THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

February 26, 2009

Mr. Thomas H. Miller
Chairman, Advisory Committee on Prosthetics
and Special-Disabilities Programs
Blinded Veterans Association
477 H Street, NW
Washington, DC 20001

Dear Mr. Miller:

This is in response to the report you submitted following the November 5-6, 2008, meeting of the Advisory Committee on Prosthetics and Special-Disabilities Programs. I appreciate the Committee's thorough deliberation on the issues presented.

The enclosed fact sheet addresses the concerns raised in your report and provides responses to those recommendations. The Committee's input helps the Department in its mission to ensure that Veterans with special disabilities continue to receive the best care and that their needs are met.

I look forward to continuing an open dialogue with the Committee. With your assistance, the Department of Veterans Affairs will continue to ensure the delivery of high quality services to our Nation's Veterans.

Sincerely,

Eric K. Shinseki

Enclosure

DEPARTMENT OF VETERANS AFFAIRS (VA)
VETERANS HEALTH ADMINISTRATION (VHA)

Fact Sheet Addressing Recommendations Made at the November 2008 Meeting of the Advisory Committee on Prosthetics and Special-Disabilities Programs

Recommendation 1: Nursing Service develops a succession plan to include training, recruitment, and retention for nurses assigned to special disability programs.

Response: Concur

While there is a national nursing shortage with some regions experiencing a more dramatic shortage than others, Veterans Health Administration (VHA) is not presently experiencing a specific shortage of nurses for special disability programs. Existing recruitment initiatives have been successful in hiring nurses for special disabilities programs. For example, currently there are six Federal recovery coordinators who are registered nurses with offers of employment extended to three more. Many nurses have been hired as care managers and program managers in the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Care Management Program at our medical centers.

The VHA Office of Nursing Services has sponsored a number of programs designed to support succession planning in general. These programs emphasize training, recruitment and retention for nurses including those for special disability programs. Examples of these programs include:

1. In 2008, a Clinical Nurse Leader Advisory Group was established to implement a plan to create clinical nurse leader positions at the four polytrauma units in Richmond, Virginia; Tampa, Florida; Minneapolis, Minnesota; and Palo Alto, California; and the fifth unit to be established in San Antonio, Texas. The clinical nurse leader is a generalist who provides a high level of clinical practice, leadership and skills to improve and coordinate patient care. A joint summit is planned for January 2009 with VHA and the American Association of Colleges of Nursing to continue to foster the development of clinical nurse leaders nationally through education and collaboration efforts.

2. Another goal of the Clinical Nurse Leader Advisory Group is to develop, by October 2009, a business plan template to be used by all nurse executives to expand the number of clinical nurse leader positions at every medical center.

3. To enhance our retention efforts, Registered Nurse Residency and Fellowship Programs are being developed to augment the orientation and mentoring of newly graduated staff nurses and clinical nurse leaders.

4. The VA Nursing Academy, a network of affiliate partnerships between local VA medical centers and schools of nursing, continues to assist in meeting VA's nurse recruitment and retention and nursing schools' faculty needs. The academy facilitates the expansion of clinical rotations at VA medical centers and affords an opportunity for VA nursing staff to serve as faculty support.

5. The Office of Nursing Service continues to assist VA medical centers in preparing for Magnet designation by the American Nurse Credentialing Center. Magnet designation supports the delivery of quality and safe patient care.

Recommendation 2: All special disability programs routinely collect and report on data by gender and race. Veterans Integrated Service Network (VISN) directors should be given the target of 22 percent (i.e., parity with male Veterans) enrollment of women Veterans within their health care programs. VA needs to develop a model for using census data to estimate the population of women Veterans eligible for VA health care, with a focus on the special disability populations.

Response: Concur in Principle

VHA concurs that special disability populations care be included in any planning and modeling done by VA. The Women Veterans Health Strategic Health Care Group recently briefed the VISN directors and the chief medical officers and provided them with their VISNs' current relative usage rates by male and female Veterans. The VISN directors and the women Veterans program managers have been strongly encouraged to increase their outreach to Veterans. VHA does not agree with establishing an enrollment-based performance target for VISN directors; since the Veteran population varies widely across the country, it would not be appropriate to mandate a set percentage of enrollees.

Recommendation 3: Physical plant planning processes need to be modified to account for women and Veterans with disabilities, especially in primary care. For example, primary care exam room layout to avoid instances where they are sub-optimal. Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation accessibility criteria should be reviewed and implemented throughout VA special disability population programs.

Response: Concur

The Office of Construction and Facilities Management recently enlisted the help of the Primary Care Program Office, along with a group of field-based primary care clinicians, to revise and update space planning criteria and standards for hospital-based and freestanding outpatient facilities. The needs of disabled, elderly and women Veterans figure prominently in the modified criteria, which are updated on a regularly scheduled basis. While those criteria are designed to be applied to new and remodeled construction, existing space must also meet accessibility standards for special populations. Primary Care has been working

closely with the Women Veterans Strategic Health Care Group to develop and specify clinic models that support the delivery of women's primary care. The Primary Care Program Office will continue to work with all relevant groups to insure that outpatient clinic space is ideally configured to meet the needs of all Veterans.

Recommendation 4: VA needs to examine and create new processes to ensure female Veterans within the special disability populations receive adequate information and access to care. VA should implement the CARF Universal Stakeholder Participation Experience Questionnaires (uSPEQ) survey for Veterans within the special disability populations.

Response: Concur

The Office of Quality and Performance (OQP), Office of Patient Care Services (PCS), and the Women Veterans Health Strategic Health Care Group (WVHSHCG) within VHA are working together to enhance processes to ensure access and enhance satisfaction for women Veterans, especially those who require specialized expertise in rehabilitation services, equipment, and training. VHA program offices have indicated interest in making the uSPEQ Consumer Experience Survey available for use by clinical program leaders. They are currently developing an Executive Decision Memorandum and funding request for implementation of uSPEQ within VHA rehabilitation programs. Since this will be an ad hoc survey, we must also obtain approval by the Office of Management and Budget (OMB). The OMB approval process is anticipated to take a minimum of 9 to 12 months. Once appropriate approvals are secured, VHA will pursue a contract modification with the CARF to implement the uSPEQ Consumer Experience Survey nationally. Implementation is anticipated to occur in fiscal year (FY) 2010. OQP will provide project management support to ensure appropriate analysis and feedback of survey results.

Recommendation 5: Encourage VISN Directors to ensure vocational rehabilitation counselors have an enduring presence at every VA medical center. Vocational rehabilitation counselors need to be integrated into VHA OEF/OIF and all special disability programs.

Response: Concur

Vocational Rehabilitation and Employment (VR&E) Service and VHA have a long-standing history of working collaboratively to serve Veterans with disabilities. VR&E counselors work with VHA vocational rehabilitation specialists to coordinate services in both the VR&E program and VHA's programs, including domiciliary programs and Compensated Work Therapy (CWT). VR&E also works collaboratively with VHA to refer Veterans for medical services and evaluations during periods of rehabilitation. VR&E counselors work closely with VHA polytrauma centers, serving as ad hoc members of the treatment and

discharge planning teams to ensure seamless service delivery as Veterans transition from medical rehabilitation to community based services. Throughout the country, VHA and VR&E staffs jointly serve on rehabilitation panels to ensure the highest level of rehabilitative services for the most severely disabled. VR&E is working collaboratively with VHA to serve Veterans with serious disabilities through their involvement with Traumatic Brain Injury, Spinal Cord Injury, and Visual Impairment Service teams. VR&E Service has formed collaborative working relationships with and provided training to Polytrauma Rehabilitation Center and CWT staff, and VHA has provided training to VR&E staff about a number of medical issues impacting Veterans' vocational success.

Recommendation 6: Veterans Benefits Administration should consider creating an Office of Program Evaluation and Outcomes Measurement for Vocational Rehabilitation.

Response: Concur

VR&E has a dedicated data team and has recently added an additional staff member to this team. In addition to routine data collection, the staff is responsible for collecting and trending information on the program's outcome measures, as well as other data to monitor the program's progress and success. Further, they coordinate with Veterans Benefits Administration's (VBA) Office of Performance, Accountability and Integrity to collect and analyze program data. In addition to formal processes already in place to evaluate program outcomes and ongoing program issues, VR&E is currently working with VA's Office of Policy and Planning to conduct an overall program evaluation. As a part of this evaluation, additional outcome metrics and return on investment is being considered. In FY 2009, VR&E is conducting a contracted customer satisfaction survey, and is in the process of putting contracts in place to conduct a work measurement study and to conduct a study designed to assess ways to increase program retention and completion.

Recommendation 7: The Committee would like an update from the Assistive Technology Task Force and its plan to implement comprehensive assistive technology services.

Response: Concur

The National Physical Medicine & Rehabilitation Program Office is providing the following update regarding the Assistive Technology (AT) Task Force and the plan to implement comprehensive AT services.

The National AT Workgroup was initiated in July 2006 to:

- Review the programs and processes by which AT is provided in VA;
- Identify gaps; and
- Make recommendations for program improvements to address gaps.

The impetus for setting up the AT Workgroup came from the following concerns expressed by the Federal Advisory Committee on Prosthetics and Special Disabilities:

- VA should have formalized processes for the provision of AT.
- VA should have a way to ensure competencies of the clinicians providing this equipment.

The Workgroup was composed of Rehabilitation Engineering and Assistive Technology Society of North America certified rehabilitation engineering technicians and assistive technology providers, as well as subject matter experts from the field including a thysical therapist, occupational therapist, speech pathologist and physiatrist.

Based on their findings and deliberations, the Workgroup made the following recommendations for action:

- Implement specialized AT teams that would provide leadership in clinical, educational, and training issues;
- Develop competencies for clinicians participating in the AT teams;
- Develop models for AT clinics and programs; and
- Collaborate with academic programs with established expertise in AT.

Actions to date:

Based on the above recommendations and current development of the Polytrauma System of Care, the following actions have been taken to respond to the recommendations of the National AT Workgroup:

- A proposal for the development of AT Laboratories at the PRCs was submitted to PCS for supplemental funding in FY 2008.
- The proposal was approved and an advisory and assistance contract solicitation has been announced.
- Proposals are expected by mid-January. Award of the contract is projected for the second quarter FY 2009.
- This contract addresses the recommendations of the AT Workgroup. It will provide for development of specialized AT laboratories at each of the four PRCs. These laboratories will be the model for VA. It will also include:
    - A curriculum for the training of the clinicians at these sites, and
    - A standardized assessment tool that can be used across the VA health care system.

- Following a survey of advanced rehabilitation equipment at the polytrauma and blind rehabilitation centers, supplemental FY 2008 funds were disbursed to these centers for procurement of equipment that would support advanced rehabilitation practices.

The former Assistive Technology Task Force has now evolved into the Prosthetics Clinical Management Program Integrated Product Team for Cognitive Orthotic Devices. This team includes interdisciplinary representation from both VHA and Computer/Electronics Accommodations Program, a project coordinated by TriCare to provide AT to active duty servicemembers. This team is currently revising the document addressing clinical practice recommendations for the evaluation, prescription, training, and outcome measurement relative to these devices. Tasks will reference and incorporate documentation and clinical programs relative to other AT including but not limited to computer access and augmentative communication. Additionally, patterns of prescription and purchase are being evaluated to determine if national standardization is necessary.

Recommendation 8: The Committee would like to see details on how Orthotics and Prosthetics will be integrated into the Amputee System of Care clinical care team. The Committee is keenly interested in having orthotists and prosthetists become fully integrated within VA clinical teams at all levels of the Amputee System of Care.

Response: Concur

A key piece of the Amputation System of Care is the collaboration of key clinical partners in the evaluation, prescription, and treatment of Veterans with amputations. Just as the physician or physical therapist have their contributions, so does the prosthetist. The program offices are working with the Tampa VA to develop a best practice model that will explicitly state these functions and roles. Additionally, the Prosthetic and Sensory Aids Service is working to elevate the competencies of all VA prosthetists. Issues being considered include revision of the qualification standards for the 667 series (prosthetists and orthotists) to begin requiring certification at the GS-11 level as opposed to the GS-12 level; creating business models to improve the quality and efficiency of a prosthetic laboratory's worth to a facility; standardizing clinical competencies and peer review measures to ensure that prosthetists and orthotists are maintaining skill sets; considering whether to establish a lead prosthetist position for each region.

Recommendation 9: Align performance plans for Orthotists and Prosthetists with the Amputee System of Care clinical care team goals.

Response: Concur

As outcome measures and goals are developed, these measures will be added to the performance plans for the participating prosthetists.

Recommendation 10: The Committee would like to receive a briefing on site visit reports for each Orthotic and Prosthetic Laboratory. The report should include:

- Who participated in the review, qualifications and affiliations for each site visit team member.
- Action plan which addresses report findings.
- Name of official who approved the report and action plan.
- How orthotists and prosthetists interact with Physical Medicine & Rehabilitation Service.
- Updates for the 7 Regional Amputee Centers and Polytrauma Amputation Network Sites.

Response: Concur

A full report and briefing will be provided at the Committee's March 2009 meeting by the Chief Consultant, Prosthetic and Sensory Aids Service or his designee.