

## VA Federal Advisory Committee on Prosthetics and Special-Disabilities Programs

The VA Federal Advisory Committee on Prosthetics and Special Disabilities Programs met on April 11 and 12, 2006, at VA Central Office in Washington, DC. A quorum was present, affording the Committee the opportunity to conduct normal business.

### **Members Attending**

Thomas H. Miller, Chairman  
Capt. Daniel M. Gade  
Lee Ann C. Golper, Ph.D.  
Louis W. Irvin  
Robert D. Rondinelli, M.D., Ph.D.  
Jerry P. Steelman

Rory A. Cooper, Ph.D.  
Robert S. Gailey, Jr., Ph.D., P.T.  
Norman B. Hartnett  
Col. Paul Pasquina, M.D.  
Douglas G. Smith, M.D.  
Margaret G. Stineman, M.D.

### **Member Not Attending**

Joseph Miller, CPO, MHA

Margaret Stineman, M.D.

### **Guests**

Gary Coates, PVA (sitting in for Louis Irvin on April 11)

### **Minutes**

Mr. Miller called the meeting to order at 8:30 a.m. Mr. Miller welcomed members and reported that two new Committee members were appointed by the Secretary and two members rotated off the Committee. Dr. Paul Pasquina, Head of Amputation Care Program and Chief, Physical Medicine and Rehabilitation Service, at Walter Reed Army Medical Center and Captain Daniel Gade, a decorated veteran of the Iraqi conflict, and also active duty. Mr. Miller acknowledged the contributions of the former members who rotated off the Committee, Carl Nunziato and Dr. Richard Salcido.

Recommendations and VA's responses from the November 2005, meeting were received. The Committee appreciates VA's efforts in its timely response to last set of recommendations. Discussion of the November 2005 recommendations and VA responses will follow the presentations on Wednesday.

## **Office of Rehabilitation Services**

Dr. Beck is pleased to announce that the new Director Blind Rehabilitation Service starts on May 1. Stan Poel is joining the VACO staff from Central TX Blind Rehabilitation Service. He has had a long career in Blind Rehabilitation and was Chief in Waco for about 20 years. He will relocate to DC and we are delighted to have him.

## **Blind Rehabilitation Service**

Our Mission, Vision and Program are designed to address the needs of visually impaired and blind veterans, with goals of successful reintegration of these individuals into their environment. VA has plans for two (2) new Blind Rehabilitation Centers: Biloxi and Long Beach. Currently there are 92 full-time Visual Impairment Services (VIST) Team Coordinators, 26 Blind Rehabilitation Outpatient Specialists (BROS). VIST Coordinators ensure blinded veterans are identified, evaluate and provided health and rehabilitation services. The number of legally blind veterans on VIST rolls again rose from FY 2004 to FY 2005. The Blind Rehabilitation Service (BRS) is doing better with documenting, capturing more data. In FY 2005, BRS had almost 45,000 veterans on the rolls. There are two (2) VISOR outpatient programs at Lebanon and West Haven. These program use HOPTEL beds, and participants stay for 9 days independently which is not a hospital admission. Patients get advanced rehabilitation for eight (8) hours a day. It is a model program. BRS is proposing the expansion of this program. Blind Rehabilitation Outpatient Specialists (BROS) work in the patient's home or medical center. Around the Polytrauma initiative, VHA has added a BROSs to each Polytrauma Center as part of team. VHA is hiring a national position BROS who will be located in DC. The primary role of this position will be to go to Walter Reed Army Medical Center and Bethesda National Naval Medical Center to work with teams there and work with veterans who are legally blind or visually impaired. This position will be located at DCVAMC and provide coverage there as well. There is legislation pending on Capitol Hill which calls for 35 medical center BROS positions to be phased in over 30 months. It has appropriations with it.

There are five (5) National Consultants. This is an area that the new Director will be focusing on in the near future. BRS will be looking at best practices and work with National Consultants on consistency. There is one vacancy in Tucson.

Currently Bed capacity is 238 beds, 198 are for the comprehensive program and 40 are for computer access program (CAT). CAT is a separate program. Catchment areas have not changed. The number of applications for admission to a Blind Rehabilitation Center rose from FY 2004 (2245) to FY 2005 (2,612). The BRS National Program Office worked very hard to improve waiting times for admission to a Blind Rehabilitation Center. From FY 2003 to January FY 2006, the patient waiting list decreased from 2500 to slightly over 1000. Average waiting time for admission decreased from close to 30 weeks in FY 2002 down to

around 12 to 13 weeks now. Waiting time for admission to the CAT program is longer, about 20 weeks, but is improving. Outpatient CAT training is available and easier to provide.

In an effort to implement a full continuum of vision rehabilitation care, locations around the country are being identified where all these services should be considered. Health System Committee has endorsed the concept, but the main problem is funding. The resource allocation model (VERA) now recognizes the higher costs for caring for blinded veterans.

One major initiative implemented was Scriptalk, a talking prescription label. Prosthetics, Blind Rehabilitation, and Pharmacy Benefits worked together on this and it is available to all veterans.

All Centers have CARF accreditation and continue to get re-accredited.

OIF/OEF patients: Blind Rehabilitation is tracking 46 blind veterans now. Inpatient and outpatient services are being provided to 28 in Blind Centers, with four (4) pending BRC admissions. We are providing extensive group follow-up/outreach. Not all chose to receive training at a Blind Rehabilitation Center. A number of the patients are at Polytrauma Rehabilitation Centers. Blind Rehabilitation Specialists are working with the Polytrauma Rehabilitation Centers, and with staff at Walter Reed and Brook Army Medical Centers.

The Blind Rehabilitation National database was supposed to be out in September, but was delayed by testing and numerous IT problems. The system is being deployed at all VAMCs and all VIST Coordinators will use. The system is very user friendly, meets compliance requirements.

### **Update on Rehabilitation Services**

Polytrauma Rehabilitation Centers under Dr. Sigford's direction has four (4) Centers and teams are being hired and trained and almost finished. Phase II of the implementation is establishing one team in each VISN. VISN Sites were selected where best compliment of rehabilitation services existed. Each site has an outpatient team to case manage and coordinate care and consists of a Physiatrist, Social Work case manager, Nurse Manager, OT/PT/Speech/ TBI, mental health. Each sites has a CARF accreditation inpatient rehabilitation unit if needed. The goal is to provide coordinated care as close to home as possible.

Brooke Army Medical Center is the site for the Center for Intrepid with funding from the Fisher Foundation. The Center will have 65,000 square feet of state of the art rehabilitation equipment. The goal of the Center is to return the soldiers to a state of readiness to return to duty. The Center will include shooting, climbing, vocational rehabilitation, and every form of physical and occupational therapy available. VA and DoD are negotiating a Memorandum of Agreements.

VA will have education and research staff assigned to the Center, and VHA hopes to establish a Prosthetic resident as well and provide special training for Prosthetists. VA has already sent 10 teams to Brooke for advanced training.

Inspector General (IG) conducted a reviewing on swallowing/feeding disorders and reported on ways VA could improve care. VHA concurred with recommendations and is addressing the interdisciplinary role, provision of therapy, and monitor feeding. A directive is currently in concurrence to establish teams and ascribe responsibility to each member. Substantial education will be required.

The draft report from IG on case management of TBI patients just released to VHA. The report looks at patients discharged in FY 2004. VHA is waiting for the official recommendations. Rehabilitation is collaborating with Office of Care Coordination to develop a telehealth network in conjunction with the Polytrauma system of care. VHA is developing a dedicated Polytrauma V-Tel network to connect 21 network sites for handoff of patients and their families from each Polytrauma Rehabilitation Center. VA/DoD clinical practice guidelines for amputee care are in process. The group has met 3-4 times on lower level extremity guidelines.

Audiology and Speech Pathology Service had a successful meeting with VA Audiologists, which included a presentation on Polytrauma, and hearing loss which can be major outcome. Logarithmic growth in terms of technology of hearing aids. Bluetooth technology and direct access to technology will redefine treatment.

PM&R has an active group working on the Assistive Technology initiative.

### **Vocational Rehabilitation & Employment – Judy Caden**

Vocational Rehabilitation and Employment (VR&E) program changed to emphasize employment a couple years ago. The goal is to help veterans obtain and maintain adequate employment. If a veteran's disabilities are so severe, VR&E will help maintain daily living and keep employment as an option. VR&E's programs Includes four (4) year college, two (2) year college, or technical school. Program services help veterans achieve maximum level of independence in daily life. VR&E provides vocational counseling to other veterans and will provide counselors for children and spouses.

VR&E works daily one on one with the veteran to determine abilities, skills, needs while assisting with job search, resume development, and even dressing for success. VR&E coordinates work-study positions and on the job training positions. To qualify soldiers must be within six (6) months of separation from active duty. Veterans have a 12 year period of eligibility, have a Service Connected disability, and must have employment handicap. Veterans have 48

months of entitlement, but must be used within 12 years of disability notification of rating.

At the request of Secretary Principi, VR&E Commission Report in April 2004, reported on how to improve VR&E program. VR&E is now implementing a five (5) track employment model with an emphasis on informed choice by veteran.

- 1<sup>st</sup> track – re-employment – provides accommodation if disabled. Work with employer to make sure they know veteran has right to job, will pay for needed equipment.
- 2<sup>nd</sup> track– rapid access—how to look for job, build resume, interview, etc.
- 3<sup>rd</sup> track– self-employment usually for more severely disabled who need flexibility with hour, etc. Veteran goes through extensive training, develop business plan, and work in community to develop business.
- 4<sup>th</sup> track– Employment through long term services and going to school.
- 5<sup>th</sup> track– Individual Living Program

A veteran goes through group orientation and receives information in track selection. VR&E has set up job resource labs in each regional office. A new website VETSUCCESS.gov, posts job listings. If veteran needs re-training, VR&E will do vocational evaluation, pay for training, tuition, books, fees, supplies monthly subsistence (\$425/mo, varies with dependence if full time).

Independent living program provides computers to allow veterans to communicate with community and provides medical, dental, optical mental health treatment. To assist keeping veterans in the program, VR&E will get veterans to their appointments. Individual case management services help veterans formulate, work through and complete their plan with monthly follow up.

A typical veteran seems by VR&E has four (4) to ten (10) years of military service, an orthopedic injury, between 37– 41 years old, is a high school graduate with two or more dependents.

Outreach is important with DTAP, if soldier believes he/she has a disability the soldier goes to a DTAP presentation. The presentation is standardized, and provided to all regional offices.

The Coming Home To Work Program started with the Information Technology Committee. Many injured veterans have time on their hands. VA brings veterans to VA to get work experience. VR&E administers and soldiers at Walter Reed Army Medical Center, get non-paid work experience while still undergoing medical treatment. Thus far 18 direct hires have been made. The program is only in VA at this time, although FAA, DOL are interested.

VR&E reports that 2,734 maintained employment in FY 2005. Northeastern University has a great work study program, 10 weeks in work and 10 weeks in school. Many graduate programs work like that, especially in professional schools.

### **Annual Ethics Briefing – Susan Bond**

Ms. Bond briefed the Committee as part of the annual ethics requirements for Committee members.

### **Update on Prosthetics and Sensory Aids Service (PSAS) – Fred Downs**

Next Joint VPRO meeting will be going back to Denver so they can see the Denver Distribution Center to introduce them. We are anxious to experiment with items that can be provided on a recurring basis. Planning an interface with ROES.

Strategic Plan for PSAS is in draft with a mission, vision, strategy, initiatives. Initiatives include standardize via national contracts, and integrating financial systems with ordering systems.

We have collaborative efforts w/DoD: Intrepid Center at Brooke AMC. PSAS will provide Prosthetist-Orthotist and technician. VA will be an integral part. Jill Manske and Dr. Sigford working on. Fred to attend MASK program there. All P&O labs are accredited, and transfer of adaptive equipment from VBA to VHA administration. PSAS is working with telehealth and providing funding from VHA.

We want to pursue creation of Amputee centers of excellence. Proposal was presented to Congress. Working with the Wounded Warrior Project, John Lucent, of my staff is the Chair, and they are proposing seven (7) VA Centers to have full range of state of art equipment, with a Research and Development (R&D) element assigned to PSAS. Currently, PSAS works with R&D, but the Board believes would be more effective if R&D element was assigned to PSAS.

IBOT has been slow going. Drs. Hammond and Sigford are working on the IBOT. 16 VA regional centers have staff who are trained to use properly. PSAS is reviewing the Segue, which is considered a vehicle. It is good for high level amputees and for people who are able to walk, but have balance problems or long distance mobility problems. Segue's total weight is about 80 lbs., with a chargeable battery.

NPPD new totals for FY 2006, 1<sup>st</sup> quarter shows where dollars are spent. Congress has not touched the NSC issue. Some Priority 8s still show up and any who were already enrolled were grandfathered and allowed to stay. We can compare number of unique amputees served, new versus repair. Eventually the numbers will plateau as veterans age.

Currently VHA has 116 Prosthetists/Orthotists, out of 185 who have become certified.

### **PACT Program Update – Dr. Jeff Robbins**

Preservation Amputation Care and Treatment (PACT) program provides the highest level of amputee care. The program was designed to meet the needs at that time mainly diabetes and neuropathy. With the war on terror, we now are seeing traumatic amputees. New Directive which is in concurrence identifies at-risk populations. VHA is tracking patients from date of entry to discharge. In 2001 VHA called for improved measures to identify patients. VHA developed a high risk registry and required VAMCs to do.

High Risk Amputee registry, helps VISNs identify patients and identify gaps. Patients are screened and a risk score assigned. Using IDC-9 and CPT codes we are able to extrapolated conditions that are most likely to be at risk. Diabetes is considered at-risk. One important benchmark is making sure the patients are seen in primary care every 12 months. The next project is an ulcer registry.

OIF/OEF veterans require additional services, such as mental health consults. VHA has a directive that each patient should be offered mental health visit. With the traumatic amputation heterotrophic ossification is unique to these patients and creates additional challenges for a proper prosthetic fit.

### **Update on Seamless Transition – John Brown**

For the first time VA has integrated VA, DoD, VBA, VHA into one office. The Seamless Transition Office has four (4) different areas, interagency collaboration, clinical and case management with both VHA and VBA, outreach, and benefits.

VA has benefit counselors imbedded into eight (8) of our DoD treatment facilities. Individual enters DoD facility and appears before MEB. If they are going to be retained, they go through PEB. If they go through separation and elect to use VA care they'll be seamlessly transferred. There is Point of Contact at each facility and each Regional office, and patients will be case managed on VHA side of house.

Outreach is a big initiative for the office, and VA conducted over 7,000 briefings to service personnel in FY 2005. We also work with family members. For guard and reserve units, an MOU allows us to be there at guard weekends, etc.

Seamless Transition developed a toolkit used to train State veterans advisors to assist with briefings to all national guards units and how they can to interface with VA.

DoD is doing pre and post health assessments to identify any problems which might appear later. Currently there is a pilot study and 53% of those studied are referred for some type of healthcare.

**Briefing from Office of Rehabilitation Research & Development (RR&D) – Dr. Ruff**

RR&D Research is one of 4 components of the Office of Research and Development. More than half of money goes to research awards, i.e., Centers Of Excellence. Less than one quarter to development., and 11% for Prosthetics and Orthotics.

Over 96% of veterans have chronic diseases. Diabetes is higher in VA patients, and obesity is a problem with VA patients, as is chronic pain. The obesity initiative had over 80 proposals for non-invasive modalities for reducing weights. The target groups were SCI and impaired mobility patients. Chronic pain is a major problem among disabilities and increases with age. Sixty (60) research applications are looking at increasing role of rehab and altering lifestyle. A vocational rehabilitation pilot project is looking at program that might be expanded on larger scale across VA system. Less than 10% of SCI patients return to work, but the likelihood is four (4) times higher if they do so in first year.

OIF/OEF battle injury due to blasts exceed those due to projectiles. Medicine has improved since Civil War, now if person is alive when they leave the battlefield, there is a 98% chance they will reach stateside alive. VA is devoting major resources to neurotrauma, cervical spine injury, burns, amputation, TBI. People are surviving with over 80% total body burns. VA partnered with Walter Reed AMC and Brooke AMC. A current research initiative looks at sockets, interface between prosthesis and limbs which needs to fit comfortably.

RR&D developed a QUERI (Quality Enhancement Research Initiative) project in conjunction with the Polytrauma centers which looks at how care is being delivered. SCI, stroke, mental health, congestive heart failure currently have research projects.

RR&D meet with staff at DoD, WRAMC and Brooke to discuss areas of research that DoD considers important. A number of R&D staff are involved in post-deployment issues. In Texas VA is fostering an interaction between University of Texas, VA, and Brooke to improve interactions. Researchers are looking at mild TBI injury, which might not have visible skull injury, but is associated with alterations in mood, behavior, PTSD, etc, where early and aggressive treatment and rehabilitation may play a significant role. Many returning military today want to return to military or productive life, and our role is to enhance delivery of rehabilitation and enable this.

## **Spinal Cord Injury and Disorders Service (SCI&D) – Dr. Margaret Hammond**

For FY 2005, utilization data, clinical care, etc, SCI served over 25,000 vets with SCI&D. The program has increase 46% since FY 1996, the first year of reporting capacity. From FY 2004 to FY 2005 VHA has seen a 3% increase. Currently there are 23 SCI centers, four (4) devoted to long term. Preventive care, hospice care and specialized care and primary care are concurrent.

Waiting time is less than 22 days waiting time for new, and less than 7 for established patients. SCI&D has an average daily census of 775 which drops on the weekends. Every center with acute care is CARF accredited. Our length of stay is longer for newly injured people. VHA is efficient, but also gives good care and longer stays as needed.

Current clinical issues are:

- Pressure ulcers - high incidence after SCI, JCAHO has heightened interest and is looking at hospital screening. We have variability in care, initial treatment, post-op management and use of protocols.
- Obesity—60% of SCI are overweight—lean muscle tissue means we need to establish easy bedside tools to recognize.
- Diabetes—at least 20% prevalence and people get it younger, associated problems of hypertension and hyperlipidemia, which is now being recognized as patients live longer.

Quality and Performance Measures capture attention of managers throughout system. Areas VHA uses are tobacco measure, flu vaccine, pneumonia vaccine, diabetes, with a number of measures re: retinal examines, lipid control. All measures exceeded their targets for SCI patients. Discharge to community living measure continues to be at 97%, which is very good nationally. Some centers have dropped a point or two, and we will follow to see if a trend develops.

SCI&D is currently working on an Outcomes Project, which is a three (3) year project, which is re-hosting of infrastructure, to analyze and measure data. Anticipate roll-out next year.

My HealtheVet has enormous potential for patient self management and allows veteran access to his/her own medical record, dialogues between patients and providers over e-mail, patient education, electronic logs for tracking, providers can bring it up on screen and discuss, and other logs for tracking blood press, etc. The system can be used for refills of prescriptions. This is the beginning of seeing profound patient self-management.

VHA is issuing a directive on how to get the iBOT into Centers. SMARTWHEEL measures upper extremity mechanics, a device in use in Seattle and we are working on program evaluation piece and goal to get one in each center. Weight-supported ambulation, for individuals with incomplete SC, research trials are evaluating. Vocational Improvement Project is a research project designed

to evaluate the need to pay attention to vocation as an important outcome. The project looks at best means of assistance to return to work. Lifestyle, exercise, and MOVE project look at what can be done from initial injury and incorporate exercises, nutrition counseling and diet.

Programs continue to be CARF accredited. Finalizing policy on long term care. Between FY 2004-05 there was a slight reduction in VA NHCU patients, from 936 to 904. But there was an increase in those in community nursing homes. Patients want to be close to social support system.

Planning initiatives include telehealth dialogues scripts of what could communicate by phone, upgrading criteria for new design/construction for long term care SCI units, medical foster homes. Tampa model has taken 7 people and placed them in family settings. Patients love it as it gets them in community, but not in institutional setting. There as to be a cooperative effort between VA and individuals who want to develop these homes. VA screens, helps develop knowledge of care giver. Patients pay for care, but we support the care.

Education initiatives include a national training program for SCI primary care team, long term care national broadcasts, pressure ulcer management collaborative effort to bring staff in from centers to look at management and outcomes. Veteran Health Initiative was distributed to 16,000 and on web. This is the second issue to be produced.

Training initiatives included SCI advanced Residency program. Durable education products included producing DVDs, videos and distributing to Centers.

Access to care is the this main geographic problem. The system has some holes without centers. VHA will start new Centers in Denver, Syracuse, Minneapolis, The new Center in Jackson is hampered with Katrina rebuilding, but has no design proposal yet. Long Term Care replacement facility is needed in Milwaukee and Bronx.

SCI QUERI HSR&D program is looking at issues over spectrum, sleep apnea, COPD, tobacco reduction, pressure ulcers, and obesity co-morbidities. We are looking at patient readiness, chronic pain, depression, abbreviated treatment. As a result of Katrina, VHA is dealing with its emergency preparedness which includes a vulnerable patients list and lessons learned from Katrina.

Trends for the future included individual management of healthcare as we develop patients to become own activist and owner of medical record. VHA is planning more home LTC and caregiver support will get more attention.

**Beneficiary Travel Update – Tony Gualiaro**

Office of Business Policy, in the VHA Business Office develops policy based on eligibility, revenue enhancement, and is responsible for beneficiary travel. Beneficiary Travel authority is in statute and is further regulated under VA statute. Veterans are eligible for travel, when 30% SC for any condition, or 0, 10, 20% SC are eligible for their disorder. VA travel also recognizes those in receipt of Aid and Attendance, and who unable to defray cost of such travel. In these circumstance a veteran can request travel, and VA can approve. Travel can be paid for non-veterans if needed to provide for attendants, donors, etc. The reimburse mileage rate is 11 cents/mile, and has not changed since 1988. Donors are unique because sometimes they do not always come from same area as veteran.

VA reviews mileage rates every year. If rate is raised, it comes out of medical care appropriation. Funds come directly from VAMCs. A&A determination is not a centralized process. Data is station specific. Currently rewriting travel regulations, which were last updated in 1990.

Additional information, VHA is working on proposal to address catastrophic disabilities, and also looking at SCI/cochlear-implants. It is under discussion with General Counsel which has decided that with transplants VA will provide that care regardless of SC. In SCI catastrophic disability designation is needed by clinician would determine a veteran's needs. The veterans becomes Priority 4. A&A also covers veterans who can migrate to Priority 8 if determined catastrophic. To effect change legislative proposal has been offered and would impact \$50 million/yr. Regulation is required to change the amount/mile.

#### Project HERO

Mr. Mark Loper, the new Chief Business Officer, is looking at when VA cannot provide services in house or at another VA facility. When VHA buys that care, we are trying to understand what we are buying and making sure the service provided meets VHA standards. Last year VHA spent \$2 billion on this care. Committee hearings on have occurred in 4 VISNs, (VISN 8, 21, 20, 23).

#### **Committee Comments**

The Committee strongly supports the reappointment of Lucille Beck, Ph. D., as Chief Consultant, Rehabilitation Services, Patient Care Services, and the Director of Audiology and Speech Pathology Service. Dr. Beck is an outstanding leader who demonstrates unique talent and compassion for those with disabilities. Her commitment to returning veterans to the highest level of functioning is unparalleled. Her incredible leadership has been most clearly demonstrated by her tireless efforts to fully implement the Polytrauma Treatment Centers and the significant improvements in the delivery of comprehensive vision rehabilitation services. In addition the Committee was impressed with the fact that Dr. Beck lead an effort which saved VA over \$10 million in hearing aid costs

for FY 2005. The Committee unanimously and enthusiastically endorses her reappointment.

**Committee Recommendations:**

**1. Research protected time for VA practicing physicians and other clinician scientists:**

The Committee remains concerned that there may be VA rehabilitation clinician scientists with funding from VA-ORD or other federal sources that do not have protected time in order to complete their research protocols. The Committee recommends that the VA-ORD survey funded investigators to identify issues related to having adequate time to conduct funded research. The survey should help to identify appropriate measures of distribution of effort between research, clinical, and educational time and metrics of quality and productivity. The Committee would also like to have a report on the variability and equitable distribution of VERA funded research protected time.

**2. Beneficiary travel:** The Committee strongly recommends that veterans in the special disability populations (e.g., spinal cord injury and dysfunction, limb-loss, vision loss, hearing loss, traumatic brain injury) would be covered by beneficiary travel. The Committee is concerned that the increased use of regional centers for the provision of medical care is creating barriers for veterans to receiving specialty care. With prosthetic device services (e.g., IBOT, Myoelectric Prosthesis, Computerized Prosthetic Components) transitioning to regional expertise for new and complex technologies, disconnects could result between the eligibility for services and access to beneficiary travel to receive these services. Regulatory or legislative changes are needed to improve access to specialty care through beneficiary travel. The Committee urges that careful consideration be given to ensure adequate access to specialty care for Category 1 through 4 veterans. The Committee also recommends better tracking the requests and needs of veterans for beneficiary travel.

**3. Amputation Care:** The Committee recommends that the VHA undertake an examination of the system for the provision of comprehensive care for veterans with major limb loss, especially traumatic limb loss. The Department of Defense (DoD) has created an excellent model of comprehensive care for service members with major limb loss that should be given consideration for adoption by the VA. The Committee recommends that the Rehabilitation Strategic Healthcare Group develop a plan to establish a program of comprehensive care for veterans with limb loss that is more parallel to DoD's model and to VA's models for Polytrauma and Spinal Cord Injury.

**4. Establishment of Centers of Excellence for Care of Veterans with Amputations:** The committee recommends that the VHA appoint physicians, therapists, social workers, prosthetists, engineers, and other appropriate participants to establish plans, goals and metrics for the possible creation of these centers of excellence. With the establishment of the "Center for the Intrepid" as a public-private sector partnership with both Department of Defense

and Department of Veterans Affairs, and the recent testimony of “Wounded Warriors,” this issue is becoming increasingly acute. The Committee is concerned that care is device driven rather than care driven.

**5. Rehabilitation Research and Development Service Resources:** The Committee recognizes the value of the VA Rehabilitation Research and Development Program, and recommends that its budget be increased to a level that a 25% pay-line can be achieved. It is generally agreed that this is the level necessary to sustain a viable program. It is especially critical to increase support for VA Rehabilitation R&D during this time of war while there is a constant influx of newly injured veterans with unique and complex injuries and concomitant issues. In parallel, there is an increasing population of aging veterans with disabilities. At this time proposals are going unfunded

**6. RR&D Advisory Committee:** The Committee would like a status report on the establishment of an RR&D Advisory Committee, which this Committee recommended in previous recommendation in May 2005.

**7. PSAS Deputy for Prosthetics:** The Committee request an update on the recruitment of a Deputy Chief for Prosthetics and Sensory Aids Service..