

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

The VA Federal Advisory Committee on Prosthetics and Special Disabilities met on October 3 and 4, 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  
Robert D. Rondinelli, M.D., Ph.D.  
Robert S. Gailey, Jr., Ph.D., P.T.  
Joseph A. Miller, CPO, MHA  
Douglas G. Smith, M.D.  
Jerry P. Steelman

Lee Ann C. Golper, Ph.D.  
Rory A. Cooper, Ph.D.  
Col. Paul F. Pasquina, M.D.  
Margaret G. Stineman, M.D.  
Norman B. Hartnett

## **Members Not Attending**

Capt. Daniel M. Gade

## **Guests**

Chad Martin (American Legion) Gary Coats (PVA)  
John Townsend, Optometry Service Kristie Gilmore (AAOS)  
Gretchen Stephens and Pam Bergbigler, PM&R Program Office

## **Minutes—Tuesday, October 3, 2006**

**Welcome and Opening Remarks—Mr. Miller.** The meeting was called to order at 8:35 am by Mr. Miller. Introductory comments from Kristie Gilmore from American Academy of Orthopedic Surgeons. Dr. Cooper reported on *Science* article on PTSD, and articles on disability. Suggestion was made to have update on mental health at the next meeting.

**Brief Update on Rehabilitation Services—Dr. Beck.** The Blind Rehabilitation continuum of care is still under review by Under Secretary for Health (USH), which is a VIAB proposal on outpatient care. Rehabilitation Services is working on a Blind Rehabilitation succession plan to help deal with the shortage in low vision specialists. We have successfully created a program and gained funding

for recruitment through the Technical Career Field program for 10 positions funded. The program is a two (2) year program which funds salary and education with commitment to work in VHA Blind Rehabilitation.

VHA has hired a BROS to work at Walter Reed and Bethesda Naval. We have reports of up to 670 eye casualties at WRAMC and 340 at Bethesda. Traumatic Brain Injury (TBI) is the signature injury in Global War on Terror (GWOT). A number of patients are not being referred to VA and are being held in Medical Holding Companies and consequently not being tracked.

Rehabilitation Services is very busy in each of the program offices. There is an excellent team and with many accomplishments. Cindy Wade will be retiring before next meeting.

**Update on Polytrauma—Dr. Sigford.** Dr. Sigford by conference call, introduced Gretchen Stephens TBI/Polytrauma Coordinator and Pam Bergbigler, Rehab Planning Specialist, both from Richmond.

Polytrauma System of Care. VA care is much longer based on pre-existing TBI programs. Patients are complicated by multiple traumas. Polytrauma is a major VHA strategic initiative, and not just PM&R issue. The majority are blast injuries, also motor vehicle accidents and gun-shot wounds, and others. There are multiple mechanisms of injury, 55% are blast related, and 25% of the motor vehicle accidents may or may not involve blast. The Polytrauma system of care is a coordinated inter-disciplinary care. Facility-based components include: Regional Polytrauma Rehabilitation Centers (PRC) (4 centers); Polytrauma Network Sites (PNS) (21 network sites). Polytrauma teams and Points of Contract are level 3 and 4 respectively. Comprehensive inpatient rehabilitation occurs at PRC. At the PRCs, 92% brain injuries at PRC have a high prevalence of fractures, wounds, sensory impairment. Amputations and burns are handled at Medical Treatment Facilities (MTF), and are usually ready for outpatient care upon discharge from MTF. Mental health and pain are also pervasive issues for the polytrauma patients. Of patient discharges, 77% are discharged to home, 14% to MTF, and 9% to another VA. Telehealth network is dedicated to Polytrauma System of Care, and examples include, monthly conference with network sites, telehealth with rural clinics, education of practitioners, and accommodate of veterans and families who do not want or cannot travel.

Communication efforts include monthly conference calls, biweekly PNS, discipline-specific conference calls, email groups, VHA has military liaisons at each PRC, VA Social Work Case Managers at MTFs, a Blind Rehabilitation Outpatient Specialist at WRAMC and NNMC, and a VA Nurse liaison at WRAMC and NNMC.

The Level III, Clinical Support Teams manage stable rehabilitation patients. Minimum membership on these teams includes a physiatrist, PT, OT, SLP,

psychologist, case manager, and other such as Prosthetics as needed. Networks nominate facilities and reviewed with Network Office.

There are new issues and new care models associated with treating these patients. There are extensive family needs. One new model deals with ambiguous loss, and coping based on grief and adjustment with a difficult grieving process. Family members need counseling. Vet Centers are playing a role, and family care is part of the care of the veteran. There is broad nationwide awareness of polytrauma care and achievements. VHA is particularly concerned with Guard and Reserve who may be lost in follow-up, especially for delayed or "mild" TBI injuries which can often lead to a significant family or social disruption and breakdown.

**Annual Update on PM&R—Dr. Sigford.** The comprehensive continuum of care which PM&R and Geriatrics are collaborating on pilot sites at Portland, Seattle, Mountain Home, Cincinnati and Dallas. The pilot sites will increase in intensity of rehabilitation in long term care setting. Certified rehab nurse pilot program started in VISN 10 with EES. CARF update: little change, with 42 Inpatient Programs, 2 Outpatient Programs, 4 PRC sites, Augusta partnered with medical holding company. VISN 9 has no plans for CARF, but Tennessee Valley has indicated interest in formal review. VISN 10 has submitted request for survey. Performance indicator: greater 80% new strokes, TBI, or amputation captured in FSOD. Supporting indicator: patients (stroke FRG, brain injury and amputation) tracked on admission to "acceptable" rehab program. ) The percentage of stroke referrals to rehab has risen from 2.9% to 48%. FY 2007 performance monitor.

For Amputation care – The PACT directive released, and current writing Clinical Practice Guidelines with a VA/DoD workgroup and should improve transition from MTF to VA. The new PACT revision recommends annual visit. Amputation planning: Education for practitioners and models of care and best practices, research, data tracking. Plan: handbook to reflect a system of care using holistic approach. Assistive technology workgroup: national process for assistive technology. Devices include communication devices, environmental controls, computers, wheelchairs, etc. PM&R is surveying the field.

PM&R created a data management workgroup, and we hired a data manager. We are reviewing data systems, and education provided to managers.

**Briefing on Office of Liaison and Transition—Dr. Huycke.** Liaison and Seamless Transition merged. Seamless Transition was established in January 2005. Our newest veterans are different than previous veterans. They are younger with families and young children and women patients. Transition: VHA, VBA, DoD, Reserve, and National Guard work in collaboration. Transition is not a linear process, service members may go from MTF to VA and back and forth for specialized care. For coordination of care, VA has Clinical Social Workers at 8

MTFs. VBA benefits coordinators are also at these facilities. Outreach programs include post deployment health reassessment, 90-180 day re-assessment to uncover delayed or emerging health problems not noted on post-deployment assessment. The Office provides case management and tracking which identifies the injured and tracks through course of care as well as benefits. The Office is concerned with the timeline for health care and benefit services, timely delivery of services, identification of seriously injured (5-6 diseases), including vision. We screen and record key diagnoses.

### **Update on Prosthetics and Sensory Aids—Mr. Downs.**

Budget is \$1.1 billion, and through August FY 2007 PSAS had requests from VISNs for \$1.3 billion. \$1.2 billion allocated (95%) but should be adequate for the year. Global War on Terror (GWOT) veterans with limb amputation is 79 uniques through 2<sup>nd</sup> Q FY 2006. Recreation and sports equipment draft handbook for rehab is in process. Workgroup developed a draft to provide guidelines on equipment since there are no restrictions on VA providing leisure equipment. PSAS has been participating in the discussion about Center for Intrepid at Brooke AMC. Prosthetist/Orthotists, PT, OT, SW, and case manager from VA will help staff the State-of-the-art rehab and treatment center. The Center is being built by private funding, will have 65,000 square feet, and geared to young, active veterans. The Center will also have educational activities. Brooke AMC determines who can enter the Center.

NPPD report through 3<sup>rd</sup> Quarter indicates 2.3 million NSC, 458,000 SC, 2,000 GWOT uniques in FY 2006. Uniques were projected at 1.6 million in FY 2006 and FY 2008 2 million projected. Funding projected at \$1.2 billion in FY 2006 and \$1.6 billion in FY 2008. VA philosophy is if enrolled a veteran is eligible for prosthetic care. Private sector insurance refuses to pay for advanced limbs and considers them as experimental. VA is leader in providing high tech equipment.

Prosthetists/orthotists are included in Title 38 Hybrid. PSB being implemented. 56 certified P/O labs (96%), 2-3 years ago there were only 5. 44 P/O labs ABC accredited and 12 are BOC accredited. 128 (68%) certified prosthetists/orthotists, 85% have ABC credential. 8 NCOPE accredited sites. Review team for upper limb contract. Contract will be rebid because no bids were adequate. Annual meeting with Academy of Orthotists and Prosthetists. Polytrauma labs being accredited and upgraded. Amputation Care Standards into Polytrauma. Draft strategic plan. Contract savings and compliance reports. Clinicians develop specifications. Clinicians also write clinical practice recommendations. National contract also contains technical support, repairs, shipping, etc. 483 GWOT amputees (Army), 80 treated at VA. Status of Deputy: review of four applicants. Clinician. Difficult to recruit to cost of living and unique job requirements. Clinical Logistics: review of clinical logistics programs. Medical Sharing Program in cooperation with Academic Affiliations. \$13 billion spent on hospital equipment

but no database available. Clinical driven workgroups to develop product guidelines.

**Annual Update on Ophthalmology and Optometry—Drs. Orcutt and Townsend.** Eye care workload increased from FY 1993. There are 2.2 million visits, with 450,000 eyeglasses prescribed at a cost of \$44 each. Clinics had 1.3 million uniques, and waiting times are down: 95% for established patients, 63% for new patients. Diabetic retinal exams also above goal. Teleretinal imaging is sending images to reading site for evaluation. 17 VISNs selected and funded. with 102 cameras and 70 are installed. 10,000 patients receive this care in primary care clinic. Remaining sites will be implemented by the end of fiscal year. The project will free space and time for non-diabetic patients. Four (4) VISNs did not apply, but they may be able to apply for equipment. Portable cameras cost \$23,000 each, but allows for remote access and screening at rural sites.

Low vision rehab program: VIAB memo to implement continuum of care is awaiting approval. VHA expects that the first FY \$15 million will be allocated, and recurrent funding of \$13 million to complement BRC, using the VICTORS and VISOR models. In June, Lake City VAMC started a VICTORS program. VHA already provided intermediate low vision care for 2,500 veterans at 22 facilities.

Polytrauma challenges. VHA has only two (2) neuroophthalmologists. Needs can be met through fee basis or contract care. There are very few of these highly specialized physicians in the U.S.

Contract compliance: 98% for CCTV, 98% for optical aids, 97% for IOL. Program office is working on a visual acuity coding project: one (1) of four (4) codes selected (blind, moderate, near normal, and normal).

**Update on Research—Dr. Kupersmith.** Polytrauma QUERI is coordinating research with polytrauma system of care. Research is working on a vocational rehabilitation project involving SCI patients who are ten times more likely to be unemployed or under-employed, and the rates may be higher for veterans. Vocational Rehabilitation for injured and non-injured veterans is using several federal agencies to provide vocational services (DOL) using local employment centers. Services appear fragmented, and the SCI Vocational Integration Program (SCI-VIP) is a funded RR&D project. Neurotrauma and PTSD overlap. Neurotrauma QUERI is looking at a signature injury which complicates readjustment to civilian life. Current research includes an assessment workshop on research directions, since these veterans have a more aggressive lifestyle than WWII era veterans. Research on amputation includes a study on torsion compensation devices, socket design, vacuum socket systems, intelligent,

adaptive knees, shock absorbing pylons, osseointegration, skin growth into rod, and neural prosthesis. Research is evaluating the predictors of long term prosthetic use with advanced myoelectric designs for upper extremity prostheses, brain computer interface, brain waves drive prosthetic devices using scalp electrodes. Research has found that implanted electrodes are invasive and require training and need stimulus evoked or event related potentials to activate devices. Research in ALS shows an increased incidence in Gulf War veterans. ALS patients are living longer.

### **Annual Update on Audiology and Speech Pathology Service—Dr. Beck**

The Service continues to grow in staff nationwide. Currently VA has 599 audiologists, 257 speech pathologists, and the largest growth has been in health technicians. Outpatient visits are increasing with the numbers of unique patients rising significantly each year. Hearing aid costs continue to remain low on a cost per unit basis. Contract administration at Denver Distribution Center (DDC) continues to be highly satisfactory. The DDC has a user groups working with the Program Office.

Advanced Clinic Access is a very important initiative for VA. It focuses on improving access to care, quality, and timeliness. Dr. Beck is on the National Steering Committee. Waiting times statistics are reported to the field monthly. Performance Goals include the percentage of new patients seen within 30 days. Advanced Clinic Access teaches staff efficiency and provides a language for talking to management.

Compensation & Pension (C&P) Exams - Hearing loss is most common disability, and tinnitus ranks third. There are still challenges in getting C&P exams scheduled. This is also a performance indicator measuring the percentage of C&P exams meeting target of 90% or more completed. Audiology scored 95-99%.

National Speech Pathology - Impact of OEF/OIF veterans is large especially in Polytrauma Rehabilitation Centers (PRCs). Speech pathology is a core treatment and the focus is on evidence-based practice. The National Outcomes Measurement System (NOMS) measures speech pathology outcomes. Sites must be registered and trained. NOMS is being proposed as pilot for Medicare.

### Hot topics

#### Dysphagia

VA created a multi-disciplinary task force to develop policy. Task force includes nursing, dietetics, geriatrics, medicine, mental health, pharmacy, speech-language pathology, and others. VA has several national experts in this area and hopes to partner with DoD which is also doing intense work with dysphagia patients. The Directive was written, and educational initiatives are in process.

### Cochlear Implants

The number of patients continues to increase and Baltimore has been added as a site. VA is contracting with DoD to provide this service, and combined annual numbers will be over 200. New sites will be added as needed. Access and logistics issues continue to be a problem for VISNs with no program. Patient Care Service has a new initiative concerning access to care and is reviewing these problems. VA shares a joint contract with DoD to provide the implants for their eligible patients. Some implants candidates are retirees, active duty or dependents. DoD uses VA contracts for these devices similar to what is done with access to hearing aid contracts that VA negotiates. This allows DoD to save money.

### Polytrauma

Speech-Language Pathology (SLP) has a role with OEF/OIF veterans. SLP is a core-discipline with Polytrauma team. The four lead TBI Centers have been reconfigured as Polytrauma Centers. Blind Rehabilitation has also been added as a core team discipline.

### Hybrid Title 38

Qualification standards have been approved. Professional Standards Boards are reviewing all employees now for a one time special boarding.

**Committee Commendations** – The Committee wishes to extend its appreciation to the following:

1. The Committee commends the polytrauma system of care and specifically Dr. Beck's and Dr. Sigford's leadership in the development of the comprehensive polytrauma system of care.
2. Committee commends and appreciates the improved quality of reports from Prosthetics and Clinical Logistics Service at this meeting.
3. Committee commends VA for reappointing Dr. Beck as Chief Consultant, Rehabilitation Services.
4. The Committee commends Dr. Sigford on successful accreditation program with CARF and the combined rehabilitation indicator. Both programs ensure the continued quality of VHA's physical medicine and rehabilitation programs.

### **Committee Recommendations**

1. **Deputy Chief, Prosthetics should be filled as soon as possible from existing list of candidates. The ideal candidate must have a clinical**

**background in treating persons with disabilities, specifically in special disabilities, and experience in medical systems of care.**

**2. The Committee recommends that Blind Rehabilitation remain under Rehabilitation Services and does not endorse the reorganization of an Eye Care SHG or as a separate SHG.]**

**3. The Committee recommends that Secretary support access to DoD database of service members who receive PEB.**

**4. The Committee recommends administration of VA-developed post-separation screening tool for veterans identified as medically separated.**

**5. The Committee recommendation that Transition and Liaison Office explain how it measures success.**

**6. The Committee recommends that Transition and Liaison Office establish a working group to outline roles, objectives, lines of communication, and collaboration among VA and DoD case managers to reduce redundancy and confusion.**

**7. The Committee recommends that education and training for prosthetists, orthotists, therapists, and clinical practitioners, specifically in area of polytrauma.**

**8. The Committee recommends that lack of VISN 9 CARF accredited rehabilitation unit be addressed.**

**9. The Committee recommends that a recreation therapist and a rehab engineer be added to polytrauma teams.**