



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

AUG 21 2006

In Reply Refer To:

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

Dear Mr. Miller:

This is in response to the report you submitted following the April 11-12, 2006, meeting of the Advisory Committee on Prosthetics and Special Disabilities Programs. Please be assured that I appreciate the Committee's thorough deliberation on the issues presented, and value their input.

The enclosed fact sheet addresses the concerns raised in your report and the responses to those recommendations. The Committee is a valuable resource and makes significant contributions 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 ongoing assistance, VA will continue to ensure the delivery of high-quality services to our Nation's veterans.

Sincerely yours,

A handwritten signature in cursive script that reads "Michael J. Kussman".

Michael J. Kussman, MD, MS, MACP
Acting Under Secretary for Health

Enclosure

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

Fact Sheet Addressing Recommendations Made at the Meeting of the Advisory
Committee on Prosthetics and Special-Disabilities Programs
(Forwarded in letter of July 14, 2006)

Recommendation 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.

Response: The Veterans Health Administration (VHA) Office of Research and Development (ORD) acknowledges that protecting time for research is important to allow VA clinician-investigators to prepare proposals, gather data, develop findings, and publish results of studies. A survey of all funded investigators would require considerable resources from VHA ORD. Rather than a survey, VHA ORD will consult with its Field Research Advisory Committee to identify issues related to having adequate time to conduct funded research and to develop approaches to help ensure protected time is granted.

The purpose of the Veterans Equitable Resource Allocation (VERA) Research Support allocation is to fund various activities that support research, including personal services costs for clinician-investigators, facility operations, and administrative services. The VERA Research Support allocation was not designed to protect researcher time, and the process for allocating those dollars is based on a formula that takes into account the history of funded research, rather than researcher time. The support of researcher time is done locally by VA medical center (VAMC) Directors and Chiefs of Services based on the needs of veterans, the importance of the research to the mission of the VAMC, as well as the productivity and performance of the researcher.

Recommendation 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.

Response: Title 38 United States Code, section 111, "Payments or allowances for beneficiary travel" provides beneficiary travel eligibility based upon service connected disability ratings and financial status. At this time veterans are eligible for travel when rated 30 percent or more SC; traveling in conjunction with treatment or care for a SC condition, in receipt of Aid and Attendance, or are unable to defray the cost of travel (as regulated). In addition, certain non-veterans such as attendants and donors can receive travel benefits when travel is directly related to the care of a veteran. While the majority of special disability veterans already fall into a beneficiary travel eligible category, the Chief Business Office (CBO), in conjunction with the Spinal Cord and Disorders Service (SCI&D), has developed a legislative proposal which would authorize payment of beneficiary travel to any veteran who meets the definition of catastrophically disabled as expressed by 38 CFR 17.36 (e). Veterans in this group are those who have a permanent severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that the individual requires assistance to leave the home or requires constant supervision to avoid physical harm to self or others. Enactment of such legislation would potentially expand travel benefits to those special disability veterans currently without such eligibility. The proposal is currently under review by VA for possible submission to Congress.

VA is committed to ensuring the needs of veterans with special disabilities have access to VA specialty care and will ensure the legislative proposal is tracked through the legislative process.

Recommendation 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.

Response: Physical Medicine and Rehabilitation (PM&R) agrees with the recommendation that an examination of the current system for provision of amputation care is warranted. We are also in agreement with the recommendation for exploring new models of amputation care to better meet the needs of those with traumatic limb loss. A work group has been established to address these issues and is scheduled to meet in Denver, Colorado on September 11-13, 2006. The goal of this group is to provide concrete recommendations for building a comprehensive amputation system of care. It is recognized that there are current successful models in DoD, polytrauma and spinal cord injury, and these will be considered in the development of a new program.

In addition, the VA and DoD have worked together on a model of care for amputation rehabilitation. The ultimate outcome of this collaboration was an Amputation Rehabilitation Clinical Practice Guideline (CPG). The guideline has been drafted, edited and sent to the field for comment. The last editing is now being completed. Having a CPG in place as a reference document will help to reduce variability in rehabilitation practice.

Recommendation 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.

Response: PM&R agrees that the amputation rehabilitation process should be care driven, not device driven. As the system of care is developed by the described in the response to Recommendation 3, it will consider the DoD, polytrauma and spinal cord injury programs which have developed specialized regional care facilities and programs that can manage complex patients. These facilities and programs offer a higher level of care and act as a resource to those needing these specialized services. Referrals are made to these specialized programs for patients that need the highest level of expertise. Variability in care is reduced by providing standardized resources and staffing across the system. The workgroup will evaluate the various systems of care, and determine which would be of most benefit to service members with traumatic limb loss.

As the amputation system of care is developed, consultants from all areas listed will be assembled to contribute to the plans, goals and metrics of the program. This expert workgroup will guide the development of the amputation system of care as the Polytrauma Workgroup has guided the development of that system.

Recommendation 5: Rehabilitation Research and Development (RR&D) 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.

Response: The Veterans Health Administration (VHA) Office of Research and Development (ORD) agrees that rehabilitation research is crucial to address the needs of veterans returning from Operations Iraqi Freedom and Enduring Freedom, as well as the aging veteran population. To maximize research aimed at improving the quality of life of impaired and disabled veterans, the RR&D Service has initiated many collaborations within VHA and with other Federal agencies (e.g., Department of Defense) to leverage its assets. VHA ORD will continue to encourage these collaborations.

Many factors affect the pay-line for approval of proposed projects. These include the number of solicitations, objectives of a solicitation, and quality of proposals, as well as available resources. For example, a reduction in a pay-line may occur if:

- the number of submitted proposals increases significantly;
- a significant number of proposals do not meet the objectives of a solicitation; and/or,
- the merit review panel determines that the proposal does not meet high quality standards for scientific merit, human protection standards, or other issues.

Recommendation 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.

Response: The VA's National Research Advisory Council provides advice to the Secretary about policies and projects, the focus of research on the high priority health care needs of veterans, the balance of basic, applied, and outcomes research, the scientific merit review process and other research-related issues. This includes matters related to rehabilitation research.

VHA ORD leadership is finalizing a decision about appointment of a permanent Rehabilitation Research and Development Service Director. Therefore, final decisions about the establishment of advisory groups to the Rehabilitation

Research and Development Service will be postponed until the appointment of a permanent Director.

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

Response: The vacancy announcement for the position of Health Sciences Officer, GS-601-15, a.k.a. Deputy Clinical Prosthetics Officer, was posted on June 1 and closed June 30. The merit promotion certificate, which provides names of qualified candidates and includes candidate application, was completed by the Human Resources Service on July 21 and provided to the Chief Prosthetics and Clinical Logistics Officer for a decision. The certificate will be discussed between the Chief Prosthetics and Clinical Logistics Officer and the Acting Under Secretary for Health.