affairs
U.S. House of Representatives

July 22, 2004

Mr. Chairman and Members of the Committee:

I speak to you today in my role both as a veteran with a spinal cord injury who has benefited from research and as a VA research scientist. For 24 years I have been a user of multiple assistive devices, and have used a wheelchair as my primary means of mobility. I have been a VA-funded research scientist for nearly fifteen years, and the Director of the Human Engineering Research Laboratories since 1994, which is one of the VA's designated Centers of Excellence in Rehabilitation Research and Development. I am going to confine my remarks to how ongoing research and development intersects with the promotion of full participation in society of veterans with severe mobility impairments, which is our main concern.

The increase in military deployments overseas has provided a steady stream of young veterans with disabilities. It is important to note that a large percentage of veteran wheelchair users are from special disability populations (SDP) such as spinal cord injury and dysfunction (SCI/D), traumatic brain injury, and amputation. There are a number of other veterans who are using or will likely use wheelchairs in the future. The chances of acquiring a disability increase with age, and people over 65 represent about 43 percent of individuals with severe disabilities. Over 35 percent of VA users are 65 or older compared to 17 percent in the general population. While VA predicts that the total number of veterans is likely to decline by 19 percent between 1990 and 2020 (without accounting for the War on Terrorism or other hostilities), the number of older veterans from the Vietnam and Korean conflicts is expected to climb sharply. VA has shifted focus from hospitalization to community integration. For veterans with disabilities, assistive technology is critical to this effort.

While our Center is focused on veterans, we would be remiss not to address the broader needs for wheelchairs. In the U.S. an estimated 2.2 million people currently use wheelchairs for their daily mobility. World wide, an estimated 100-130 million people with disabilities need wheelchairs, though less than 10 percent own or have access to one. While these numbers are staggering, experts predict that the number of people who need wheelchairs will increase by 22 percent over the next ten years. The leading cause of disabilities in the world can be attributed to landmines, particularly in developing nations, leading to 26,000 people injured or killed by landmines worldwide each year.

Given that major limb loss, spinal cord injury and traumatic brain injury affect a growing number of military personnel serving in Operation Enduring Freedom, Operation Iraqi Freedom, and other foreign deployments, further research is particularly important. There is an overwhelming need for wheelchairs and prosthetic limbs and the research and development required to make them safer, more effective, and widely available. This was pointed out by the VHA Rehabilitation Strategic Healthcare Group who identified the following areas as being of particular importance: practitioner credentials, accreditation, device evaluation, device user training, patient education, clinical prescribing criteria, national contracts, and access to new technology.

Wheelchair-related research is a broad topic with many focused areas of investigation. The studies proposed in the following section represent this diversity, covering topics ranging from remote monitoring, to vibration exposure, to clinical education related to assistive technology. Recent deployments have resulted in the largest number of young, military-aged American veterans with amputations since Vietnam. Veterans of the Vietnam War were the last major influx of individuals acquiring traumatic or surgical amputations from injuries sustained during conflict deployment. Since that time, the focus of prosthesis design has shifted away from deployment-related, traumatic amputations, and moved towards older individuals who have required amputations due to peripheral vascular disease. Clearly, there is a need for deployment-related research and development, especially for veterans with traumatic limb loss.

The main reason I have been involved with research and development in VA for the past 15 years is that I feel that VA is a particularly favorable place for providing excellent prosthetics and assistive technology services. Among VA's advantages are the computerized patient record, including the national prosthetics patient database, and the veterans themselves who are a particularly rewarding group to work with, and who participate in research more actively and with greater enthusiasm than the average person in the private sector. In addition, VA has a long history of notable accomplishment in rehabilitation research and clinical service delivery often setting a standard for this field.

I would like to address how our research benefits veterans within a VA healthcare environment. I will limit my remarks to our research program in Pittsburgh; however, other VA medical centers have analogous stories. Our VA research program covers a wide spectrum of studies and development projects, from basic biomechanics through development of new devices to clinical studies and new structures of service delivery. All of our studies are veteran-focused, and many of our research and development concepts are directly inspired by veterans' needs. For example, a fundamental driver for the high prevalence of upper extremity pain and joint degeneration is the improper selecting and fitting of manual wheelchairs. My colleagues, Drs. Michael Boninger and Alicia Koontz, were intimately involved in developing clinical practice guidelines with a consortium of organizations, including the Paralyzed Veterans of America, to reduce the incidence of, if not to prevent, repetitive strain injuries to the upper extremities. Many of the recommendations were based upon their work on the biomechanics of manual wheelchair propulsion and modeling of the upper extremities. These studies were able to show that the use of ultra-light weight wheelchairs fitted for the user placed less stress on the upper extremities during propulsion and reduced the incidence of arm pain and injury. In addition, they prompted the design of more ergonomically designed manual wheelchairs and components. Through the application of advanced engineering materials, design processes and manufacturing techniques, manual wheelchairs today are nothing like the first wheelchair I received 24 years ago. This is an example of how a problem faced by

many veterans who use wheelchairs was investigated and led to new products and changes in clinical practice.

Surveys of therapists working in seating and mobility clinics have reported that about 50 percent of individuals who are assessed are unable to independently operate a wheelchair due to physical, mental or technological limitations. This has prompted my colleagues and me to develop and investigate the clinical application of new control algorithms, sensors, and human interface technologies to allow people with severe traumatic brain injury, multiple sclerosis, or amyotrophic lateral sclerosis the ability to independently operate an electrically powered wheelchair and more fully participate in life's activities. Our approach has been to work with veterans in identifying the design issues and to team with clinicians to meet the veteran's goals. Through the integration of sensors to detect obstacles in the environment, algorithms to compensate for irregular movements and unexpected events, coupled with natural interfaces, we expect to increase the number of veterans and others who will be able to move independently. This combination of advanced electronics and software would also have spin-off benefits for individuals who use prosthetic limbs in the development of more advanced limbs to promote greater community participation.

I mentioned the development of clinical practice guidelines earlier, but VA has also been a leader in the development and application of technical standards, especially for wheelchairs. Technical standards help to ensure minimum quality and allow the objective comparison of products or devices. There is currently a suite of technical standards adopted by the Rehabilitation Engineering and Assistive Technology Society of North America and the American National Standards Institute that VA uses in its purchasing decisions. VA research and development has been, and continues to be, a cornerstone for clinical and technical standards development. These standards affect thousands of veterans who use wheelchairs, and millions of non-veterans with disabilities.

Mr. Chairman, I have tried to give a few examples of the spectrum of wheelchair and rehabilitation engineering research in Pittsburgh and to show you how it is integrated into VA medical care, which is our primary focus. I will be happy to answer any of your questions. Thank you.

Statement of
Bruce W. Davis, MSW
Visual Impairment Services Team Coordinator
North Florida/South Georgia Veterans Health System
VA Medical Center, Gainesville FL
Before the
Committee on Veterans' Affairs
House of Representatives
July 22, 2004

Mr. Chairman and Members of the Committee:

For the past 21 years I have been the Visual Impairment Services Team (VIST) Coordinator at Malcolm Randall VA Medical Center (VAMC) in Gainesville, Florida. The North Florida/South Georgia Veterans Health System is committed to providing quality services to our blind and visually impaired veterans. In 1983, we had identified a total of 275 legally blind veterans. These veterans were served by two part-time VIST Coordinators. As of July 12, 2004, we had identified 1,114 legally blind veterans within the North Florida/South Georgia Veterans Health System. They are currently served by 3 full-time VIST Coordinators, 2 part-time VIST Coordinators, and one full-time Blind Rehabilitation Outpatient Specialist (BROS). My personal caseload is comprised of 454 legally blind veterans.

As the VIST Coordinator at the Gainesville VAMC, I am responsible for coordinating the efforts of a multi-disciplinary team to provide comprehensive medical and rehabilitative services for the blind. We work to identify the legally blind veterans in our primary service area and invite them to participate in the services provided by the Department of Veteran Affairs. This is accomplished by an active outreach effort to local and state agencies that work with the visually impaired, as well as other consumer advocates groups. We also work with medical center staff to identify and refer veterans with visual impairment to the VIST program.

We invite all blind veterans to participate in the annual VIST review, which is comprised of a medical examination, eye examination, hearing screening, and a psychosocial assessment. During the VIST review, we assess each veteran's adjustment to vision loss, his or her need for blind rehabilitation, and his or her need for

adaptive equipment. We also review the veteran's eligibility for VA compensation, pension, and other benefits. Based on the findings of the VIST review, referrals are made to VA Blind Rehabilitation programs, local blind rehabilitation training with the BROS, low vision services, veterans benefits, prosthetics and sensory aids, medical sub-specialties and other local and state benefits and services as indicated.

I serve as the point of contact for the blinded veteran within the medical center. I assist the veteran and their families in the establishment of primary care, coordination of appointments, prosthetic requests, pharmacy concerns, eligibility questions, VA benefits, travel consults and other requests for services.

I run two support groups for blinded veterans to help them and their families adjust to their vision loss. These groups meet monthly at the Gainesville VAMC and at the Florida Center for the Blind in Ocala. We have a variety of speaker's present information on topics ranging from the causes of vision loss to veteran benefits. We sponsor activities that allow the veterans in the area to reintegrate themselves into activities, which they may have given up due to their vision loss. These have included an annual bowling activity, support group luncheons, and a deep-sea fishing trip.

As the subject matter expert on blindness within the medical center, I conduct ongoing in-service training to eye care professionals, nursing staff, and other medical center personnel. I also meet regularly with state and local agencies for the blind, as well as fraternal organizations such as the Lions Club to inform them of VA services for the blind. I also provide ongoing consultation for the part-time VIST Coordinators at the Tallahassee and Daytona Beach Outpatient Clinics.

In an effort to reach out to the community, we have sponsored an annual Vision Awareness Day Open House. We invite agencies, veteran service organizations, and private vendors that work with the blind to display their services and adaptive equipment. We work closely with the State Division of Blind Services, WUFT Radio Reading Service, and the Bureau of Braille and Talking Book Services to invite both the legally blind veterans and other visually impaired individuals from throughout North Florida and South Georgia to attend. The open house is also available to all VA employees and allows them an opportunity to learn more about visual impairment and

the services that are available to assist the blind in leading a more productive and independent life.

We are working with an aging veteran population. There is a positive correlation between the incidence of blindness and age. Sixty-nine percent of our legally blind veterans are over the age of 75. This shift in demographics has required our VIST program to identify alternative methods of providing blind rehabilitation services for our blind veterans. We currently have one Blind Rehabilitation Outpatient Specialist who is providing training for those veterans who are unable to participate in one of the VA residential blind rehabilitation programs. She also works with those veterans who are returning from VA Blind Rehabilitation to help them reintegrate those newly acquired skills into their home setting.

The North Florida/South Georgia Veterans Health System recently funded a new full time VIST Coordinator position at the Lake City Division to meet the needs of the veterans in northern Florida and southern Georgia. This has allowed these blind veterans to receive services closer to their home instead of traveling to Gainesville for VIST services.

The VIST program at the Gainesville VAMC is working to implement enhanced services that will improve patient safety. We are working with Pharmacy and Prosthetics to implement Script Talk, which will allow a blind veteran to independently identify their medications. We are also implementing a means to provide computer access training with local agencies for the blind and other vendors in an effort to shorten the lengthy wait list for these services at the regional VA Blind Rehabilitation Centers.

Mr. Chairman and Members of the Committee, I have tried to give a few examples of the spectrum of blind rehabilitation services we provide at the Gainesville VAMC. I will be happy to answer any of your questions. Thank you.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

United States Government Accountability Office
Washington, DC 20548

August 25, 2004

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Evans:

This letter responds to your July 28, 2004, request that we provide answers to questions relating to our testimony at the committee's July 22, 2004, hearing on needed reforms in the Department of Veterans Affairs (VA) blind rehabilitation services. At that hearing we released our report on the accuracy of VA's reported wait times for blind rehabilitation services and discussed the need for VA to expand outpatient rehabilitation services.[1] Your questions, along with our responses, follow.

1. *Did your work consider how VA blind programs need to evolve to meet the needs of service members that will need services after the current deployments? Would you change any of your findings or recommendations to address this population?*

   We did not specifically address the issue of how VA's blind rehabilitation programs will need to evolve to meet the needs of service members who lost vision as a result of recent military action. As of August 17, 2004, eleven soldiers have obtained blind rehabilitation services for injuries received during Operation Iraqi Freedom and Operation Enduring Freedom. Our work, and resulting recommendation, pointed out and supported the need for VA to maintain a broad range of inpatient and outpatient blind rehabilitation services. A full continuum of services should address the needs of both traumatically blinded veterans as well as those of older veterans whose visual impairments are due to age related diseases.

[1] GAO, *VA Health Care: VA Needs to Improve Accuracy of Reported Wait Times for Blind Rehabilitation Services*, GAO-04-949 (Washington, D.C.: July 22, 2004) and GAO, *VA Health Care: More Outpatient Rehabilitation Services for Blind Veterans Could Better Meet Their Needs*, GAO-04-996T (Washington, D.C.: July 22, 2004).

2. *You have recommended that VA establish "a uniform standard of care policy that ensures that a broad range of inpatient and outpatient blind rehabilitation services are more widely available to legally blind veterans." Help us understand what such a policy might entail. Access standards? Ratios of legally blind veterans to programs?*

   VA has drafted a uniform standard of care for visually impaired veterans intended to provide a full range of low vision and blind rehabilitation services from alternative shorter-term models of outpatient service delivery to comprehensive inpatient rehabilitation training but this policy has not been finalized. Although the proposed policy does not identify specific access standards or a ratio of providers to veterans, it includes a provision for VA to develop access measures. VA plans to complete an analysis comparing currently available blind rehabilitation services with anticipated needs during the first quarter of fiscal year 2005 and then submit the proposed policy for approval by their Health Systems Committee.

3. *Dr. Kussman will describe some changes being discussed to revise the Veterans Equitable Resource Allocation methodology for blind services. Are you familiar with these changes and if so will they be adequate to address the concerns your statement raises?*

   VA's revision to the Veterans Equitable Resource Allocation methodology as it relates to outpatient blind rehabilitation services is in draft and subject to change. For this reason VA has not provided it to us for detailed review and therefore, we cannot comment on whether it addresses the funding concerns raised in the statement.

In responding to these questions, we relied on our recent evaluations of the services VA offers through its blind rehabilitation program. We conducted our work in accordance with generally accepted government auditing standards during July and August 2004.

Should you or your staff have any questions on matters discussed in this letter, please contact me at (202) 512-7101 or Michael T. Blair, Jr., at (404) 679-1944.

Sincerely yours,

Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues

Questions for the Record
From the Honorable Lane Evans
Ranking Democratic Member
House Committee on Veterans Affairs
July 22, 2004

Hearing on Blind Rehabilitation

Question 1: I am told that there may be significant problems in hiring prosthetists, blind rehabilitation outpatient specialists, and others with specialized training that offer important services to veterans in need of rehabilitation because there are shortages in the numbers of individuals who have or are seeking specialized training to meet these growing demands. Does VA believe this is the case? If so, are there ways in which VA could enhance the recruitment and retention of individuals into these professions?

Response: Recruitment of qualified Prosthetists is challenging for most VA Prosthetic/Orthotic Laboratories. There are only 8 schools that are accredited to offer degrees or certificates in prosthetics. Each of these schools graduate 10 to 15 students per year. VA must compete with over 400 private laboratories for these graduates. In the past, the cumbersome title 5 hiring process put VA at a serious competitive disadvantage. However, Public Law 108-170 converted VA Prosthetists to hybrid title 38 status, which should make VA more competitive. In addition, VA is working to establish prosthetics residency programs at each of the 5 laboratories that are certified by the National Commission on Orthotic and Prosthetic Education. It is hoped that these programs will improve VA's ability to recruit new graduates.

VA hires most Blind Rehabilitation Specialists and Blind Rehabilitation Outpatient Specialists at the Masters Degree level. There are five specialized areas within the Veterans Health Administration (VHA) for Blind Rehabilitation Specialists. The first three listed below (designated by *) require either a Masters degree or a Bachelors degree in a related area (i.e. rehabilitation teaching) plus completion of a certification program in the specialty area. Currently, Manual Skills Specialist and Computer Training Specialists are trained by VHA and have a degree and/or specialty certification in one of the three blind rehabilitation specialty areas. In the past, Manual Skills Specialists were educated as Manual Arts Teachers or Occupational Therapists, but that trend has changed in recent years in VHA to use cross-trained blind rehabilitation specialists. VHA generally hires at the GS-9 entry level with full performance at the GS-11.

Orientation and Mobility Specialist - certification program *
Rehabilitation Teacher -certification program *
Low Vision Therapist - certification program *
Manual Skills Specialist
Computer Training Specialist

Recruitment challenges for blind rehabilitation outpatient specialists stem from the fact that few universities teach blind rehabilitation for adults.

VHA has established educational assistance programs, such as the Employee Incentive Scholarship Program, that can be utilized to assist employees in obtaining education required to qualify for health care positions for which recruitment and retention is difficult, including Prosthetists and Blind Rehabilitation Specialists. Facilities can also use the Education Debt Reduction Program as a recruitment tool for title 38 and hybrid title 38 occupations, which currently includes Prosthetists.

Question 2: You describe a "gap analysis" that is now being undertaken for VA's blind and low vision programs that will describe the differences between veterans' need for these programs and the programs' availability. This May, the Secretary approved a major realignment planning exercise, which made some recommendations for additional blind services such as adding 2 more blind rehabilitation centers and some additional blind rehabilitation outpatient services. Did CARES not adequately address the needs for blind and low vision rehabilitation? Did it consider the evolving needs of specialized services for veterans in the current deployments? How did it address amputee care and is there also a need for a gap analysis for these programs?

Response: Phase II of CARES addressed the gaps in workload capacity for veterans needing Blind Rehabilitation Centers (BRCs) by planning to open two new BRCs in Biloxi, MS (VISN 16) and Long Beach, CA (VISN 22). This proposed expansion continues VA's current emphasis on placing blind rehabilitation services closer to populations in outpatient settings. Continuation of planning to improve access to low vision programs will be a part of VHA's FY 2005 Strategic Planning Process.

The CARES Phase II process primarily aligns workload projections with capital asset planning and it was a very important first step. The current planning model was utilized to plan for the years 2012 and 2022. Each year VHA will be updating the enrollment-workload demand model that was used in the CARES process. These new projections will be utilized in our program capacity and capital-planning rolling. While future workload impact from the most recent CARES planning decisions did not specifically address the impact of current war service needs, this will begin to influence future projections as the veterans begin to utilize VHA services and the model is updated yearly.

Specific diagnoses of current users were a part of the CARES workload demand modeling as the disease and illness burden of the users impact the array and demand for services. While amputee care was not specifically profiled, the modeling did take into consideration a projection of workload based upon this condition as well as other health burdens that increase the risk of amputations.

We do not believe there is a need for a gap analysis on amputee care since extensive initiatives are underway for improving amputee care and enhancing amputee rehabilitation and research. A multidisciplinary team has been formed within VHA to insure that consistent high-quality care is provided to amputees and that care is patient-centered and expertly coordinated. The duties of the team include:

- coordinating all amputation care and amputation prevention activities,
- reducing the duplication of services,
- ensuring the effective use of resources,
- disseminating information,
- increasing interdisciplinary communication,
- integrating clinical service needs with research and development
- sharing lessons learned,
- supporting the goals of the Seamless Transition Task Force, and
- ensuring that all VHA medical facilities are in compliance with national policy.

Question 3: What does VA's blind program need to do to evolve to serve the acute needs of the younger veteran with traumatic injuries?

Response: VHA has agreed with the GAO findings on VA's blind rehabilitation services that a uniform standard of care policy be developed that provides for a broad range of inpatient and outpatient blind rehabilitation services that would be more widely available to legally blinded veterans. In accepting the recommendation, VHA believes that a continuum of care plan will augment the services already in place for legally blind veterans and will also meet the needs of the younger veteran population. Each VISN will work with its Medical Center Directors to develop and implement an approved plan for the provision of vision rehabilitation care to visually impaired veterans across the continuum (from 20/70 to total blindness). VHA will provide the full range of low vision and blind rehabilitation services from basic low vision care through inpatient blind rehabilitation centers (BRC). Services can be provided through a combination of "in-house" services, VISN sharing, and contracts with community services. Inpatient blind rehabilitation will be provided through sharing with other VISNs. All visually impaired veterans, including those with chronic diseases or traumatic injuries, will have access to appropriate vision rehabilitation services.

Question 4: How has the lack of shared electronic medical records impeded progress in VA and DOD's quest to provide a seamless transition for veterans between agencies?

Response: VA and DoD both agree that care will be improved through data shared electronically. We believe that data shared electronically has the potential to improve the care coordination between VA and DoD and enhance programs established under the seamless transition initiative. Our response,

therefore, will briefly focus on both electronic medical record sharing and seamless transition initiatives.

VA is working closely with DoD to develop interoperable electronic medical record systems to support bidirectional data exchange. VA and DoD have successfully completed Phase I of the plan to achieve interoperability. The plan is called the VA/DoD Joint Electronic Health Records Plan – HealthePeople (Federal).

Between May 2002 and March 2004, VA and DoD successfully developed and implemented Phase I, the Federal Health Information Exchange (FHIE). FHIE now supports the transfer of electronic health data from the DoD to VA at the point of a service members' separation. FHIE permits VA clinicians and VBA disability claims adjudicators to have access to pre-separation health data on separated or retired service members seeking care. These data include outpatient laboratory results, retail and government pharmacy data, radiology results, consult reports, allergy information, admission disposition and transfer, discharge summaries, outpatient coding data from the Standard Ambulatory Data Record, and patient demographics.

VA and DoD will soon supplement the one-way flow of electronic health data through FHIE from DoD with the development of the Bi-directional Health Information Exchange (BHIE). By October 2004, BHIE will provide a real-time bi-directional exchange of select health data elements between VA and DoD sharing sites where shared patients present for care. Also under development, is a technical solution to transfer military electronic pre and post deployment health assessments from DoD to VA systems.

The Departments are now developing Phase II of the VA/DoD Joint Electronic Health Records Plan - HealthePeople (Federal). It includes collaboration on development of interoperable data repositories. Work on a pharmacy prototype was completed in October 2004. The pharmacy prototype will demonstrate the real-time bi-directional exchange of computable pharmacy information between next-generation systems, the Clinical Data Repository of CHCS II and the Health Data Repository of HealtheVet-VistA. The next phase of this project, known as "CHDR", will provide interoperability between the data repositories by October 2005.

We also wish to note that an important element of interoperability concerns the security and privacy of shared data. VA and DoD are, therefore, engineering systems to incorporate appropriate security and privacy controls.

Although the development of interoperable electronic health records is proceeding, VA has implemented a number of initiatives that currently support seamless transition, and especially focus on recent combat veterans from Operation Iraqi Freedom and Operation Enduring Freedom.

- VA works closely with DoD to maintain a current list of military personnel who recently served in theaters of combat in Afghanistan and Iraq and subsequently separated from active duty.

- The Seamless Transition Taskforce has developed training materials for staff including a script and video for front-line staff to ensure that they can reliably identify veterans who have served in a theater of combat operations and take the steps necessary to ensure they receive appropriate care.

- VA has assigned social workers and benefits counselors to the major Military Treatment Facilities (MTFs), including Walter Reed Army Medical Center (WRAMC) and the National Naval Medical Center in Bethesda, to assist the treatment team with discharge planning activities, orientation to VA, transfer of care to VA medical facilities, and the filing of disability claims with VA. A Seamless Transition Point of Contact (POC) is assigned at each VA regional office and VA medical center. These POCs in the field collaborate with each other to ensure that returning service members receive the full range of benefits and health care to which they are entitled.

- A Memorandum of Understanding is presently under development to standardize VHA and VBA information transfer processes to sustain our progress.

- VA is actively working with DoD to develop a comprehensive separation physical examination protocol for service members who plan to file a VA disability claim that will both document a veteran's health status at the time of separation from military service and meet the requirements for disability applications for benefits.

Question 5: How many of the 10 blind rehabilitation centers have Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation? Is this important?

Response: All ten blind centers have received three-year CARF accreditation. CARF accreditation promotes quality, value, and optimal outcomes of services through a consultative accreditation process that centers on enhancing the lives of the persons served. CARF accreditation is important.

CARF's purposes are to (1) develop and maintain current, field-driven standards that improve the value and responsiveness of the programs and services delivered to people in need of rehabilitation and other life enhancement services; (2) seek input and be responsive to persons served and other stakeholders; (3) provide information and education to persons served and other stakeholders on

the value of accreditation; (4) recognize organizations that achieve accreditation through a consultative peer-review process and demonstrate their commitment to the continuous improvement of their programs and services with a focus on the needs and outcomes of the persons served; (5) conduct accreditation research emphasizing outcomes measurement and management and provide information on common program strengths and areas for improvement; and (6) provide consultation, education, training, and publications that support organizations in achieving and maintaining accreditation of their programs and services.

Question 6: VA and DOD appear to be engaged in some very exciting research and development ventures. Some private sector manufacturers also have expertise that may not be profitable enough to market because of the small numbers of individuals who need them. Nonetheless, these products may benefit VA patients and others. Is there a role for VA to fund outside grants? How should VA tap the expertise in private sector to develop these "orphan" products?

Response: VA Research and Development is an intramural research program and cannot provide grants to private sector manufacturers. However, VA can collaborate with private sector manufacturers to develop products or conduct research that may benefit the veteran population. VA participation typically focuses on clinical trials. In addition, VA investigators may conduct research on behalf of manufacturers at the latter's expense. In all cases, VA has agreements in place that safeguard its intellectual property.

Question 7: Senator Graham has introduced legislation to authorize a Blast Injury Research Education and Clinical Center. Has VA developed views of this legislation? How would it be different than National Center for Rehabilitation being developed by VA and DOD? You have also testified that VA is in the final stages of approving criteria for centers of excellence in rehabilitative research. What will be the mission of these centers?

Response:

A. On September 15, 2004, VA transmitted to Congress a views letter on Senator Graham's legislation, S. 2524. A copy of that letter is attached.

B. VA has not proposed development of a VA/DoD National Center for Rehabilitation. VA has discussed several VA models for rehabilitation (including Blind Rehabilitation programs, PTSD programs, the Amputation Care Centers of Excellence in Rehabilitation Research, etc). Each of these VA rehabilitative components could supplement DoD acute and post acute care to support the rehabilitative needs of blast injury patients.

C. Within the concept of the Amputation Care Centers of Excellence in Rehabilitation Research, VA is exploring the establishment of one or more

Centers of Excellence in Prosthetic Research and Rehabilitation. The overall goal has been to identify several potential sites representing clinical and research expertise in the area of prosthetic care for individuals with amputations. The mission of the Center(s) is to improve amputation care and to assure the consistent provision of state-of-the-art services across all medical facilities in VHA. The Center(s) would incorporate all aspects of clinical care, state-of-the-art prosthetics and orthotics services, evaluate new technologies, measure functional outcomes, increase research and development, and provide education and training.

Sites are being identified and evaluated. Our evaluation is taking into consideration a potential site's (1) focus on areas of research identified as clinically important (upper extremity prostheses, lower extremity prostheses, platform technology, implementation and outcomes, prescriptive guidelines, and rehabilitation); (2) ability to provide appropriate clinical expertise and resources to provide excellent amputation care; and (3) possession of the potential to develop this expertise and acquire necessary resources or to be able to align with geographically distant sites that have the required expertise and resources. Geographical distribution is also a factor in the event the decision is made to establish more than one center.

Question 8: What types of expertise will the National Center draw from? Will retired service members/veterans remain eligible for service?

Response: As mentioned above in 7B, VA has not proposed development of a VA/DoD National Center for Rehabilitation. VA has discussed several VA models for rehabilitation (including Blind Rehabilitation programs, PTSD programs, the Amputation Care Centers of Excellence in Rehabilitation Research, etc). Each of these VA rehabilitative components could supplement DoD acute and post acute care to support the rehabilitative needs of blast injury patients.

Question 9: VA has established a number of work groups to identify prosthetics and other medical devices that it should purchase for veterans—is this methodology flexible enough to tailor to individual veteran's needs?

Response: Yes. Prosthetics and Sensory Aids Services Clinical Practice Recommendations (CPRs) serve a very valuable function to assure continuity of care throughout the Veterans Health Administration. The CPRs give guidance that did not previously exist to various clinic teams. This guidance is not restrictive and is written in general terms that provides flexibility and options for veterans with varying disabilities.

Question 10: Are VA procurement task forces evolving to include input from younger veterans and those who understand the compound needs of veterans with blast injuries?

Response: It is VA's policy to be able to provide the medical equipment and supplies that meet the changing and differing needs of our patients. VA is able to provide new and emerging technology as it becomes available. Any products available in the marketplace are available to veterans. For example, as new technology in the area of amputee care is rolled out, VA amputee clinic teams can prescribe the new limbs. We provide the technology through a system of over 500 private contractors who are part of the Amputee Clinic Teams at VA medical facilities. As a veteran progresses through life, we refit, repair, adjust, and replace the equipment provided, to meet the veteran's changing needs. VA is fully prepared to provide the high-tech prosthetic limbs that are now being provided by the Army to the amputees returning from Iraq. VA and WRAMC have been working together since the beginning of Operation Iraqi Freedom to ensure that service members and veterans receive whatever is necessary.

In some cases, an amputee may receive a product not available in the general market. The Department of the Army receives some of the new technology directly from the manufacturers' laboratories. In cases where the amputee is fitted with a limb that is not yet available to the general market, VA will pay the amputee's travel costs to enable the amputee to return to WRAMC if he or she needs a repair or requests a new limb.

Question 11: How many VA prosthetic labs are certified? Is this important?

Response: Sixteen Prosthetic/Orthotic Laboratories have received accreditation from either the American Board for Certification or the Board for Certification. Accreditation by these two organizations constitutes the standards and measures by which the credentials and capabilities of VA Prosthetic/Orthotic Laboratories are readily identified. This accreditation is important, in that achieving these industry standards places these laboratories in a category that requires no additional VA agency standards and raises no adverse comparison to private industry Prosthetic/Orthotic Laboratories.

DEPARTMENT OF THE ARMY
WALTER REED ARMY MEDICAL CENTER
WALTER REED HEALTH CARE SYSTEM
WASHINGTON DC 20307-5001

REPLY TO
ATTENTION OF

March 1, 2005

Deputy Commander for Clinical Services

Lane Evans, Ranking Democratic Member
Democratic Staff Committee on Veterans' Affairs
ATTN: Ms. Debbie Smith
335 Cannon House Office Building
Washington, D. C. 20515

Dear Mr. Evans:

This is in response to your letter dated July 28, 2004 to Lieutenant Colonel (LTC) Paul Pasquina, Chief of Physical Medicine and Rehabilitation Services at Walter Reed Army Medical Center. We apologize for not responding to the questions you posed in your letter in a more timely fashion. LTC Pasquina provided the information below in response to the committee's questions.

The Department of Defense (DoD) and Veterans' Affairs (VA) are working closely together to help invigorate the scientific community in promoting research related to amputee care. In particular, we recognize that private industry is less likely to expend large amounts of resources in areas without significant financial gain. This is especially of concern in the area of prosthetic development where there may be a small market. Joint scientific and research conferences between the DoD and VA's Rehabilitation Research and Development (RRD) have helped to identify needs within amputee research and help ensure funding is available through existing federal research programs. Programs currently exist within the VA RRD, the U.S. Army Medical Research and Material Command through the Telemedicine and Advanced Technology Research Center (TATRC), as well as the Defense Advanced Research Projects Agency (DARPA). Broad agency announcements (BAA) have been released defining the research objectives of these available grants. Opportunities also exist within these organizations to develop Cooperative Research and Development Agreements (CRADA's) with manufactures and developers.

LTC Pasquina is not familiar with a joint venture between the VA and DoD to develop a National Center for Rehabilitation. His discussions with VA leadership have focused on the need for centers of excellence within the VA that are capable of delivering the highest quality of care for individuals who sustain multi-trauma especially those subject to blast injuries. The casualties that are returning from Operations Enduring and Iraqi Freedom are unique. The types of injuries they are sustaining, largely from improvised explosive devices (IED's) typically involve multisystem damage as well as extremity trauma. It is not uncommon for individuals to require rehabilitation from multiple fractures, soft tissue wounds, nerve injuries, loss of limb, head injury, and loss of vision and/or hearing simultaneously. Caring for these complicated patients requires expertise, which is difficult to find and needs to be developed. The VA and

DoD have developed and continue to conduct educational conferences regarding this subject matter for health care providers to include physicians, therapists, nurses, prosthetics, and rehabilitation personnel in order to help meet this need.

LTC Pasquina understands that Senator Graham's legislation to authorize Blast Injury Research Education and Clinical Centers is well on its way. As it was explained to him by Dr. Barbara Sigford, a leader within rehabilitation services for the VA, the current plan within the VA is to utilize those VA sites that have already received designation as centers of excellence for brain injury and convert them to "Blast Injury Centers". To help facilitate this transition, LTC Pasquina participated by giving a presentation at the "First Annual Blast Injury Conference" hosted by the James Haley VA Hospital, Defense and Veterans Brain Injury Center, and the University of South Florida in Tampa on 12 Dec 2004. It has since come to Dr. Pasquina's attention that the terminology within the legislation has since evolved to reflect the terms "multi-trauma" or "poly-trauma" centers instead of "blast centers". In response to this effort, LTC Pasquina recently had the privilege of serving on a DoD panel formed from Army and Navy medical staff at the VHA Polytrauma Lead Centers Conference held February 2-4, 2005 in Washington D.C. The purpose of this conference was to provide an educational opportunity for the four poly-trauma centers and referring military Medical Treatment Facilities (MTFs) to address existing, emerging and future issues impacting their mission.

In response to the question raised about advances in prosthetics, the military is currently gaining valuable experience by planning and conducting research with technological advances in prosthetics in order to evaluate the clinical value and impact on quality of life that these devices have. This information is being gathered in association with VA researchers and clinical staff in order to help better define the optimal devices to purchase for all veterans. Furthermore it is hopeful that this information will help to better define the needs of non-military beneficiaries with loss of limb in the civilian sector.

We appreciate the time you have taken to seek LTC Pasquina's unique insight into these issues. If you should have any additional questions please do not hesitate to contact LTC Pasquina at (202) 782-6369.

Sincerely,

Thomas M. Fitzpatrick
Colonel, Medical Corps
Deputy Commander for
Clinical Services

Hearing Date: July 22, 2004
Committee: HVAC
Member: Representative Lane Evans
Witness: LTC Paul Pasquina, MD
Question # 1

VA and DoD Research and Development Ventures

Question: VA and DOD appear to be engaged in some very exciting research and development ventures. Some private sector manufacturers also have expertise that may not be profitable enough to market because of the small numbers of individuals who need them. Nevertheless, these products may benefit VA patients and others. Describe the process by which DOD funds outside grants for private sector ventures and whether these processes might assist in bringing these "orphan" products to market.

Answer: The United Stated Army Medical Research and Materiel Command (USAMRMC) utilizes two primary mechanisms to obtain and fund proposals for medical research and development projects, those being specific solicitations and Broad Agency Announcements (BAA). A solicitation is issued when a specific requirement is known and can be defined in sufficient detail for prospective offerors. The solicitation includes a performance work statement to clearly define the Government's needs, the criteria by which proposals will be evaluated and proposal submission instructions. By contrast, a BAA is utilized as a vehicle to solicit research ideas under the provisions of the Competition in Contracting Act of 1984 (Public Law 98-369), as implemented in the Federal Acquisition Regulations (FAR). The BAA is a general announcement of an agency's areas of scientific interest, with a description of USAMRMC's research programs, including specific areas of interest; general information; the criteria utilized for evaluation and selection of proposals; and proposal preparation and submission instructions. Unlike other types of solicitations which have common cut-off dates, proposals may be submitted at any time under the BAA. Proposals under either mechanism are evaluated for scientific merit and programmatic/military relevance. Generally speaking, only those proposals that address a relevant military-related medical problem that can be solved by research and development studies are funded. Thus, any "orphan" projects would need to be relevant to a defined USAMRMC/Army/DOD need or to one of USAMRMC's areas of scientific interest in order to be considered for funding.

Hearing Date: July 22, 2004
Committee: HVAC
Member: Representative Lane Evans
Witness: LTC Paul Pasquina, MD
Question # 2

VA and DoD Research and Development Ventures

Question: Please describe the joint venture VA and DOD are undertaking to develop a National Center for Rehabilitation. What types of expertise will the National center draw from? What types of problems will it address? Will retired service members/veterans remain eligible for services?

Answer: With some investigation and coordination with key personnel in the Army Medical Department and Health Affairs' DoD/VA Program Coordination Office, the Army Medical Department (AMEDD) has no knowledge of a National Center for Rehabilitation Joint Venture beyond a simple concept verbalized by Dr. Michael J. Kussman, Acting Deputy Under Secretary for Health for the Veterans Health Administration of the Department of Veterans Affairs. The only documentation that can be found to reference a rehabilitation center is from the minutes of the 17 Jun 04, VA/DoD Health Executive Council meeting where there was a brief on The Defense and Veterans Brain Injury Center. During that brief, Dr. Kussman stated, "...there is a proposal to have a National Center that deals with all these issues, which will become one place were they can get everything they need." At present this reference to a national center is still only a concept.

Hearing Date: July 22, 2004
Committee: HVAC
Member: Representative Lane Evans
Witness: LTC Paul Pasquina, MD
Question # 3

VA and DoD Research and Development Ventures

Question: Senator Graham has introduced legislation to authorized a Blast Injury Research Education and Clinical Center. Are you aware of this legislation? How might the National Center now under development interact with this center?

Answer: Some individuals in the Army are aware of this legislation to authorize a Blast Injury Research Education and Clinical Center presumably in Florida. The focus appears to be an area of research that has not been well addressed: that of long-term findings of cognitive dysfunction in individuals who have suffered a blast injury event. While this Blast Injury Center may interact with the National Center discussed in your other questions, the emphasis on cognitive dysfunction is clearly a different focus, and because it has had little emphasis in the past, is worthy of some amount of study. The level of competition appears to be minimal as the emphasis is different.

Hearing Date: July 22, 2004
Committee: HVAC
Member: Representative Lane Evans
Witness: LTC Paul Pasquina, MD
Question # 4

VA and DoD Research and Development Ventures

Question: Is DOD now taking part in the work groups VA has established to identify prosthetics and other medical devices that it should purchase for veterans? What is the military's role on these work groups? How are they involved in the assessments of products and protocols VA's rehabilitation researchers are undertaking?

Answer: The Veterans Affairs Minneapolis Core Workgroup on Pre-Post Amputation Care consists of five subgroups, these are: Clinical Care Subgroup, Orthotic/Prosthetic Labs Subgroup, New Technology Subgroup, Outcomes Subgroup, and Research Subgroup. Since September 2003, individuals from the Walter Reed Amputee Patient Care Program have been active participants in each of these groups. While each group has a different focus area in amputee patient care, the military's role in participating in these groups is to ensure a coordinated, complementary effort is occurring between the VHA and DoD and that there is no redundancy of effort.

On November 17th and 18th, 2003, the Department of Veterans Affairs and Walter Reed Army Medical Center co-sponsored the "Amputee Healthcare & Prosthetics Workshop." This workshop focused the establishing the collaborative efforts of the VA and DoD in the provision of prosthetic devices and the research efforts to validate our combined prosthetic and rehabilitation efforts.

In May 2004, the VA held a Traumatic Amputation QUERI Workshop to familiarize WRAMC and VA researchers with the QUERI process. QUERI is a data-driven, outcomes-based, quality-improvement program. It uses a six-step process to promote the translation of research findings into better care for veterans. Special focus is placed on documenting best practices, developing strategies for implementation, and disseminating results and recommendations.

Walter Reed Staff, including Dr. Marin, Dr. Gamble, Dr. Pasquina, and Mr. Miller all participated in the Rehabilitation Research and Development Service Scientific Merit Review Board Meeting Aug 30-31, serving as panel members to evaluate and help score potential VA sponsored research projects across the U.S. Our involvement helped evaluate not only the scientific merit of these proposals, but also the clinical relevance to the field of prosthetic and amputee care.

Hearing Date: July 22, 2004
Committee: HVAC
Member: Representative Lane Evans
Witness: LTC Paul Pasquina, MD
Question # 4 (Con't)

VA and DoD Research and Development Ventures

Several VA researchers are currently collaborating with WRAMC staff on pertinent research projects related to prosthetic care. These studies include: Rigorous testing of commercially available above-the-knee prostheses using vacuum assisted socket system (VASS) to promote residual limb health and exploring the limits and developing appropriate rehabilitation programs for the microprocessor controlled knee (C-Leg®). In addition, WRAMC, DCVAMC, Catholic University (CU) and National Rehabilitation Hospital (NRH) began a collaborative project in May 2004 to incorporate the use of video games and advanced technology for strengthening of upper limb muscles prior to- and during the initial phases upper limb prosthetic training. There are several other collaborative research efforts currently being developed with the DoD, VA, and civilian institutions. The VA has detailed a PhD researcher to Walter Reed Army Medical Center to coordinate our efforts to maximize both VA and DoD benefits for our patients.

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