VA SPECIALIZED SERVICES: LOWER EXTREMITY CONDITIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
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VA SPECIALIZED SERVICES: LOWER EXTREMITY CONDITIONS

Tuesday, May 2, 2017

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 2:54 p.m., in Room 334, Cannon House Office Building, Hon. Brad Wenstrup [Chairman of the Subcommittee] presiding.

Present: Representatives Wenstrup, Dunn, Higgins, Brownley, Takano, and Kuster.

Also Present: Representative Abraham.

OPENING STATEMENT OF BRAD WENSTRUP, CHAIRMAN

Mr. WENSTRUP. The Subcommittee will come to order. Good afternoon, and thank you all for joining us.

Before I begin, I would like to ask unanimous consent for my friend and colleague and former Committee Member, Dr. Ralph Abraham, to sit on the dais and participate in today's proceedings. Without objection, so ordered.

Today's hearing is the first of what I hope will be a series of hearings to examine specialty care access and quality in depth. Given the high rate of lower limb injuries and conditions among veterans of all ages and the issues this Subcommittee has been discussing since 2015 regarding recruitment and retention among professionals trained to treat foot and ankle issues in the Department of Veterans Affairs, I thought it most appropriate to begin today with a discussion of lower extremity injuries, conditions, and treatment.

Musculoskeletal injuries are the top concern among veterans newly separated from service in the armed forces and are also a primary concern among older generations of veterans with conditions that may be exacerbated, not only by military service, but also by aging and chronic illnesses like diabetes.

According to a February 2017 VA white paper, almost 2 million veterans in the VA health care system are at risk for major foot wounds, infections, and amputations. And there is increasing demand among VA patients, particularly those with polytraumatic injuries, spinal cord injuries, and major limb amputations, for primary and specialty podiatric services.

I ask unanimous consent to insert that white paper into the record. Without objection, so ordered.

Mr. WENSTRUP. Given increasing demand, it is imperative now more than ever that the VA be equipped with the highly trained workforce necessary to provide timely access to quality foot and ankle care within VA medical facilities. The VA's ability to do that, however, is hampered by antiquated statutory requirements that have held podiatrists practicing within the VA's walls back and, as a result, limited access to podiatry care for veteran patients.

The podiatry profession has been transformed over the last few decades, yet due to a law developed in 1976, 41 years ago, the VA's podiatry practice has fallen far short of the private sector in terms of pay and advancement opportunities. According to the VA, this has led to an inability to recruit and retain the most experienced podiatrists, the ones we want treating our most vulnerable veterans, as well as recent graduates just starting out. Needless to say, it has also led to lengthy hiring delays, averaging 14 months for new podiatry positions. At a time when veteran demand for foot and ankle care is growing, this is unacceptable.

I have introduced a bill, H.R. 1058, the VA Provider Equity Act, that would address this issue by including VA podiatrists within the definition of VA physicians and, in turn, ensure that podiatry pay is more in line with industry standard and allow podiatrists to attain promotion and leadership positions in the VA health care system. Similar language passed the House last Congress, and for our veterans' sakes, I am hopeful it will see the President's desk this Congress.

During today's hearing, I look forward to hearing our witnesses' and Committee Members' thoughts on H.R. 1058 and on what else this Subcommittee can do to guarantee timely access to specialized foot and ankle care veterans have earned and deserve.

I also want to discuss today how the VA can improve the provision of both foot and ankle care and orthotic and prosthetic care in the community for veteran patients. As the American Orthotics and Prosthetics Association states in their written testimony, 90 percent of the orthotic and prosthetic care that our veterans receive is in the community. However, there are persistent concerns about care coordination and communication between VA and community providers treating veterans with major amputations.

Unfortunately, this is not just an issue of concern for prosthetics. During a Full Committee hearing earlier this year, Dr. Dunn shared a story about a veteran constituent of his whose delayed and disjointed experience seeking podiatry care through the Choice Program led to an unnecessary lengthy and burdensome episode of care.

I ask unanimous consent to insert that constituent's story into the record for this hearing as well. Without objection, so ordered.

Mr. WENSTRUP. As we continue to move forward to develop the next generation of VA care and community programs, we must take those stories to heart and ensure that they are not repeated.

I appreciate our panelists and audience members for being with us this afternoon, and I very much look forward to today's discussion.

I will now yield to Ranking Member Brownley for any opening statement that she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman. And thank you for holding today's hearing.

The ability of the VA to hire and retain skilled medical professionals to treat veterans with lower extremity medical conditions is vitally important. Many veterans who receive VA care have lost limbs due to combat, others develop serious medical conditions affecting the lower extremities later in life due to their military service. These conditions and injuries can significantly affect a veteran's quality of life.

I want to thank Chairman Wenstrup for being willing to work in a bipartisan way to address this issue impacting the VHA and the veterans it serves. I appreciate his insight into the issue as a podiatrist and appreciate his leadership on this issue as Chairman.

The number of veterans receiving amputations has tripled since 2000, according to the VHA Amputation System of Care. While many of these amputations were the result of injury, some were the product of a preventable or treatable illness or disease such as diabetes, hypertension, or obesity. Podiatrists often act as the first line of defense against these types of illnesses by providing preventative care that allows veteran patients to improve their quality of life and avoid amputation.

I look forward to the discussion today. I hope that we may use the testimony and information we receive to shape solutions to these pressing problems. We cannot expect to solve the VHA's access problems without the providers, supplies, and resources that are urgently needed. I look forward to continuing the bipartisan work on this issue in this Committee. And I yield back.

Mr. WENSTRUP. Thank you.

We are fortunate today to be joined this afternoon by several distinguished witnesses. Joining us this morning on our first and only panel is Dr. Steven Goldman, the President of the American Board of Podiatric Medicine; Dr. Seth Rubenstein, Treasurer of the Board of Trustees and Immediate Past Chairman for the Legislative Committee for the American Podiatric Medical Association; Dr. James Ficke, the Chairman of Orthopedic Surgery at Johns Hopkins School of Medicine and a member of the American Association of Orthopaedic Surgeons and the American Orthopaedic Foot and Ankle Society; Jeffrey Brandt, Chief Executive Officer and Founder of Ability Prosthetics and Orthotics and a member of the American Orthotics and Prosthetics Association; and Dr. Jeffrey Robbins, the Department of Veterans Affairs Chief of the Podiatry service.

I want to thank you all for being here today and taking time from your schedules to join us.

Dr. Goldman, we will begin with you, if you will, and you are now recognized for 5 minutes.

STATEMENT OF STEVEN L. GOLDMAN

Dr. GOLDMAN. Dr. Chairman, Ranking Member, distinguished Members of Congress, and guests, at the outset, I would like to express my appreciation for the honor to address this Committee today. In discussing this topic, I do so as a private citizen, not as the chief of podiatry and the director of a podiatric residency train-

ing program at a Veterans Administration medical center; I do so not as the former interim chief of surgery or the site director of surgical services at a second VA medical center; and I do so not as a retired lieutenant colonel in the United States Air Force, who served as a podiatrist and also as a surgical operation squadron commander for the last 4 of my 20-year career in the Air Force.

I am testifying as a private citizen, one who graduated almost 35 years ago and was an associate professor at the New York College of Podiatric Medicine for nearly 15 of those years, during which time I have witnessed firsthand the metamorphosis of my profession.

I am currently the president of the American Board of Podiatric Medicine, and in this position I represent thousands of podiatrists across the country, many of whom are employed by the Federal Government.

As a veteran myself, I am also now the consumer of the medical services of the system about which you have invited me here to testify.

I have witnessed the best of our profession as it has grown over the past 35 years since I graduated in 1982. I am in awe of how far we have come. Today, all graduating podiatrists are 3-year residency trained in podiatric medicine and surgery, and we are an integral part to the collaborative health care delivery system providing essential services alongside our distinguished allopathic and osteopathic specialists.

Today's podiatrists manage the complex nature of foot and ankle deformities and are a part of the multidisciplinary team serving the needs of a seemingly ever-growing diabetic population. We take call, provide inpatient and outpatient care, respond to emergencies, prescribe medications, and independently perform surgery of the foot and ankle. Fundamentally, we perform a vital role in the continuum of health care, equal to other physicians, often for a patient population whose choice for health care is only the VA. More often than not, those patients present with more multiple comorbidities than the average population.

In the Veterans Administration, podiatry is often the first specialty consulted for foot and ankle services, and we provide more of these services than any other specialty.

Podiatrists in the private sector have witnessed salaries commensurate with the profession's growing skills. By contrast, salaries in the Veterans Health Administration, VHA, have not kept pace, and the gap grows larger every day. Podiatrists in 42 percent of the regions across the country have reached legislatively capped rates of pay under VHA. What that practically means is that a podiatrist at the absolute top end of the pay charts will earn exactly the same as much less senior podiatrists, with no hope of ever being further remunerated commensurate with the added time of service or experience.

Podiatrists are defined as physicians under Title XVIII of the Social Security Act, section 1861(r)(3). The VA definition of podiatry is a vestige of a 41-year-old antiquated 1976 VA Omnibus bill and is sorely outdated. Consequently, podiatry salaries under the VA Health Administration are locked into that same 41-year-old pay scale. As a result, it is becoming increasingly harder to fill posi-

tions and keep people with the vital skills under the VHA. I think we can all agree that all of us, but particularly our veterans, deserve the very best of care. When looking at the bell curve for salaries in podiatry on salary.com, virtually no matter where you look by ZIP Code, podiatry salaries in Federal services are in the lowest 10 to 15 percent of that curve.

Podiatrists in leadership positions within the administration have been members of pay panels, making salary decisions for their medical colleagues who enjoy salaries that are at the very least 40 percent greater than the top end VHA podiatry salaries.

Heretofore, the demographic for those seeking employment under VHA used to be board certified, seasoned professionals who came with many years of experience and who wanted to make careers in Federal service. Podiatrists currently employed by VHA remain in the system primarily for one of two reasons: either they have a refined sense of purpose and wish to give of themselves out of a sense of commitment to our veterans, or they do so because they themselves are veterans and they are compelled by a continued sense of mission tending to the medical needs of their comrades in arms.

I have said many times the VA hospital system is the only health care system that I have ever known where you will see a patient with one leg being pushed to his appointment in a wheelchair by a patient or volunteer with one arm, and they don't know each other. Veterans get this.

These good-hearted providers are getting harder to find and even harder to keep. Podiatrists with less than 10 years of experience make up 60 percent of the new hires at VHA. The VHA podiatry workforce has effectively become the private sector's farm team now being filled by younger, often nonboard certified providers who seek to acquire the required case volume and diversity to qualify to sit for their board certification examinations, and after passing, take those skills to the private sector where they can manage—where they can make a fair wage in order to repay a student debt burden that often averages and exceeds $194,000.

Specifically in 2016, only 30 percent of new hires were board certified. Until then—until we can offer better compensation, this has and will continue to trickle down to affect patient access, because skilled, board certified, experienced practitioners can manage larger patient populations more efficiently than inexperienced, younger professionals.

To make matters even worse, in 2016, the VA's average delay in hiring a podiatrist to fill a vacant position was 14 months. That means 14 months of patients having to seek care elsewhere or forego necessary foot and ankle care all together.

Based on the salary.com data mentioned earlier, the takeaway message is that the VA's top performing podiatrists, those making the highest possible salaries in the VA, are paid about 25 percent less than the median salaries of their non-VA counterparts, and in most cases, only about half of what the top non-VA performers earn.

In hospital leadership positions, both in the public and private sectors, podiatrists have had the oversight of numerous surgical and medical subspecialties, utilizing an insight of core and fundamental medical and surgical principles. These principles, coupled

with consultation and input from the chiefs of the respective medical and surgical colleagues that they oversee, provide for an effective leadership model.

Should a podiatrist be the chief of a subspecialty like neurosurgery or orthopedists, should—or orthopedics? The answer has to be, no more than a neurosurgeon or orthopedist should be the chief of podiatry. But that does not mean a podiatrist who is the overall chief of all the surgical subspecialties can't work with and oversee and provide effective administrative leadership of those departments with collaborative input from the subspecialties with whom they work.

In conclusion, Dr. Chairman, Ranking Member, and Members of the Committee, I thank you again for inviting me here to share my thoughts with you all and for your efforts and your desire to discuss this topic to hopefully right this inequity. I am available to address any questions you may have for me.

[THE PREPARED STATEMENT OF STEVEN L. GOLDMAN APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Dr. Goldman.

Dr. Rubenstein, you are now recognized for 5 minutes.

STATEMENT OF SETH RUBENSTEIN

Dr. RUBENSTEIN. Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee, I welcome and appreciate the opportunity to testify before you today on behalf of the American Podiatric Medical Association. I commend the Subcommittee for its focus to assist and direct the Veterans Administration to effectively and efficiently recruit and retain qualified medical professionals to treat veteran patients and improve access to quality health care in the VA.

I am Dr. Seth Rubenstein, member and trustee of the American Podiatric Medical Association. I am before you today representing the APMA, the podiatric medical profession, and specifically our members currently employed and those seeking to be employed by the VA. I do not represent the Veterans Administration in my capacity today, though I bring with me knowledge of widespread disparity between podiatric physicians and other VA physicians.

Dr. Chairman, the VA's qualification standards for podiatry were written and adopted in 1976. Podiatry starkly contrasted with other physician providers at the time and, for that matter, with what podiatry is today. Unlike 41 years ago, current podiatric medical school curriculum is vastly expanded in medicine, surgery, and patient experiences and encounters, including whole body history and physical exams. Back then, residencies were few and not required for licensure. Today, there are mandated standardized, comprehensive 3-year medicine and surgery residency positions of sufficient number to satisfy the full number of our graduates, with 63 positions housed within the VA, each requiring completion of a broad curriculum comparable with medical and osteopathic residency training.

Today's podiatrists are appointed as medical staff at the vast majority of hospitals and they serve in leadership roles within those institutions, including but not limited to chief of staff and chief of surgery. Podiatric physicians also serve as members of their State

medical licensing board. Many of my colleagues have full admitting privileges and are responsible for emergency and trauma call.

The competency, skill, and scope of today's podiatric physicians has vastly improved since 1976. Because of this, CMS recognizes today's podiatrists as physicians and TRICARE recognizes us as licensed independent practitioners.

The veteran patients we treat, often plagued by socioeconomic and psychosocial issues, are ailing, have more comorbid disease and disproportionately poor health status compared with their nonveteran counterparts. Such patients suffer from a greater burden of diabetic foot ulcers, amputations, and associated complications. As documented in my written testimony, almost 2 million veterans are at risk of amputation secondary to diabetes, sensory neuropathy, and nonhealing foot ulcers.

Dr. Chairman, the veteran population is far more complex to treat than patients in the private sector. One of the major missions of podiatrists as providers of lower extremity care is amputation prevention and limb salvage, which provides a cost savings to the VA and plays an integral role in a veteran's quality of life.

As part of an interdisciplinary team, podiatrists independently manage dermatologic, rheumatologic, and orthopedic pathology and trauma within our relative scope of practice. We assume the same clinical, surgical, and administrative responsibilities as any other unsupervised medical or surgical specialty. Despite this equality in work responsibility, there exists a marked disparity in the recognition and pay of podiatrists as physicians within the VA.

The majority of new podiatrists recently hired within the VA have less than 10 years of experience and lack board certification. The majority of these individuals will separate from the VA within 5 years.

Seven years ago, APMA leadership made VA recruitment and retention a top priority. Since then, we have alerted the VA to our concerns, and in response, former Under Secretary Petzel created a working group, with whom we participated in several meetings and from whom we received support for a legislative solution to address this issue.

I come before this Committee today to respectfully request that Congress help the VA and its patients by passing legislation to recognize podiatric physicians and surgeons as physicians in the physician and dentist authority. We believe that changing the law to recognize podiatry, both for the advancements we have made to our profession and for the continuing contributions we make in the delivery of lower extremity care for the veteran population, will resolve recruitment and retention problems for the VA and for veterans.

Dr. Chairman and Members of the Subcommittee, thank you again for this opportunity. This concludes my testimony. I am available to answer your questions.

[THE PREPARED STATEMENT OF SETH RUBENSTEIN APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Doctor.

Dr. Ficke, you are now recognized for 5 minutes.

STATEMENT OF COLONEL JAMES FICKE

Dr. FICKE. Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee, on behalf of the American Association of Orthopaedic Surgeons, which represents over 18,000 board certified orthopedic surgeons, and the American Orthopaedic Foot and Ankle Society, which represents over 2,200 orthopedic surgeons specializing in foot and ankle disorders, I thank you for the opportunity to speak to you today about lower extremity care for veterans.

My name is Colonel James Ficke, retired, and I am an orthopedic surgeon specializing in foot and ankle care. I am currently the chairman of orthopedic surgery at Johns Hopkins School of Medicine. I served in the United States Army for 30 years, deploying to Iraq from 2004 to 2005 as a deputy commander and chief medical officer for the 228th Combat Support Hospital in Mosul. I have led the Extremity War Injuries Project Team for 12 years, an effort focused upon improving care of warriors who have sustained battlefield injuries. This effort has identified the gaps in knowledge as well as research needs that have shaped the generous congressional funding of over $330 million for veterans with limb injuries commonly sustained in combat.

There are many orthopedic surgeons serving the veterans proudly through the VA and many others caring for veterans through the Choice Program. Orthopedic surgeons play a role in saving limbs, reconstructing function, and returning veterans to a healthy, active lifestyle. The AAOS was honored to receive a Joint Warfighter Program award in collaboration with the Major Extremity Trauma Research Consortium, the purpose of which was to determine the best evidence for treatment of injuries to our warriors, including lower extremity injuries. We are honored to receive that support with your effort—through your effort, Dr. Chairman, and we appreciate your many years of support for orthopedics and our patients.

We acknowledge the significant need for access and for care of veterans through the VA with lower extremity conditions. Current statistics are staggering regarding the burden of injury and the disability. My own teams have reported and published literature showing that up to 92 percent of warriors with battlefield injuries will have permanent disability of the musculoskeletal system. As of April 2017, 6,920 men and women have given their lives in the defense of our Constitution, and 52,540 men and women have sustained wounds in action, of which as many as 80 percent involved a limb injury, and many of these are lower extremity.

We absolutely agree that musculoskeletal care for veterans is imperative. We will only meet these needs with a strong force of well-trained providers of all backgrounds, including podiatric surgeons and physicians and orthopedic surgeons.

Concerning H.R. 1058, the VA Provider Equity Act, the orthopedic surgeons of the AAOS strongly agree and support that high quality podiatric surgeons should be more equitably compensated to support their recruitment and their retention. Podiatrists are an essential part of the care team at the VA and provide excellent service to veterans. During my service in the Army, I practiced alongside podiatrists in many military bases and had a podiatric surgeon on my staff at Mosul, who served in a nonclinical leader-

ship role, Lieutenant Colonel John Gouin, Doctor of Podiatric Medicine.

The American Association of Orthopaedic Surgeons and the Orthopaedic Foot and Ankle Society are concerned with two aspects of the legislation that are not essential to the goal of paying podiatrists what they are worth at the VA. Firstly, this legislation would label podiatrists who have the Doctor of Podiatric Medicine, or DPM, within the VA as physicians, including them in a category currently reserved for doctors of medicine and doctors of osteopathy. Secondly, the bill would allow DPMs to attain clinical leadership positions over MDs and DOs.

Podiatrists and orthopedic surgeons are trained differently. The lower extremity is one of the more complex areas of the human musculoskeletal system, and an orthopedic surgeon will attend 4 years of medical school, serve a 5-year orthopedic surgery residency, and then typically take an additional year of subspecialty fellowship training. All MDs and DOs are trained in multisystem clinical care and disease management, which is not the case for all podiatrists, and it is a prerequisite for peer review of physicians.

While recent changes have improved podiatric education, it is not the same as the multisystem medical education required to become a DO or an MD, nor is it the same accreditation process. Podiatry does not participate in the United States Medical Licensing Examination, which is the standard for all advanced medical care and essential to practice as a physician. We believe that the title of physician should be attained through the accreditation process and not the legislative process.

The AAOS and the AOFAS stand ready to work with the Subcommittee in good faith to improve this legislation and to improve the care of veterans provided by both orthopedic surgeons and podiatric surgeons.

Thank you for the opportunity to appear before the Subcommittee and for your work on behalf of our Nation's veterans. I look forward to answering any questions you may have.

[THE PREPARED STATEMENT OF JAMES FICKE APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you very much, Dr. Ficke.

Mr. Brandt, you are now recognized for 5 minutes.

STATEMENT OF JEFFREY M. BRANDT

Mr. BRANDT. Chairman Wenstrup, Ranking Member Brownley, and Members of the Committee, thank you for inviting AOPA's insights regarding lower extremity care for veterans. My name is Jeffrey Brandt, and I am the CEO of Ability Prosthetics and Orthotics. We work with seven VAMCs to provide prosthetic and orthotic services to veterans across VISNs 4, 5, and 6.

Nationally, 80 to 90 percent of veterans' orthotic and prosthetic care, known as O&P, is provided within the community. The private sector's procurement relationship with the VA and its workforce must be a part of any discussion of care for veterans with limb impairment or loss.

TBI and amputation are signature injuries of Iraq and Afghanistan. As of June 2015, more than 327,000 servicemembers had suffered a TBI, which can require orthotic management. More than

1,600 amputations had been performed for wounded warriors, with 80 percent affecting one or both limbs. But most amputations are a result of diabetes or cardiovascular disease. In 2016, the VA served 89,921 veterans with amputations. Seventy-eight percent of veterans undergoing amputation last year were diabetic.

AOPA commends the VA for its leadership granting access to advanced prosthetic technology, often before Medicare or private insurance. AOPA is also deeply grateful to the VA for rejecting a devastating prosthetics proposal put forward by the Centers for Medicare and Medicaid Services in 2015.

When it comes to O&P care for individual veterans, in my experience, it is very uneven. Some VAMCs have excellent clinicians, embrace innovation, and maintain cordial working relationships with the private-sector providers providing the majority of care to veterans. In other places, VA staff appear not to be very knowledgeable about O&P. Some treat private providers as though we are competing for patients, or we are just in it to take advantage of the taxpayer.

There are many advantages to veterans from the private-sector partnership in O&P. Veterans receive the care they need more quickly. Care can be provided closer to the veterans' homes or workplaces. We often adopt cutting-edge practices and implement innovations earlier than our Federal agency colleagues. For example, at Ability, every new patient receives three objective evaluations to establish their K-level, or capacity for activity, and determine what technology is appropriate given that classification. But the VA very often does not use such tests or even a consistent approach in determining those K-levels.

Frequently, the VA won't accept our evaluation, even if we have more O&P expertise and are using a more rigorous evaluation. If we call or write the VA to say our evaluation shows that the patient is, for example, a K2 and wouldn't benefit from microprocessor control technology, we often hear comments like, "to be on the safe side, all my patients get that technology."

Conversely, when our evaluation shows the veteran needs more advanced technology than the VA perhaps recommended, we find ourselves accused of lining our own pockets. At that point, I have a choice: I can continue to advocate for my patient at the expense of my relationship with the VA, or I can fill a prescription my assessment tells me is not best for my patient. If the veteran comes back 10 times in the next 6 weeks because the prosthesis wasn't fit properly, then the veteran hasn't been served, and our reputation is damaged.

All of this could be averted by use of proper clinical protocols by the VA, and better collaboration with outside providers.

Sometimes patients come to us having heard about new technology. It is hard to tell a patient he or she doesn't need the device that was featured on a magazine cover. Our tests and data help patients understand and accept those difficult determinations. The VA, with its concerns of fraud and abuse, should welcome an approach that objectively determines patients' needs.

I do see some things changing, though slowly, in some parts of the VA. Some recent RFPs have more emphasis on outcomes, data,

and objective evaluations. But that change is uneven and slow, and it is the veterans who suffer the most with those delays.

Now I would like to turn to a challenge facing both the VA and private-sector providers, and that is maintaining a highly qualified workforce. Demand for O&P is increasing, experienced clinicians are retiring, and we have got a shortage. Already in California and Florida, an advertised opening can take longer than 12 months to fill. Currently, 13 universities offer O&P master's degrees, graduating fewer than 250 students annually. These positions pay good wages and can't be outsourced overseas, but master's programs are costly to expand.

The Wounded Warrior Workforce Enhancement Act, introduced with bipartisan support by Representative Cartwright in the last Congress would help. This bill is a limited, cost-effective approach to assisting universities in creating or expanding accredited O&P master's degree programs. Priority is given to the programs that have a partnership with the VA or DoD facilities, so students learn to respond to the unique needs of servicemembers and veterans. We need this bill, and I ask for your support.

AOPA looks forward to working with you to meet the needs of veterans with limb loss and limb impairment. No veteran should suffer from decreased mobility or independence because of lack of access to high quality care, regardless of where it is provided.

Thank you for considering my comments today. I would be happy to answer any of your questions.

[THE PREPARED STATEMENT OF JEFFREY BRANDT APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Mr. Brandt.

Dr. Robbins, you are now recognized for 5 minutes.

STATEMENT OF JEFFREY ROBBINS

Dr. ROBBINS. Thank you.

Good afternoon, Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee. My name is Jeffrey M. Robbins, and I am the national program director for podiatry services for the VA's central office. Thank you for the opportunity to discuss lower extremity injuries and conditions among veteran patients and the ability of VA to recruit and retain high quality providers.

The VA's podiatry service is dedicated to the mission of providing high quality foot and ankle health care to veterans. In fiscal year 2016, the podiatry service cared for some 577,000 unique patients in over 1.4 million encounters. This is a 12 percent increase over fiscal year 2014.

Podiatrists treat a wide variety of conditions, including major foot deformities from both battle and other service-related injuries, to wound and amputation care for those with traumatic and chronic disease-related amputations. Podiatry service performed almost 16,000 operating room procedures in fiscal year 2016 alone.

In addition to my role as national program director for podiatry services, I am also the national chairman for the VA's Amputation Prevention Program, currently called Prevention of Amputation in Veterans Everywhere, or PAVE.

The VA has been engaged in amputation prevention since 1993, after Public Law 102-405 in 1992 established the importance of high quality amputee, and identified veterans with amputations as a special disability group.

In 2006, the VA Oversight Committee recognized that we needed to address new traumatic amputees from Operation Iraqi Freedom and Operation Enduring Freedom. In order to determine those needs and write effective policy, I have visited Walter Reed to speak with veteran amputees, their families, and their caregivers. As a result of those conversations, the 2006 directive on this matter added a mandatory offer of a mental health consultation to any veteran who had or was about to undergo an amputation. This consultation was aimed to address the adjustment disorder common in those who have lost a limb, regardless of cause.

In 2012, the VA's Amputation Prevention Program was identified as an innovation by the Amputation Coalition of America, not only for its evidence-based program, but also for its continuous quality improvement. In fact, the latest directive was signed on March 17, 2017.

The VA cares for 1.7 million veterans at risk for amputation, of which 1.5 million suffer from diabetes, 46,000 suffer from end-stage renal disease, and 617,000 have peripheral vascular disease. Overall, the VA treats over 66,000 patients yearly who have suffered an amputation, with more than 6,000 veterans having undergone an amputation in fiscal year 2016.

Podiatry services are provided in 134 medical centers and many VA community-based outpatient clinics, and VA podiatry is an extremely hardworking service. However, our compensation system has fallen behind the times, as the current pay authority is over 41 years old and was established when podiatric medicine was a very different profession. As a result, it has been increasingly difficult in the past several years to recruit and retain experienced providers.

To illustrate this point, in fiscal year 2015 and 2016, we brought in 142 new hires, for a net gain of 54. What this means is that 88 providers left the system, or almost 62 percent of medical centers had to replace providers, disrupting patient continuity. Additionally, in 2016 alone, the national podiatry standards review board processed 53 new hires. Of those 53 new hires, 66 percent had less than 10 years of experience and only 30 percent were board certified.

The pattern that has emerged that in the past several years is one of young providers coming into the system, gaining experience, as well as their cases for board certification, becoming board certified, and then leaving for the private sector, where the average compensation, the average compensation is $30,000 higher than the highest compensation in the VA. In fact, 58 percent of our pay regions have reached the legislative cap established in 1976, making it extremely difficult to recruit and retain staff.

The podiatrists that make up the VA's podiatry services are all proud to provide the best care they can to Americans' veterans. We are also proud that this includes many veterans within our ranks. As a service, we are dedicated to continuous improvement and continue to look for ways to improve how we care for veterans. As

such, the Department of Veterans Affairs supports H.R. 1058, the VA Provider Equity Act.

Thank you for this opportunity to address this Committee, and I look forward to your questions.

Mr. WENSTRUP. Thank you, Dr. Robbins.

I thank all of you. I am going to now yield myself time for questions and comment.

First of all, Mr. Brandt, I want to thank you very much for your testimony today, and I look forward to working with you and your profession on how we can increase capabilities and fulfill the needs of so many of our veterans. And those numbers, as you know, are growing and the need for your profession is greatly needed.

On the podiatry issue, it first came to my attention, not really because I am a podiatrist, but because I serve on this Committee, and it was brought to our attention by Secretary McDonald during the last term that there was a tremendous shortage of podiatry, there was a reason for the shortage, and the need was tremendous. And at that time, the Secretary and his staff put together a paper on the idea of being able to fix this problem by moving podiatric physicians and surgeons into the category of physicians and surgeons, which they are under Medicare and throughout the States. And that would solve the problem, increase the pay, and the problem would be solved. We ran into some roadblocks in the Senate, as we did get a bill to do that through the House of Representatives.

You know, first of all, I want to say that this is not about the provider as much as it is about the patient. This is about the veteran in need of care. And you are going to hear of situations and the long waits, and you have heard about it today, for so many that seek the expertise of podiatry. And this is about recruitment, retention, and, therefore, access for our veteran patients.

We say, do no harm. Right now, those that are being harmed are our veterans that do not have access to podiatric care because of the inability of the VA to recruit and retain in the way that they could if this problem was corrected. So I thank the Secretary and the current Secretary for their VA paper, which is now in the record.

I want to be clear. This is not a scope of practice issue. This is not about expanding the realm of credentialing that a podiatrist has or has had. It is about access, access that is stymied by a classification, by a limited career path for podiatrists, and opposition that has come against the notion of moving podiatrists into the category of physicians and surgeons.

We talk about education. Podiatry is a medical school curriculum, 4 years after 4 years of college. During that medical school curriculum, there are 2 years of lower extremity biomechanics that is unique to the profession. There is a 3-year surgical residency. When completed, podiatrists have a full prescribing license, and they are licensed to do complete body history and physical examinations. Now, that isn't because it was just granted; it is because it is part of the training.

Just for some comparison, because I am listening to some of the things that were said, so I have a question for Dr. Ficke. You have,

within the American Academy of Orthopaedic Surgeons, a foot and ankle society. Is that correct?

Dr. FICKE. Yes, there is a foot and ankle society.

Mr. WENSTRUP. And you are a member of that?

Dr. FICKE. That is correct.

Mr. WENSTRUP. Okay. Is there a board that you need to take to become a member, like there is for hand, say, within orthopedic surgery?

Dr. FICKE. There is a board of orthopedic surgery, and I sit on that board. I write questions for that board as a foot and ankle surgeon.

When one is in the process for which you are asking, the person is eligible at the completion of 5 years of orthopedic surgery residency. They sit for a written examination. I am one of the question writing task force for the written questions. After 2 years of case collections, those cases are collected and submitted. Those cases are peer reviewed. When a person is, as a specialty of foot and ankle, like hand, they sit for their ABOS, the American Board of Orthopaedic Surgeons, on a panel of fellowship-trained, board certified orthopedic foot and ankle surgeons, at the end of 2 years of collection. When they are—they succeed in the oral boards, which is, again, 2 years after a 5-year residency, they are qualified as American Board of Orthopaedic Surgeons. There is not a certificate of additional qualification for foot and ankle surgeons.

Mr. WENSTRUP. So when you—do you need—there are 1-year fellowships after the 5-year residency in foot and ankle that are available?

Dr. FICKE. That is correct.

Mr. WENSTRUP. Does everyone in the society, are they required to complete that fellowship?

Dr. FICKE. Everyone in the—which society? The Foot—

Mr. WENSTRUP. The foot and ankle.

Dr. FICKE [continued].—and Ankle Society? No. The Foot and Ankle Society is, by its constitution, embraced for anyone who has a practice or has an interest in foot and ankle surgery after they have completed—

Mr. WENSTRUP. But not specifically the fellowship—

Dr. FICKE [continued].—a foot and ankle—

Mr. WENSTRUP [continued].—like you have completed and—

Dr. FICKE [continued]. That is not a requirement for the Foot and Ankle Society.

Mr. WENSTRUP. Okay. And I hope things have changed, because I am looking at a study—you are familiar with Foot and Ankle International? Is that an orthopedic journal?

Now, this is a while ago, so maybe things have changed. And your process for foot and ankle sounds like it is up to the same measure that exists for podiatry, as far as oral exam, written exam, and case presentation. But this abstract from this article, "Foot and ankle experience in orthopedic residency," says: Current residency training in the United States does not universally require commitment to foot and ankle education. A large number of residency programs do not have a faculty member committed to foot and ankle education, and almost one-third have no time specifically allocated to foot and ankle education.

Has that changed in orthopedic residencies?

Dr. FICKE. Dr. Chairman, could you tell me the date of that publication?

Mr. WENSTRUP. Yeah. It was a while ago. It was 2003.

Dr. FICKE. 2003? Yes, I am familiar with that study.

As a result of the 2003 paper, which is, you know, 14 years ago, there has been a radical change in education. The Foot and Ankle Society as an organization has put out a series of lectures, has—and, really, everyone who is board certified in orthopedic surgery is required to do a series of milestones, and the milestones project is accredited—the ACGME, the American Council on Graduate Medical Education, is really the entity that reviews the milestones. And the milestones, including foot and ankle surgery, require a rotation, require a certain number of minimums.

Mr. WENSTRUP. So since that time—

Dr. FICKE. Radically changed, similar to the podiatry residency that we all agree have changed.

Mr. WENSTRUP. Requirements.

Okay. One of the things that—I guess for Dr. Goldman, and I want to know if you agree with this statement or not from Dr. Ficke, it says: MDs or DOs participate in active clinical care and multisystem trauma and disease management, which is not the case for all podiatrists, and is a prerequisite for peer review oversight.

Would you agree that is not the case for all podiatrists today?

Dr. GOLDMAN. If you could repeat the question, sir. I am sorry.

Mr. WENSTRUP. Yeah. Well, the comment was that—do podiatrists basically actively participate in multisystem trauma and disease management in their training?

Dr. GOLDMAN. I would say we do, along with our medical colleagues. Certainly, we have scopes of practice that we all work within, and with that, certainly there is a collaborative effort with any system condition that we may experience, whether it be infectious disease, primary care, internal medicine, vascular surgery, that we will collaborate that effort.

Mr. WENSTRUP. And participate actively in the care of that patient—

Dr. GOLDMAN. Yes, sir.

Mr. WENSTRUP [continued].—correct, especially in residency training?

Dr. Ficke, you had a concern, I believe, when we talked before and today about the administration roles of podiatrists. And I think your concern predominantly was clinical oversight, podiatrists over orthopedists or, for that matter, any other specialty.

Dr. Robbins, could you clarify for me, can a podiatrist have clinical oversight over an orthopedic surgeon in the VA?

Dr. ROBBINS. No, not clinical oversight. That is actually a joint commission requirement that peers evaluate peers. So, for example, if a urologist was a chief of surgery, they couldn't do an ongoing professional practice evaluation on an orthopedist, or a psychiatrist couldn't do it, and so on. That has to be peer to peer.

Mr. WENSTRUP. And that makes sense to me. You know, you should be able to be within your own section. So as far as that concern, it sounds like you can't do it anyway, so hopefully that is

clarified. And I would agree with that 100 percent with you, Dr. Ficke.

I want to applaud you for your 30 years, I believe, of military service, your deployments, and all that you have done for our troops. And I have enjoyed working with you on many issues and hope to continue to do that. We may have a little disagreement here on some things today, but I do extend that and truly mean that.

One of the things—you talked about your roles in theater as deputy commander. I also served as a deputy commander of clinical services. I was the assistant to the DCCS, but for 3 months, I was the DCCS, and served at the same time as chief of surgery in that role, and things went well. And I think it is a small world story to be able to say that I was appointed to those positions by your medical school roommate, Jim Terrio.

So I just wanted to clear some things up. And I want to give other people a chance to ask their questions. And with that, Ms. Brownley, you are now recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman. And I would agree with all of your arguments around the need for more services to our veterans. The only thing I would take objection to is when the problem arise that you weren't sought out because you were a podiatrist but because you were a Member of the Committee. I think it has to be both.

Mr. WENSTRUP. Well—

Ms. BROWNLEY [continued]. Anyway, I wanted to ask Dr. Robbins, you gave some statistics about the rise of podiatric need within the VA. Can you just give me a quick explanation why that increase has occurred? It is pretty significant.

Dr. ROBBINS. It is quite significant, and partially due to returning vets from the three theaters now, Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn, with new problems, these are young people, very complex problems, they want to stay active, and they require, especially if they have lower extremity injuries, they require good podiatric biomechanical care.

We also have a significant aging population that are coming to us with diabetes, end-stage renal disease, peripheral vascular disease, that are at extremely high risk for an amputation.

The VA also takes a much more enlightened approach about what kind of basic foot care we provide. So veterans who are blind can't get podiatric care in the private sector, patients who have dementia cannot get podiatric services in the private sector, patients who have movement disorders, like Parkinson's, anticoagulation therapy, severe debilitating arthritis.

We expanded that scope of eligibility for veterans back in 2002 as we saw that, especially with the aging population coming down the pike, that they were also at risk for amputation, and, more importantly, for quality of life. When you lose the ability to walk, your life expectancy goes down significantly. So we expanded that, and that is the reason that we are seeing increasing numbers of veterans seeking podiatric care.

Ms. BROWNLEY. Thank you very much. And in terms of the salary schedules within the VA, it is my understanding that they have been in effect since 1976. Is that correct?

Dr. ROBBINS. Yes, ma'am.

Ms. BROWNLEY. And as someone responsible for these services to veterans, why is it that this hasn't been revisited in terms of salary schedules?

Dr. ROBBINS. I have actually revisited for the last 11 years writing legislative proposals to move podiatry into the same pay authority as other physicians and dentists. What has occurred is that we have gotten full support through VHA, but when it got up to VA and OMB, because it had a price tag on it of any sort, it was kicked back.

In addition to that, the OMB looked at it and said, well, it looks like you can hire new podiatrists. We don't really care about their experience. It appears you can hire podiatrists. So that also when—I made the argument that we can't hire highly experienced providers, that we were getting inexperienced providers or older providers without board certification, that sort of fell on deaf ears, and here we are 11 years later.

Ms. BROWNLEY. Thank you for that. It seems like it has been an ongoing issue.

So, Dr. Ficke, if you could talk a little bit about—I think you mentioned it in your testimony, but—and I only have a minute left, but if you could talk a little bit about, going back to the accreditation requirements and, you know, comparing the two, but could you kind of explain the barriers, from your vantage point, barriers a podiatrist may have in providing administrative oversight and leadership as a medical director?

Dr. FICKE. Yes, ma'am. I am seeing 30 seconds to try to answer this. We will do our best.

The question, first of all—

Ms. BROWNLEY. The Chairman is giving us a little more time.

Mr. WENSTRUP. You can have more time.

Dr. FICKE. Thank you, Dr. Chairman.

And to attribute this, Dr. Chairman mentioned that he served as the assistant deputy commander for clinical services. And I will attest that at that time, Lieutenant Colonel and now Colonel—congratulations, sir—Wenstrup did a fantastic job, and by our mutual friendship with Jim Terrio, who was the deputy commander, said he was exceptional.

There is no question that leadership is a character quality. Congressman Wenstrup demonstrates that, we all would agree. Leadership as a character quality has nothing to do with orthopedic surgeons, podiatric surgeons, or any other training. It is a character quality, bar none.

So that the obstacles to these really have to do with administrative leadership, which is, as I have said—and we all agree, chief of staff, commander of a hospital, president of a hospital, those are roles that offer leadership enticement. And we completely agree that those are roles that if they provide incentives that are nonmonetary but job satisfaction for any provider, especially in this situation, podiatric surgeons, who we need in the VA, we completely endorse that. I hope that answers your question.

Ms. BROWNLEY. It does. Thank you.

And I yield back.

Mr. WENSTRUP. Dr. Dunn, you are now recognized for 5 minutes.

Mr. DUNN. Thank you, Mr. Chairman. And thank you also to the members of our expert panel here for devoting your time and your expertise to our veterans.

Colonel Ficke, I am impressed by the vast—I too am impressed by the vast body of your military service and accomplishments. I served in the U.S. Army Medical Corps the same time as you did. I am sure I—we didn't—I don't recall crossing paths with you, but it is a big army. I think it would be fun for us to get together sometime and swap social stories.

I want to ask you a couple of questions, and please don't take any umbrage if it appears that I am disagreeing with your conclusions. I am just trying to understand how you arrived at those conclusions and how important you think your conclusions are to the questions that we are addressing here today.

So the first one was, you evinced a concern that the term "physician" would be used to refer to podiatrists. I have been a civilian for over the last 20 years, and in the civilian world, the term "physician" has long since left the barn. It has migrated to a wide variety of health care practitioners. As a matter of law in Florida, chiropractors can use the term "acupuncturists."

So I wonder how important is it to our veterans, our patients, the ones that we treat in the VA that we continue to hue to the classic use of the term "physician" only to refer to MDs and DOs? And I will wait for your answer on that.

Dr. FICKE. Thank you for your question. I certainly take no umbrage, Mr. Congressman.

The statement that I made was that the definition by Merriam's dictionary and several other organizations for "physician" is that they have passed the U.S. Medical Licensing Examination. There are many doctors, there are doctors of chiropracty, there are doctors of physical therapy. That is by no implication lesser or more, superior or inferior. It is a definition.

I don't think that—and so I would—you asked how important that is. I think it is the least important aspect of this testimony or this bill.

The American Academy of Orthopaedic Surgeons, the Foot and Ankle Society, both agree that the VA desperately needs foot and ankle care. So we have more in common, I believe, than we do differences.

Let me ask—let me make one clear point. The difference is there are six core competencies recognized by the double AMC, the American Association of Medical Colleges. Those six core competencies, one critical of those is systems-based practice. That creates the education, the basis for care of all systems.

We are not trying to make something of this that it isn't. That is not one of the core competencies of the APMA or the podiatric education process. They have six core competencies, but they don't have systems-based practices. I don't—I really—

Mr. DUNN. So the actual term "physician" isn't—

Dr. FICKE [continued]. I think the most important aspect of this is that we are—that our public and our veterans need to understand that there are differences in training, make the decision.

Mr. DUNN. All right. Let me go to the second question, then, also for you, Dr. Ficke. So you have evinced a concern about, and we

have began to address this, right, just before, a podiatrist's clinical leadership. And certainly in academia, such as Johns Hopkins, it would be unheard of to have a podiatrist be the chief of orthopedics. But in the military, when I was a surgeon, I had commanding officers and leaders in the hospital who were medical service corps officers, there was hospital administrators for the nonmilitary, and nurses and whatever, and I never felt that that was a problem for me or my patients in terms of how we applied our clinical judgment or our surgical practices.

And I think that you mentioned, Dr. Robbins, that in the VA, the rough—you know, we wouldn't have a urologist overseeing an orthopedic surgeon, even though that sounds pretty good to me as a urologist, but anyway.

So what was your concern about the clinical leadership as it were? So is it okay to have a chief of surgery in a VA hospital who is not an MD or a DO?

Dr. FICKE. Yeah. So—yes, sir. I had addressed that concern as far as the leadership opportunities. We agree completely. There was a point in my career not far—long ago that I had no single physician in supervisory roles over myself.

Mr. DUNN. I am running out of time, so just let me say, Colonel, thank you very much again for being here, and thank you for the time you devote to our veterans. And I would seriously enjoy a chance to spend time with you in a smaller group and exchange ideas.

I yield back, Mr. Chairman. Thank you.

Mr. WENSTRUP. Ms. Kuster, you are now recognized for 5 minutes.

Ms. KUSTER. Thank you, Mr. Chairman.

I wanted to direct my questions to Dr. Robbins. Moving on from the credentialing issue, we have had a great deal of discussion, most recently, with regard to the Washington, D.C., VA, but I know this has been an issue all around the system about the delays for veterans needing prosthetics. We had a conversation just this week with our colleague, Tammy Duckworth, in the Senate about her own experience after her injuries and getting prosthetics and prosthetics that fit and prosthetics that worked and the delays.

So could you comment about describing our national procedures currently and what we could be doing to make sure that our veterans who are in need of prosthetics can get those devices in a timely way, that they fit well, that they are effective for their quality of life, any other suggestions that we should be focused on in this regard?

Dr. ROBBINS. Well, I can't answer the question from the prosthetics side since I am not a prosthetist or have any authority over prosthetics. I can address it from the provider side.

Ms. KUSTER. Okay.

Dr. ROBBINS. So we will oftentimes need to work with prosthetics to provide a shoe with a special insert for a partial amputation in order to have that veteran ambulate properly. And so we will work very, very closely with prosthetics to provide that care.

The variation in the prosthetic departments throughout the VA is quite significant. So we have some services that are outstanding, some prosthetic services, that work with podiatry get what they

need when they need it; others that don't have the same resources in order to provide that care.

And this is not something that is not something that we are aware of. This is something that we work on year after year to improve the work with the prosthetics folks. But, again, I don't run prosthetics, so I can't respond specifically to that portion of your question.

Ms. KUSTER. Who at the VHA would be in charge of that? Is that the Chief Logistics Officer? Or who works with the prosthetic companies to make sure that—I am not so concerned about the companies; I want to know at the VA—to make sure that these devices are available for your patients?

Dr. ROBBINS. We have a department of prosthetics and rehabilitative care services.

Ms. KUSTER. And do you have any suggestions for us about improvements to that department?

Dr. ROBBINS. If they are asking for more resources, they can absolutely use resources. Because, as we just heard, the VA is also having some issues getting well-qualified folks in prosthetics and orthotics that have the kinds of credentials that we now expect from those folks, and getting those people into the VA in order to provide that care.

And also—and I think that the new Choice bill addresses some of this, if I am not mistaken, from my brief review of that—it also strengthens that relationship between the private sector, so that if we can't do it, we should be able to outsource it to someone who can in time. Just-in-time care.

Ms. KUSTER. Anybody else on the panel?

And adding that dimension to it, should we be going the private route with prosthetics? Do you think we have the expertise in-house? Can we get it? What recommendations do you have for your patients to get the prosthetics that they need for their quality of life in a timely way?

Mr. BRANDT. Yes. Thank you.

So, as I testified, 90 percent of prosthetics are provided from private providers outside of the VA. If there is an initiative to decrease that, then, you know, the VA would have to look at how are they going to increase the qualified providers on staff. And then you have a similar type conversation in the O&P realm that we are having about podiatry; how are you going to attract, retain highly qualified CPOs, or certified prosthetists/orthotists, within the VA system.

If the VA believes that it still wishes to have 90 percent of that service provided through private contractors or outside contractors, then, at least through my own experience, where I start to see some of those gaps is the facilitation of those cases as a need is determined by the VA and a veteran chooses a provider.

My recommendation for veterans to get quality care is largely related to the clinical protocol or the outcomes measures, those aspects of the care that is being provided. Our field, too, has sanctified over the years our educational requirements as prosthetists/orthotists, we are now master's-degree-holding practitioners with 1 year of residency in each, orthotics and prosthetics, and pass board exams.

We are also seeing—with the advent of the quicker movement of technology, we are seeing patients that want to come out of the VA, to a private facility. Most of our private practitioners at this point have biomedical engineering backgrounds. And we have to interface with the VA system, where qualifications, skill levels, protocols are a bit hit or miss. Patient evaluations may be a bit more anecdotal. That VA determination can, many times, come down to prior experience or what has worked in the past, not objective tests and assessments.

We are sitting in the private sector with protocols, saying, all we need to do is follow these. It is not the be-all and end-all of quality care, but it is a start. Because all of us, whether private sector or VA, we all should be looking at evidence-based outcomes and supporting why we do what we do.

Ms. KUSTER. Thank you very much.

Mr. WENSTRUP. Mr. Higgins, you are now recognized for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman.

Dr. Goldman, from your posture as president of your board, is a podiatrist capable of making an accurate diagnosis of diabetes based on if it is an initial examination where a veteran has been sent to that?

Dr. GOLDMAN. Certainly, using the entire scope of what is available to us as laboratory data, clinical evaluation, we can certainly make that diagnosis. I mean, it is, unfortunately, too easy to diagnose, as we can all speak to.

Mr. HIGGINS. All right. I ask that because, in speaking with veterans—and I represent a district with one of the highest densities of veteran populations anywhere, certainly in my State. I represent 133,000 veterans, and some of them, that their initial symptoms that they noticed were foot pain and problems with their feet. And that led them eventually to a diagnosis of diabetes.

So nontreatment of diabetes leads to cholesterol and blood pressure problems, loss of vision or vision impairment. It doubles the risk of heart attack, kidney failure, neurological complications, and leads me to my next question, which will be for Mr. Brandt. Failure to treat diabetes also can lead to loss of lower limbs and amputations. People with diabetes have undergone 73,000 lower-limb amputations, on average, each year, or roughly 60 percent of total amputations.

And you stated, Dr. Brandt—we have just heard Dr. Goldman say that a podiatrist, a modern podiatrist, can make an accurate diagnosis of diabetes. If you disagree with that, please tell me.

But, in your written statement, you stated that "the VA staff making decisions, in some cases, affecting lower-extremity care appear not to be particularly knowledgeable about prosthetics and orthotics. Some VA prosthetic and orthotic clinicians welcome the partnership with private providers, while other VA staff seem to believe that some private-sector providers are in competition with them for patients."

So my question, Dr. Brandt, is: How would you suggest the VA improve coordination and communication with community prosthetic and orthotic providers? And what are the costs to veteran patients if effective coordination and communication is not in place?

Mr. BRANDT. Thank you for your question. And to clarify for the record, I am not a doctor. I am just, for the record, Mr. Brandt.

Thank you for that—

Mr. HIGGINS. Did I call you "Dr. Brandt"?

Mr. BRANDT. You did.

Mr. HIGGINS. Well, congratulations. You have been promoted.

Mr. BRANDT. So, number one, the first part of your question—I am sorry.

Mr. HIGGINS. I am asking regarding the coordination with private—

Mr. BRANDT. Right. So—

Mr. HIGGINS [continued]. Regarding prosthetics and orthotics.

Mr. BRANDT. I am sure the association could put a detailed position forward on what could be done in the VA to facilitate more collaboration and coordination of care.

As for me, my personal experience, that is a big topic. It ranges from the qualifications of those certified prosthetists/orthotists or their credentials, to continuing education, to—

Mr. HIGGINS. But you believe your organization could provide for this Committee a specific recommendation regarding that?

Mr. BRANDT. Correct.

Mr. HIGGINS. Could you get that to us down the line? I have one more question for you.

Mr. BRANDT. Yes, I can. Thank you.

Mr. HIGGINS. Okay.

Your testimony indicates that, in an effort to reduce costs and eliminate fraud and abuse, the VA dismisses clinical recommendations made by community partners. However, you also state, "The VA often will make unnecessary purchases for prosthetics which wouldn't benefit the patient."

Could you speak more on that a little bit for us, please?

Mr. BRANDT. Right. I think the easiest way to describe it is we see instances of overprescription and underprescription. Correcting this fits very nicely into outcomes measures, or attempting to baseline patients. There are ways to score patients regarding their functional levels, and then you can track that through the treatment of a veteran with limb loss, or any patient with limb loss. So, once you apply those measures, it is not a silver bullet, so to speak, but it can contribute to your overall determination of matching componentry to functional level.

So there are methods—and this is a big topic in our profession right now, which is advancing outcomes measures so that we can qualify and quantify why we are doing what we are doing. And it is not just based on things that we can't base decisions on that we might have in the past.

Mr. HIGGINS. Yes, sir. Thank you.

And I will ask, if possible, regarding both of my questions, that your organization perhaps provide to this Committee within a reasonable timeframe some specific recommendations that we may perhaps move forward to address both of these concerns.

Thank you, Mr. Chairman. I yield back.

Mr. WENSTRUP. Dr. Abraham, you are now recognized.

Mr. ABRAHAM. Thank you, Mr. Chairman.

For the panel, I am an M.D. by training. I graduated from the LSU School of Medicine in Shreveport. I have been very fortunate to practice medicine, family medicine, in the Louisiana and Mississippi Delta, treating thousands of veterans and certainly tens of thousands of civilian patients.

And when I need a higher level of care, certainly in the lower extremity, I don't look at the initials after the name; I look at the name before the initials.

And, Dr. Ficke, you alluded to that when you referenced character. And whether you are an M.D., a medical doctor, a D.O., a doctor of osteopathic medicine, or a DPM, a doctor of podiatric medicine, the patients and the veterans—to your statement earlier, Dr. Ficke, about educating that veteran as to the different standards, the different educational training of those three different specialties—the veterans and the VA, they know, but, again, the initials don't mean anything to them. These are all physicians in their mind and certainly in the mind of myself. Again, they want to be healed, and the definition of "physician" is one of a healer.

We all, when we—and Dr. Wenstrup alluded to this—when we applied to our respective medical schools, whether it was M.D., D.O., DPM, we had to write out an essay, and if we were fortunate enough to get past the essay part, we got before an admission board. And the question was always: Why do you wish to become a physician? And I assure you, for every one of us in here that are physicians, the answer was: to take care of patients. That is what we do, as physicians.

So I think it is tragic that we are arguing over semantics for our veterans when we have such a disparity of economy in the VA system between what podiatrists and other physicians get paid.

Dr. Ficke, Dr. Wenstrup, you guys practiced your profession in what I imagine is the most trying conditions, where artillery shells were literally going off around you. In some cases, you were probably dodging bullets. But you did your job, and you saved lives, and you saved limbs.

We heard today where podiatrists, D.O.s, M.D.s, we can all do physical exams. We all understand, certainly you guys, your specialties, in your specialties, you know bones, ligaments, tendons, nerves, blood vessels, and how they all are interrelated through the whole body.

So, you know, I think it is unfortunate and, in fact, silly that we are arguing over this definition of "physician" between these three specialty groups of providers here. Whether it is a DPM, a D.O., or an M.D., we are all physicians. And the only thing that should matter here, especially for our veterans since 9/11—you guys have been under the most trying conditions, hundreds of thousands of patients, unfortunately hundreds of thousands of new veterans feeding into the VA system because of these ongoing wars that we have continuously. I think we actually need to come together instead of trying to fight each other here.

And I understand, Dr. Ficke, that the USMLE doesn't recognize their board, but they have their board, and I am sure it is as good as the USMLE board that you took.

You know, I think we are better than this. I think we need to—I think we forget that, as physicians, our job, but not only that, our

passion is to do thing in this world, take care of the patient, and that is our priority.

So, semantics aside, you know, let's get this behind us. Let's get the podiatric profession and the VA up on the salary schedule, up on the respect schedule, and let's take care of these veterans.

And I appreciate it, Mr. Chairman. That is all I wanted to say.

Mr. WENSTRUP. Thank you, Doctor. And I appreciate that.

I am going to take another question here. And the statement was made about systems-based care. And I am not sure where you think that is missing in podiatry. You know, as a podiatrist, I sometimes am the first one to find someone's hypertension, congestive heart failure, vascular disease, neuropathy due to diabetes or alcohol, take a skin lesion, find a melanoma, all those things. All those things, I can tell you, I have seen and been the first to suspect, do the proper tests, and make the appropriate referral to the specialist. That is what we do.

I don't know why you are saying systems-based care is missing there. Yes, we have a scope of practice surgically that pertains to the foot and ankle, but it doesn't mean that the systems-based care and ability to diagnose or suspect or to order the appropriate tests, make the proper referral—that is what we do. That is what you do. That is what you do. If you took off a lesion on a foot and it was malignant melanoma, you are going to refer that, I would assume.

And so I think we really need to take a look at this. And as far as the definition of "physician," I have, you know, Webster's right here: "a person skilled in the art of healing; specifically: one educated, clinically experienced, and licensed to practice medicine as usually distinguished from surgery." And, in this case, we do both. Some of the definitions I looked at, it gave the example of M.D., but it didn't limit it to that.

And so for us to be hung up on this word, at the expense of veterans having a large pool of physicians able to take care of them, I think it is a shame. And I hope we can get beyond this as we move forward with this bill. And I know we will have continued discussions.

And I just want to finish by saying I appreciate each and every one of you being here today, because I do know that it is on behalf of veterans that you are all here. And we will move on from here. And I want to thank you again for attending today.

And Ms. Brownley?

Ms. BROWNLEY. I just have one quick question. And my question really, I think, doesn't directly relate to the essence of what we are talking about here relative to the specific bill.

But, Dr. Robbins, I just wanted to ask you—I wanted to go back to the salary schedule again. And if you could tell me how the VA determines the minimum and maximum allowable salaries for physicians, for dentists? And then how do they do the same determination for minimum and maximum allowable for podiatrists? Are they different, or are they the same?

Dr. ROBBINS. Yes, they are different as of 2006 when the physicians' and dentists' pay bill was passed. The physicians and dentists moved into different tables and tiers, and the podiatrists stayed in the same GS-12, -13, -14, and -15 categories as they had been, again, since 1976.

Within that process, the physicians and dentists are boarded locally, where in podiatry we are boarded nationally—and I am actually the chairman of the National Podiatry Board—and qualification standards are issued. And the ones in podiatry are from 1976, in VA Handbook 5005. And it is scary that I know that, but that is the directive that that information comes from.

So we are obligated to use those qualification standards in order for us to provide a grade and rank for podiatrists, so much so that, in the past 3 years, we have had to go through there and write equivalencies to bring it up to 2017, because a lot of the stuff written in 1976 doesn't really apply. So we had to determine equivalencies, which is a document that we use as the qualification standards now.

Ms. BROWNLEY. Thank you. I guess my question was relevant to the essence of what we are talking about today.

And just, you know, one final question quickly is, you know, how many podiatrists are really expected to retire from the VA in the next 10 years? And do we have a succession plan in place to fulfill those jobs for current and future needs?

Dr. ROBBINS. We have a significant number—I don't have the exact number, but we have a significant number of people I call "less young" that are approaching retirement age and that are going to retire. And many of those folks are the mentors and the residency directors. And someone talked a little bit about access a little bit earlier. That has a profound potential negative effect on access, as the more experienced providers, who can deal with more complex problems see patients more effectively and efficiently, are leaving the system, and younger providers, who don't have the same experiences, can't see patients as effectively and efficiently as those providers.

The best system, of course, is when you have mentor and mentee and develop that kind of succession plan. What we are hoping from this legislation is to give us the opportunity to start recruiting some of those mid-career folks who have board certification, have those experiences, to act as those mentors for our younger folks. That will provide us with that succession planning that veterans deserve.

Ms. BROWNLEY. Thank you.

And, Mr. Chairman, I yield back.

Mr. WENSTRUP. Any other questions?

Okay.

To the panel, I want to thank you all once again for good conversation today. If there are no further questions, the panel is now excused. Again, I thank you all for coming.

And I ask unanimous consent and all Members have 5 legislative days to advise and extend their remarks and include extraneous material.

Without objection, so ordered.

The hearing is now adjourned. Thank you.

[Whereupon, at 4:18 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Steven L. Goldman

Dr. Chairman, Ranking member, Distinguished Members of Congress and Guests;

At the outset I would like to express my appreciation for the honor to address this committee today. In discussing this topic, I do so as a private citizen and not as the Chief of Podiatry and Director of a Podiatry Residency training program at a Veterans Affairs Medical Center. I do so not as the former interim Chief of Surgery or the Site Director for Surgical Services at a second VA facility, and I do so not as a retired Lt Colonel in the United States Air Force Reserve who served as a podiatrist and also as Surgical Operations Squadron Commander for the last four years of my 20 year Air Force career. I am testifying as a private citizen, one who graduated almost 35 years ago and was an Associate Professor at the New York College of Podiatric Medicine for nearly 15 years, during which time I witnessed firsthand the metamorphosis of my profession. I am currently the President of the American Board of Podiatric Medicine and in this position I represent thousands of podiatrists around the country, many of whom are employed by the Federal Government. As a veteran, I am now also a consumer of the medical services of the system about which you have invited me here today to testify.

I have witnessed the best of our profession as it has grown over the past 35 years since I graduated in 1982. I am in awe of how far we have come. Today, all graduating podiatrists are three-year residency trained in podiatric medicine and surgery, and we are integral parts of the collaborative health care delivery system, providing essential services alongside our distinguished allopathic and osteopathic specialists. Today's podiatrists manage the complex nature of foot and ankle deformities and are part of the multidisciplinary team serving the needs of a seemingly evergrowing diabetic population. We take call, provide inpatient and outpatient care, respond to emergencies, prescribe medications, and independently perform surgery of the foot and ankle. Fundamentally, we perform a vital role in the continuum of health care equal to other physicians, often for a patient population whose only choice for healthcare is the VA. More often than not, those patients present with more multiple comorbidities than the average population. In the Veterans' Administration, podiatry is often the first specialty consulted for foot and ankle care services, and we provide more of these services than any other specialty.

Podiatrists in the private sector have witnessed salaries commensurate with the profession's growing skills. By contrast, salaries in the Veteran's Health Administration (VHA) have not kept pace, and the gap grows larger every day. Podiatrists in 42 percent of the regions across the country have reached legislatively capped rates of pay under VHA. What that practically means is that a podiatrist at the absolute top end of the pay charts will earn exactly the same as much less senior podiatrist, and with no hope of ever being further remunerated commensurate with the added time of service or experience. Podiatrists are defined as physicians under Title XVIII of the Social Security Act ◆1861(r)(3) [42 U.S.C. 1395x] *. The VA definition of podiatry is a vestige of a 41-year-old, antiquated, 1976 VA Omnibus Bill, and is sorely outdated. Consequently, podiatry salaries under the Veterans Health Administration are locked into the same 41-year-old pay scale. As a result, it is becoming increasingly harder to fill positions and keep people with vital skills under VHA. I think we can all agree that all of us, but particularly our veterans, deserve the very best of care. When looking at the bell curve for salaries in podiatry on salary.com, virtually no matter where you look by zip code, podiatry salaries in federal services are in the lowest 10–15 percent of that curve.

Podiatrists in leadership positions within the administration have been members of pay panels, making salary decisions for their medical colleagues who enjoy salaries that are, at the very least, 40 percent greater than the top-end of VHA podiatry salaries.

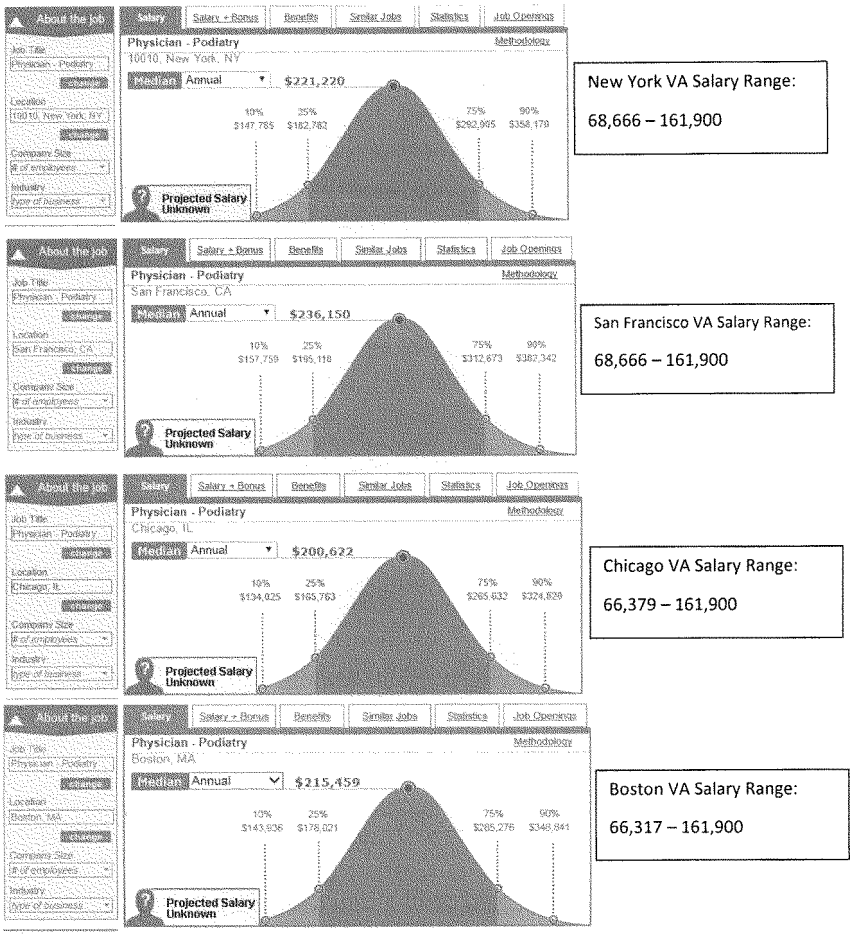
Heretofore, the demographic for those seeking employment under VHA used to be Board Certified, seasoned professionals who came with many years of experience

and who wanted to make careers in federal services. Podiatrists currently employed by VHA remain in the system primarily for one of two reasons; either they have a refined sense of purpose and wish to give of themselves out of a sense of commitment to our veterans, or they do so because they themselves are veterans and they are compelled by a continued service mission, tending to the medical needs of their comrades in arms. I have said many times, the Veterans' Administration hospital system is the only healthcare system that I have ever known where you will see a patient with one leg being pushed to his or her appointment in a wheelchair by a patient or volunteer with one arm, and they don't know each other. Veterans truly get this. These goodhearted providers are getting harder to find and even harder to keep.

Podiatrists with less than 10 years of experience make up 66 percent of the new hires at VHA. The VHA podiatry workforce has effectively become the private sector's farm team now being filled by younger, often non-Board Certified providers who seek to acquire the required case volume and diversity to qualify to sit for their Board Certification examinations and, after passing, take those skills to the private sector where they can make a fair wage in order to repay a student debt burden that averages, and often exceeds, $194,000. Specifically, in 2016, only 30 percent of new hires were Board Certified. Until we can offer better compensation, this has, and will continue to trickle down to affect patient access because skilled, Board certified, experienced practitioners can manage larger patient populations more efficiently than inexperienced, younger professionals. To make matters even worse, in 2016, the VA's average delay in hiring a podiatrist to fill a vacant position was 14 months - that means 14 months of patients having to seek care elsewhere, or forgo necessary foot and ankle care altogether.

Based on the salary.com data mentioned earlier, the take-away message is that the VA's top performing podiatrists, those making the highest possible salaries in the VA, are paid about 25 percent less than the MEDIAN salaries of their non-VA counterparts, and in most cases, only about half of what the top non-VA performers earn.

SALARY.COM VA



New York VA Salary Range:

68,666 – 161,900

San Francisco VA Salary Range:

68,666 – 161,900

Chicago VA Salary Range:

66,379 – 161,900

Boston VA Salary Range:

66,317 – 161,900

In hospital leadership positions, both in the public and private sector, podiatrists have had oversight of numerous surgical and medical subspecialties, utilizing an insight of core and fundamental medical and surgical principles. These principles, coupled with consultation and input from the Chiefs of the respective medical and surgical colleagues that they oversee, provide for an effective leadership model. Should a podiatrist be the Chief of a subspecialty like neurosurgery or orthopedics? The answer has to be, "no more than a neurosurgeon or orthopedist should be the Chief of Podiatry." But that does not mean that a podiatrist, who is the overall Chief of all of the surgical subspecialties, can't work with and oversee and provide effective administrative leadership of those departments with collaborative input from the subspecialists with whom they work.

In conclusion, Dr. Chairman, Ranking Member, and members of the Committee, I thank you again for inviting me here to share my thoughts with you all, and for your efforts and your desire to discuss this topic to hopefully right this inequity. I am available to address any questions you may have for me.

Prepared Statement of Dr. Seth A. Rubenstein

Chairman Wenstrup, Ranking Member Brownley and members of the Subcommittee, I welcome and appreciate the opportunity to testify before you today on behalf of the American Podiatric Medical Association (APMA). I commend this Subcommittee for its focus to assist and direct the Veterans Administration (VA) to effectively and efficiently recruit and retain qualified medical professionals to treat veteran patients and improve access to quality health care in the VA.

I am Dr. Seth Rubenstein, member and trustee of the American Podiatric Medical Association (APMA). I am before you today representing APMA and the podiatric medical profession, and specifically our members currently employed, and those seeking to be employed, by VA. I do not represent VA in my capacity today, though I bring with me knowledge of the widespread disparity between podiatric physicians and other VA physicians.

APMA is the premier professional organization representing America's Doctors of Podiatric Medicine who provide the majority of lower extremity care, both to the public and veteran patient populations. APMA's mission is to advocate for the profession of podiatric medicine and surgery for the benefit of its members and the patients we serve.

Dr. Chairman, the Veterans Health Administration (VHA) qualification standards for podiatry were written and adopted in 1976. Podiatric education, training and practices in 1976 starkly contrasted with those of other physician providers of the time, and with podiatric medicine as it is today. Unlike 41 years ago, the current podiatric medical school curriculum is vastly expanded in medicine, surgery and patient experiences and encounters, including whole body history and physical examinations. In 1976, residency training was not required by state scope of practice laws. Today, every state in the nation, with the exception of two, requires post-graduate residency training for podiatric physicians and surgeons. In 1976, podiatric residency programs were available for less than 40 percent of graduates. Today there are 613 standardized, comprehensive, three-year medicine and surgery residency positions to satisfy the full number of our graduates, with 64 positions (or 10 percent) of those residency position housed within the VA. In contrast to 1976, today's residency programs mandate completion of a broad curriculum with a variety of experiences and offer a direct pathway to board certification with both the American Board of Podiatric Medicine (ABPM) and the American Board of Foot and Ankle Surgery (ABFAS). These certifying bodies are the only certifying organizations to be recognized by the Council on Podiatric Medical Education (CPME) and VA. These bodies not only issue time-limited certificates, but they participate in the Centers for Medicare and Medicaid Services (CMS) Maintenance of Certification (MOC) reimbursement incentive program. Unlike the residency curricula in 1976 (which were not standardized, nor comprehensive), today's residency curriculum is equitable to MD and DO residency training and includes general medicine; medical specialties such as rheumatology, dermatology, and infectious disease; general surgery; and surgical specialties such as orthopedic surgery, vascular surgery, and plastic surgery. CPME-approved fellowship programs did not exist in 1976, but since their creation in 2000, they offer our graduates opportunities for additional training and subspecialization. Today, podiatric physicians are appointed as medical staff at the vast majority of hospitals in the United States, and many serve in leadership roles within those institutions, including but not limited to chief of staff, chief of surgery, and state medical boards. Many of my colleagues have full admitting privileges and are responsible for emergency room call as trauma and emergency medicine are now also incorporated into post-graduate training. The competency, skill and scope of today's podiatric physicians are vastly expanded and truly differ from the podiatrist who practiced when the statue was originally adopted. Because of this, CMS recognizes today's podiatrists as physicians, and Tricare recognizes us as licensed, independent practitioners.

The total number of VA enrollees has increased from 6.8 million in 2002 to 8.9 million in 2013(1). While we are slowly losing our Vietnam veteran population, we are gaining a solid base of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) patients, returning from war with their unique lower extremity issues. The projected patient population of Gulf War Era veterans is expected to increase from 30 percent in 2013 to approximately 55 percent in 2043(1). The number of service-connected disabled veterans has increased from approximately 2.2 million in 1986 to 3.7 million in 2013(1). More than 90 percent of disabled veterans were enrolled in VHA in 2012(1). The likelihood of service-connected disabled veterans seeking VA health care generally increases with the veteran's disability rating(1). The majority of male veterans who are currently seeking care from VA served during the Vietnam era(1).

As a matter of fact, veteran patients are ailing and have more comorbid disease processes than do age-matched Americans(2, 3, 4, 5, 6). This includes major amputation, where age-specific rates are greater in the VHA compared to the US rates of major amputation(7). Elderly enrolled veterans have substantial disease burden with disproportionately poor health status compared to the same age enrolled in Medicare(8). The prevalence of diabetes is substantially greater among veteran patients compared to the general population, and unfortunately, the data reflect that the prevalence is trending up(6). While diabetes affects 8 percent of the US population, 20 percent of veteran patients carry this diagnosis(9).The aging veteran population combined with these increased rates of diabetes has increased the burden of diabetic foot ulcers and amputations(10). Veteran patients with one or more chronic diseases account for 96.5 percent of total VHA health care(9). In addition to diabetes, some of the most common chronic conditions documented in veteran patients manifest in the lower extremity such as hyperlipidemia, coronary artery disease; chronic obstructive pulmonary disease; and heart failure(9).

Socioeconomic and psychosocial issues often plague our veterans and further complicate disease management. Veteran patients statistically have lower household incomes than non-veteran patients(1). Sadly, many of our nation's veterans are homeless and suffer from comorbid conditions such as diabetic foot ulcers, sometimes with a level of amputation, so management of this patient population can be extremely challenging. Health care expenses combined with disability and compensation coverage account for the majority of VA utilization and have demonstrated significant growth since 2005(1).

This is the VA patient population. Patients who are statistically comorbid with psychosocial and socioeconomic issues, all of which play a role in the delivery of care and final outcome. The veteran population is far more complex to treat than patients in the private sector, as a whole. Greater than 90 percent of the veteran podiatric patient population is 44 years and older, with the majority of patients of the Vietnam era, who are plagued by the long-term effects of Agent Orange. Because of this and because of the increasing number of OEF, OIF, and Operation New Dawn (OND) veterans with lower extremity conditions, one of the major missions as providers of lower extremity care is amputation prevention and limb salvage.

Dr. Chairman, the value of podiatric care is recognized in at-risk patient populations. Care provided by podiatrists, as part of an interdisciplinary team approach, reduces the disease and economic burdens of diabetes. In a study of 316,527 patients with commercial insurance (64 years of age and younger) and 157,529 patients with Medicare and an employer sponsored secondary insurance, there was noted a savings of $19,686 per patient with commercial insurance and a savings of $4,271 per Medicare-insured patient, when the patients had at least one visit to a podiatric physician in the year preceding their ulceration(11). Nearly 45,000 veterans with major limb loss use VA services each year. Another 1.8 million veterans within the VA Healthcare Network are at-risk of amputation. These at-risk veterans include 1.5 million with diabetes, 400,000 with sensory neuropathy, and 70,000 with non-healing foot ulcers(12). Despite having a large at-risk patient population from the Vietnam era, VA podiatric physicians are seeing increasing numbers of OEF, OIF and OND patients who are at-risk for amputation. From FY 2001 to 2014, the number of foot ulcers increased in the OEF, OIF, and OND populations from 17 documented cases to 612(12). Despite these statistics for at-risk patients, lower extremity amputation rates among all veteran patients decreased from approximately 11,600 to 4,300 between fiscal year 2000 and 2014(12). Given the magnitude of amputation reductions, podiatric physicians not only provide a cost-savings to VA, but we also play an integral role in the veteran quality of life(12).

While limb salvage is a critical mission of the podiatry service in the VA, the care delivered by the podiatric physician is of much broader scope. As the specialist of the lower extremity, we diagnose and treat problems ranging from dermatological issues, to peripheral vascular disease. We perform falls prevention and orthopedic surgery. As one of the top five busiest services in VA, podiatry provides a significant amount of care to veteran patients, and the bulk of foot and ankle care, specifically. In fiscal year 2014, the foot and ankle surgical procedures rendered by the podiatry services totaled 4,794, while foot and ankle surgical procedures performed by the orthopedic surgery service was a sum total of 72.

The mission of VA health providers is to maintain patient independence and keep the patient mobile by managing disease processes and reducing amputation rates. Podiatric physicians employed by VA assume essentially the same clinical, surgical, and administrative responsibilities as any other unsupervised medical and surgical specialty. Podiatrists independently manage patients medically and surgically within our respective state scope of practice, including examination, diagnosis, treatment

plan and follow-up. In addition to their VA practice, many VA podiatrists assume uncompensated leadership positions such as residency director, committee positions, clinical manager, etc. Examples include:

- Steve Goldman, DPM, Chief of Podiatry and Residency Director, Department of Veterans Affairs - Northport Health Care System - Former Site Director for Surgical Service, Department of Veterans Affairs - New York Harbor Health Care System;
- William Chagares, DPM, Research Institutional Review Board Co-Chair, Chair of Research Safety Committee and Research Integrity Officer at the James A. Lovell Federal Heath Care Center;
- Aksone Nouvong, DPM, Research Institutional Review Board Co-Chair at the West Los Angeles VA;
- Lester Jones, DPM the former Associate Chief of Staff for Quality at the VA Greater Los Angeles Health Care System for eight years, and podiatric medical community representative while serving on the VA Special Medical Advisory Group.

Despite this equality in work responsibility and expectations, there exists a marked disparity in recognition and pay of podiatrists as physicians in the VA. These discrepancies have directly resulted in a severe recruitment issue of experienced podiatrists into the VA, and unfortunately have also been the direct cause of retention issues. The majority of new podiatrists hired within the VA have less than 10 years of experience and are not board certified. As a result of the disparity the VA is attracting less experienced podiatric physicians. The majority of these new podiatrists hired into the VA will separate within the first five years.

Compounding the recruitment and retention issues, there exist lengthy employment vacancies when a podiatrist leaves a station. The gap between a staff departure to the time of filling the position is in excess of one year. Because of employment gaps as a consequence of the inherent and chronic recruitment and retention challenges, wait times within the VA for lower extremity care are unacceptably long. Since October 2014, 22,601 of the 191,501 (11.8 percent) established patients suffered a wait time of greater than 15 days, with some greater than 120 days. During this same time period, 23,543 of the 25,245 (93 percent) new patients suffered a wait time of the same magnitude. The prolonged vacancy exists partly because the VA is not capable of attracting experienced candidates, but also because the credentialing process is ineffectively burdensome.

It is precisely because of the aforementioned issues that legislative proposals to amend Title 38 to include podiatric physicians and surgeons in the Physician and Dentist pay band have been submitted by the Director of Podiatry Services annually for more than 10 years now. These proposals have been denied every single year. Additionally, several requests for an internal fix have been denied, despite written letters of support for this movement from former Under Secretary of Health, Robert Petzel, MD.

Seven years ago, the APMA's House of Delegates passed a resolution making this issue a top priority. Since then we have alerted the VA to our knowledge of this issue. In response, former Under Secretary Petzel created a working group composed of Dr. Rajiv Jain, former Assistant Deputy Under Secretary for Health for Patient Care Services; Dr. Margaret Hammond, former Acting Chief Officer for Patient Care Services; and Dr. Jeffrey Robbins, Chief of Podiatry Service. We participated in several meetings with members of the working group and received written support of Patient Care Services and Podiatry Service for a legislative solution to address this issue.

Occam's razor is a problem solving principle whereby the simplest solution is often the best. I come before this committee today to respectfully request that Congress help the VA and its patients by passing legislation to recognize podiatric physicians and surgeons as physicians in the physician and dentist authority. We believe that simply changing the law to recognize podiatry, both for the advancements we have made to our profession and for the contributions we make in the delivery of lower extremity care for the veteran population, will resolve recruitment and retention problems for VA and for veterans. Dr. Chairman and members of the Subcommittee, thank you again for this opportunity. This concludes my testimony and I am available to answer your questions.

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12. Preventing Amputation in Veterans Everywhere (PAVE) Program

Prepared Statement of Colonel (ret) James Ficke, MD

Chairman Wenstrup, Ranking Member Brownley, and members of the Subcommittee,

On behalf of the American Association of Orthopaedic Surgeons (AAOS), which represents over 18,000 board-certified orthopaedic surgeons, and the American Orthopaedic Foot and Ankle Society (AOFAS), which represents over 2,200 orthopaedic surgeons specializing in foot and ankle disorders, I thank you for the opportunity to speak to you today about lower extremity care for Veterans.

My name is Colonel (retired) James Ficke, and I'm an Orthopaedic Surgeon specializing in foot and ankle care. I'm currently the Chairman of Orthopaedic Surgery at Johns Hopkins School of Medicine. I served in the United States Army for 30 years, deploying to Iraq from 2004–2005 as the Deputy Commander and Chief Medical Officer for the 228th Combat Support Hospital in Mosul. I have led the Extremity War Injuries Project Team for 12 years, an effort laser-focused upon improving care from injury to final resolution of battlefield injuries. This effort has identified the gaps in knowledge, as well as research needs, that have shaped the generous Congressional funding of over $330 Million dollars for Veterans with limb-injuries commonly sustained in combat.

There are many orthopaedic surgeons serving Veterans proudly at the VA, and many others caring for Veterans through the Choice program. Orthopaedic surgeons play a role in saving limbs, reconstructing function, and returning Veterans to a healthy, active lifestyle. AAOS was honored to receive a Joint Warfighter Program award in collaboration with the Major Extremity Trauma Research Consortium, the purpose of which was to determine the best evidence for treatment of injuries to our Warriors. We were honored to receive your support for this effort, Mr. Chairman, and we appreciate your many years of support for orthopaedics and our patients.

We acknowledge the significant access to care challenges at the VA in lower extremity conditions. Current statistics are staggering regarding the burden of injury and disability. My own teams have reported and published literature showing that

up to 92% of Warriors with battlefield injuries will have permanent disability in the musculoskeletal system. As of 27 April 2017, 6,921 men and women have given their lives in defense of the Constitution, and 52,540 have sustained wounds in action, of which as many as 80% include a limb injury - the vast majority in the lower limb. We absolutely agree that musculoskeletal care for Veterans is imperative, and we will only meet their needs with a strong force of well-trained providers of all backgrounds.

Concerning H.R. 1058, the VA Provider Equity Act, AAOS strongly agrees that high quality podiatrists should be more equitably compensated to support their recruitment and retention. Podiatrists are an essential part of the care team at the VA and provide excellent service to Veterans. During my service in the Army, I practiced alongside podiatrists in many military bases and had a podiatrist on my staff in Mosul, who served in a non-clinical leadership role, LTC John Gouin DPM.

AAOS and AOFAS are concerned with two aspects of the legislation that are not essential to the goal of paying podiatrists what they're worth at the VA. Firstly, this legislation would label podiatrists within the VA as "physicians," elevating them to the category currently reserved for doctors of medicine and doctors of osteopathy. Secondly, the bill would allow podiatrists to attain clinical leadership positions over MDs and DOs.

Podiatrists and orthopaedic surgeons are trained differently. The lower extremity is one of the more complex areas of the human musculoskeletal system, and an orthopaedic surgeon will attend four years of medical school, serve a five year orthopaedic surgery residency, and typically take an additional year of subspecialty fellowship training. MDs or DOs participate in active clinical care in multi system trauma and disease management, which is not the case for all podiatrists, and is a prerequisite for peer-review oversight.

While recent changes have improved podiatric education, it is not the same as the multi-system medical education required to become a MD or DO, nor is it the same accreditation process. They do not participate in the United States Medical Licensing Examination, which is the standard for all advanced medical care and essential to the degree of MD and DO. We believe that the title of physician should be attained through the accreditation process, and not the legislative process.

AAOS and AOFAS stand ready to work with the subcommittee in good faith to improve this legislation and increase Veteran access to the care provided by both orthopaedic surgeons and podiatrists.

Thank you for the opportunity to appear before the subcommittee and for your work on behalf of our nation's Veterans. I look forward to answering any questions you may have.

Prepared Statement of Brandt

Ensuring High Quality Lower Extremity Care for Veterans

TESTIMONY BY THE

AMERICAN ORTHOTICS AND PROSTHETICS ASSOCIATION

Chairman Wenstrup, Ranking Member Brownley, and Members of the Committee,

Thank you for inviting the American Orthotic and Prosthetic Association to offer insights and recommendations regarding the Department of Veterans' Affairs ability to meet the need for high quality clinical care and procurement of prosthetic and orthotic devices for Wounded Warriors and Veterans with limb loss and limb impairment. My name is Jeffrey Brandt, and I am a Certified Prosthetist/Orthotist as well as the Founder and CEO of Ability Prosthetics and Orthotics. Since I founded the company in 2004, we have grown to ten clinics in the states of Pennsylvania, Maryland and North Carolina. As part of our work, we work with seven VA Medical Centers to provide prosthetic and orthotic services to Veterans. We have active contracts with four VAMCs across VISNs 4, 5 and 6.

I am pleased to be here today representing the Association. AOPA, as we call it, represents over 2,000 orthotic and prosthetic patient care facilities and suppliers that evaluate patients for and design, fabricate, fit, adjust and supervise the use of orthoses and prostheses. Still, sadly, fewer than half of all amputees in the United States ever receive a prescription for a replacement limb. The likelihood of receiving a prosthesis declines by 50% with every 10 years of advancing age. That results in percentages of US patients who are untreated that are much higher than several European countries. Our members serve Veterans and civilians in the communities

where they live, and our goal is to ensure that every patient has access to the highest standard of O&P care from a well-trained clinician. It is not widely known that 80–90% of prosthetic/orthotic care delivered to Veterans is provided in a community-based setting, outside the walls of a VA Medical Center. The vast majority of your constituents who are Veterans and who need a prosthesis or orthosis received a device that was provided and maintained by an AOPA member.

The VA contracts with community-based providers to offer Veterans timely, convenient and high quality prosthetic and orthotic care near the locations where they live and work. Because such a high percentage of care is delivered by community-based providers, the private sector workforce and procurement relationships with the VA must be a part of any discussion of lower extremity prosthetic and orthotic care for Veterans.

Caring for Wounded Warriors

Traumatic Brain Injury (TBI) and amputation are the signature injuries of the wars in Iraq and Afghanistan. Traumatic Brain Injury often manifests in the same way as stroke, with orthotic intervention needed to address drop foot and other challenges balancing, standing and walking. The Department of Defense Surgeon General reported to the Congressional Research Service that from the start of 2000 through June 2015, more than 327,000 service members had suffered a TBI.

Although the death rate from conflicts in Iraq and Afghanistan is much lower than in previous wars, the amputation rate has doubled. The Department of Defense and the Department of Veterans' Affairs have reported that in past wars, 3% of service members injured required amputations; of those wounded in Iraq, 6% have required amputations. The DoD Surgeon General reported to CRS more than 1,600 service-related amputations from October 2001–June 2015. More than 80% of amputees lost one or both legs. Concussion blasts, multiple amputations, and other conditions of war have resulted in injuries that are medically more complex than in previous conflicts. The majority of these amputees are young men and women who should be able to live long, active, independent lives if they receive timely, high quality, and consistent prosthetic care.

Caring for Senior Veterans

Most Americans are unaware that the majority of Veterans with amputations undergo the procedure as a result of diabetes or cardiovascular disease. According to VA statistics, one out of every four Veterans receiving care has diabetes; 52% have hypertension; 36% are obese. These conditions are associated with higher risk for stroke, neuropathy, and amputation.

These underlying health conditions are the reason that the number of Veterans undergoing amputation is increasing dramatically, and is expected to increase at an even more rapid pace in the future. VHA Amputation System of Care figures show that, in the year 2000, 25,000 Veterans with amputations were served by the VA. By 2016, that number had more than tripled to 89,921. Between 2008–2013, an average of 7,669 new amputations were performed for Veterans every year; in 2016, 11,879 amputation surgeries were performed. 78% of the Veterans undergoing amputation last year were diabetics. 42% had a service-connected amputation condition.

AOPA commends the VA for its historical leadership in ensuring that Veterans who have undergone amputations have access to appropriate, advanced prosthetic technology, often before the same technology is made available to patients in the private sector. For example, when the first microprocessor-controlled knee came to market, it was initially considered beneficial for the fittest, most active amputees. The late Fred Downs, then National Director of the Prosthetic and Sensory Aids Service, was himself a Vietnam Veteran who lost an arm in combat. He had the idea that the greater stability offered by microprocessor control might actually be equally or more beneficial to older, less active Veterans with limb loss who were less steady on their feet. After testing the computer-controlled knees with older Veterans undertaking activities such as walking in the community and riding Metro escalators, the VA became the first payer to approve microprocessor-controlled knees for older and less active patients. Today, following the VA, Medicare and private insurance companies widely accept that microprocessor-controlled knees improve safety and increase activity levels for patients with limb loss across a wide spectrum of activity levels.

AOPA also wishes to express its deep gratitude to the Veterans' Administration for its feedback to the Centers for Medicare and Medicaid Services in response to a devastating proposed policy regarding eligibility for prosthetics. In 2015, CMS issued a draft Local Coverage Determination (LCD) that, if enacted, would have denied access to prosthetic technology to large groups of seniors with limb loss, and

potentially carried implications for denial of care to Veterans as well. The guidelines in the LCD were arbitrary, were not supported by clinical research or practice, and included provisions such as disqualifying amputees for advanced prosthetic devices if, during any part of the day or night, they used a cane, walker, or wheelchair. The VA's leadership, combined with outcry by patients and advocacy by the O&P field, resulted in the suspension of implementation of this ignorant, unscientific and inappropriate policy.

Partnering with the Private Sector to Provide Timely, Quality Care

O&P care is unusual in that for decades, about 90% of care provided to Veterans has been through contracts with private sector providers - often small businesses, such as my own.

My experience with the VA, and that of my colleague AOPA members and the Veterans we serve, is that the quality of care, the implementation of policies, and the approaches taken by the VA to prosthetic and orthotic services, are extremely uneven, variable, and in many circumstances, dependent upon personalities. Unquestionably, some VA medical centers have excellent clinicians, embrace innovation and best practices to the extent the bureaucracy allows, and maintain strong and cordial working relationships with private sector providers who are responsible for the majority of care for the Veterans that Medical Center serves.

In other places, VA staff making decisions affecting lower extremity care appear not to be particularly knowledgeable about prosthetics and orthotics. Some VA prosthetic and orthotic clinicians welcome the partnership with private providers as a needed resource to meet the growing demand for care. Other VA staff seem to believe that some private sector providers are in competition with them for patients, and are out to take advantage of the taxpayer with more expensive, unwarranted components. Some VAs have begun a practice of excluding community providers from the VA prosthetic clinic where patients are referred to providers, or to make attendance at those clinics dysfunctional. Contentiousness in relationships between the VA and the clinicians actually providing the prosthesis does not serve Veterans well. The best care is supported by a genuine rehab team approach.

There are multiple advantages to the VA, and to Veterans, from this long-time public-private partnership in O&P.

We are all familiar with stories about wait lists, delays in care, and the VA's struggle to provide timely care to its patients. With a private sector network of O&P clinics supplementing care available from VA employees, wait times are reduced and Veterans receive the care they need more quickly than if they were relying solely on overburdened VA facilities and federal employees.

Community-based providers, such as myself, are often closer to Veterans' homes or workplaces. Frequently, we offer Veterans more convenient care, with less travel time and expense, less time away from work, and less interruption to their daily lives.

Another significant advantage is that, in my experience, community-based providers are often more nimble in adopting cutting-edge practices, collecting data, and implementing innovations than our colleagues operating in a large federal agency.

For example, at Ability, our practitioners work with every new patient to complete a series of questionnaires and three objective baseline outcome evaluations, to establish the patient's physical capacity for activity. That capacity determination, called a "functional level," indicates what kind of technology will best facilitate mobility for that patient.

But the VA very often does not use such objective, validated tests, or even an observably consistent approach, to evaluating functional levels.

Regardless of the VA evaluation, when a Veteran comes to us with a VA doctor's prescription for a prosthesis, we give that Vet the same expert care that we give all our patients. Before we start work on the prosthesis, Ability uses our own assessment process to evaluate what will best suit the Veteran's needs. Sometimes, our evaluation confirms the prescription provided by the VA.

When our evaluation differs from the VA's - maybe the VA evaluated the Veteran at a K3 but we put the Veteran at a K2 - we call the VA clinic, and ask to talk with the staff there. We ask for additional information, including the prosthetic evaluation notes, so we can understand why the VA recommended something different. Most of the time, the VA staff don't welcome our call. It can take two weeks to get a call back - two weeks when the Veteran is waiting for the medical device that makes it possible to walk. Then the Veteran has to become the squeaky wheel, calling the VA on our behalf to try to open the lines of communication. When the VA staff calls us back, they're often annoyed. They tell us that they can't share the evaluation notes with us. They tell us that the VA's electronic medical record has

no way to extract and send information. They treat us like a vendor, instead of a professional. They accuse us of making them look bad.

Here's the irony: in an effort to reduce costs, supposed fraud and abuse initiated by community-based providers, the VA often won't accept our expert professional recommendations. If we call to say our evaluation shows that the patient is a K2 and wouldn't benefit from a microprocessor-controlled ankle, we hear comments like "I don't want the Veteran to complain" or "to be on the safe side, all my patients get that ankle." When our evaluation methodology shows that the Veteran needs more advanced technology than was recommended by the VA's subjective exam, we can find ourselves accused of trying to line our own pockets by providing more advanced devices.

At that point, I have a choice. I can continue to advocate for my patient, at the expense of my relationship with my VA client. Or, I can proceed to fill a prescription my evaluation assessment tools tell me is not necessarily best for my patient. If the Veteran comes back ten times in the next six weeks because the prosthesis isn't appropriate, then the Veteran hasn't been served, and my reputation is damaged. I have to sit down with the patient and explain what the problem is. The Veteran often has to go back to the VA and do his or her best to articulate why a change in componentry might be appropriate. The VA staff may become defensive, and accuse the outside provider of not just providing what was initially discussed, looking for more money, and putting the Veteran up to asking for something different. All of this could be averted with proper clinic protocol, use of outcome metrics and better communication.

All of us - patients, clinicians, and taxpayers - would benefit from a more consistent, and more data-driven system. Sometimes, patients come to our office having seen or heard about more expensive, advanced new devices. Maybe a buddy with a similar injury received one. Sometimes, that device is absolutely appropriate for our patient. Sometimes, it would help the Veteran reach his highest activity potential, and engage in activities he used to do before losing a leg. But sometimes we find, when we go through our assessment, that that Veteran can't really take advantage of that advanced technology, and probably shouldn't get it. It's always hard to tell a patient that he or she really doesn't need the new device that was featured on a magazine cover, generated buzz in a Veterans' chat room, or that a buddy received. We find that our process, with its objective tests and data, is valuable in helping Veterans and other patients understand and accept those difficult determinations. We tell them that, as time goes on, we can always re-evaluate them by giving them the tests again, and upgrading the technology as the data warrants. And sometimes the opposite is true - our data helps us work with private insurance companies to get more advanced technology for our private patients. You might think that the VA, with its concerns about fraud and abuse, would welcome an approach that objectively documents advanced technology for their patients. In our experience, that's rarely the case.

There are multiple other challenges that can make it difficult for a community-based provider, and particularly for a small business, to work with the VA to provide care to Veterans. In brief, these include, but are not limited to:

- Contracts that expire and take more than a year to renew
- Contracts that are not awarded until 12–18 months after the bid process closes
- VISNs that allow contracts to expire, and then permit any provider to offer care, regardless of the quality of that provider
- Outdated methodologies for evaluating the quality and capacity of private sector bidders (ie, how many band saws do you have on site?)
- Accelerated approval processes for technology when provided by an in-house VA clinician, creating incentives for patients to shift care from a community provider to a federal employee.

Before I close on this point, I would like to make one additional observation. Often, as Veterans, AOPA members and representatives discuss these issues with Members of Congress and their staff, policymakers are surprised that these problems were not solved by the Veterans' Access, Choice and Accountability Act of 2014. O&P is not covered by the Veterans' Choice Act. Inconsistencies in the recent VA reforms only got part way to the target. Veterans located a distance from a VAMC can exercise the option to see a doctor in the community with the VA's guarantee of payment at Medicare rates. But Veteran amputees are not accorded that option or guarantee. Nobody seems to be able to explain why. AOPA looks forward to working with you, and with the new Administration, to find solutions to these challenges.

As you know, the VA is a large ship, and it is difficult to turn quickly. I do see some things changing, slowly, in some places. There does seem to be a heightened

emphasis on outcomes in some of the recent RFPs that have been released. There are more questions being asked of private sector providers about data and objective, rather than subjective, evaluations of patients. But, from a small business perspective, that change is uneven, and it's not coming quickly enough. And, unfortunately, it's the Veterans who suffer the most.

Demand for High Quality Care is Growing While Provider Population Shrinks

I'd like to turn now from procurement issues to a different kind of challenge facing both the VA and private sector providers: maintaining and growing a highly qualified workforce.

From the battlefield to the homeland, medical conditions requiring prosthetic and orthotic care have become more complex and more challenging to treat. New prosthetic and orthotic technology is more sophisticated. To ensure professional, high quality care that could respond to these shifts, earlier this decade the entry-level qualifications for prosthetists and orthotists were elevated from a bachelor's degree to a master's degree.

Veterans need and deserve clinicians who can successfully respond to their battlefield injuries with appropriate, advanced technologies. As the population of amputees grows, many experienced professionals who were inspired to enter the field to care for Vietnam Veterans retiring. Providing high quality care to our Wounded Warriors, Veterans, seniors, and civilian amputees is going to require more master's degree graduates from American universities to be the next generation of practitioners.

The National Commission on Orthotics and Prosthetics Education (NCOPE) commissioned a study of the O&P field, which was completed in May of 2015. The study found that in 2014, there were 6,675 licensed and/or certified orthotists and prosthetists in the United States. It concluded that, by 2025, "overall supply of credentialed O&P providers would need to increase by about 60 percent to meet the growing demand." Subsequent analysis conducted by NCOPE and AOPA suggests that the current number of providers is closer to 5,500, an even more significant shortage than than previously predicted. Already, my colleagues in states including Florida, California, and Texas tell AOPA that an advertised opening for a licensed prosthetist or orthotist can take more than twelve months to fill.

Currently, there are thirteen schools in the US that offer master's degrees in orthotics and prosthetics. The largest program, Northwestern, accepts 48 students. The majority of programs have classes of 20 or fewer students per year. Nationwide, fewer than 250 students are anticipated to graduate with master's degrees in orthotics or prosthetics this year.

Current accredited schools will barely graduate enough entry-level students with master's degrees to replace the clinicians who will be retiring in coming years. Class sizes simply aren't adequate to meet the growing demand for O&P care created by an aging population and rising incidence of chronic disease.

Positions as licensed, certified prosthetists and orthotists are good jobs. Nationally, the average wage exceeds $65,000. These jobs pay good wages, support a family, and can't be outsourced overseas. Most importantly, they help improve the health and quality of life for our fellow citizens - including Veterans. I am proud of my profession, and of the work we do. Veterans, and civilian amputees, need care. Companies need high quality employees. People want fulfilling careers. Schools are getting more applicants for O&P programs than they can accept. Why is this so hard?

The Wounded Warrior Workforce Enhancement Act

O&P master's programs are costly and challenging to expand. The need for lab space and sophisticated equipment, and the scarcity of qualified faculty with PhDs in related fields, contribute to the barriers to expanding existing accredited programs. There are currently no federal resources available to schools to help create or expand advanced education programs in O&P. Funding is available for scholarships to help students attend O&P programs, but do not assist in expanding the number of students those programs can accept.

One way to address this problem is by passing The Wounded Warrior Workforce Enhancement Act, introduced in the House last Congress by Representative Cartwright with bipartisan support. This bill is a limited, cost-effective approach to assisting universities in creating or expanding accredited master's degree programs in orthotics and prosthetics. It authorizes $5 million per year for three years to provide one-time competitive grants of $1–1.5 million to qualified universities to create or expand accredited advanced education programs in prosthetics and orthotics. Priority is given to programs that have a partnership with Veterans' or Department

of Defense facilities, including opportunities for clinical training, to ensure that students become familiar with and can respond to the unique needs of service members and Veterans. The bill was endorsed by Vietnam Veterans of America and VetsFirst, which recognized the need for additional highly qualified practitioners to care for wounded warriors.

In May of 2013, the Senate Committee on Veterans Affairs held a hearing to consider the Wounded Warrior Workforce Enhancement Act and other Veterans' health legislation. The VA testified that the grants to schools were not necessary because it did not anticipate any difficulty filling its seven open internal positions in prosthetics and orthotics. The VA testified that its O&P fellowship program, which accepted nineteen students that year, was a sufficient pipeline to meet its need for internal staff. The VA offered similar testimony at a House Veterans Affairs Health Subcommittee hearing in November 2015.

The Senate rejected the VA's argument. Acknowledging that more than 80% of prosthetic and orthotic care to Veterans is provided by community-based facilities, the Committee concluded that nineteen students could not meet the system-wide need. Committee members also agreed that Veteransand the VA would benefit from a larger pool of clinicians with master's degrees, whether those graduates were hired internally at the VA, or by community-based providers. The Committee included provisions of the Wounded Warrior Workforce Enhancement Act in S. 1950, which passed Senate VA Committee unanimously in 2013. Due to factors unrelated to O&P, the omnibus bill did not advance. Related provisions were included in the Senate's omnibus package Veterans' legislation in 2016, but were not included in final legislation passed late last year.

AOPA looks forward to working with you to expand the number of highly qualified prosthetists and orthotists who can meet the needs of Veterans with limb loss and limb impairment, and to reducing the barriers to timely, appropriate lower extremity care. No Veteran should suffer from decreased mobility or independence because of lack of access to high quality care, regardless of where it is provided.

I am the principal in a private sector company with my foot on the gas pretty much all the time. I've got a good facility, and good practitioners ready to serve Veterans. I want to give back to the folks who have suffered in the service of our country. It just shouldn't be this hard.

Thank you for considering my comments today, and for your commitment to providing the highest level of O&P care for our Veterans. If you have any questions or would like more information, please do not hesitate to contact AOPA.

Statements For The Record

CLIFFORD J. BUCKLEY, M.D., F.A.C.S.

Commentary in Support of Improved Compensation Package for Podiatrists Employed in the Veterans Administration

My name is Clifford J. Buckley, M.D., F.A.C.S. and I am providing a voluntary statement in support of efforts to improve compensation for podiatric physicians and surgeons that are employed by the Veterans Health Administration. I feel qualified to comment on this issue because I have relied heavily on the support provided by appropriately qualified podiatrists in caring for patients who have problems related to their lower extremities and especially their feet. By way of background, I am a Board Certified Vascular Surgeon and hold the rank of Professor of Surgery (unmodified title) Texas A&M University College of Medicine. I have spent 15 years on active duty with the United States Military, 15 years in the private practice of medicine and 24 years in academic medicine - nearly half of that time in association with Veterans Health Administration. Specifically, my work with the VA has been as Associate Chief of Staff Surgical Services, CTVHCS, Chief Surgical Consultant VISN 17 VHA and former chair and member of the Vascular Surgery Advisory Board to the National Director of Surgery.

Throughout my entire time working with the Veterans Health Administration, it is my personal judgment that podiatric physicians and surgeons have been under compensated and undervalued with respect to their peers and to their overall role in providing comprehensive care for the feet and lower extremities of our Veterans. This observation spans a time frame of at least 15 years or more. In CTVHCS, it would be impossible for me to recruit and retain Board Certified and clinically well-qualified podiatrists if I did not have supplemental salary assistance for our podiatric faculty provided by our University Affiliate. Currently, VA Podiatrists appear to be compensated at a level substantially lower than their civilian counter-

parts. In fact, when I attempt to recruit new podiatric faculty, my choices are usually limited to physicians with either medical/legal or substance abuse problems or new training graduates who have social reasons requiring them to remain in our local area. The primary driving factor for a young podiatrists seeking employment with the VA and who have a desire for some degree of academic affiliation in their practice has been access to VA research support - financial and administrative. Unfortunately, these young podiatrists often leave for a more lucrative and generally professionally satisfying practice environment once they have established at least their local reputation.

I have been extremely fortunate to have had faculty staffing our podiatry section who are extremely well qualified, clinically experienced and for the most part, are rear foot and ankle surgery qualified through additional training and certification. My recent Chiefs of the Podiatry Section have earned promotion to the rank of Professor of Surgery because of their academic productivity, clinical outcomes, and their regional and national reputations. Podiatrists of this quality could not be retained at our institution without the disproportionate supplemental salary support provided by our university affiliate.

Podiatrists are the main stay for appropriately managing problems related to the feet. Their knowledge and skills in wound management identifying sources for pain and soft tissue injury and recognizing the complications of systemic illnesses like diabetes mellitus, chronic venous insufficiency and renal failure have saved the extremities of countless Veterans from amputation. P.A.V.E program, which is generally managed by podiatrists across the VA, is a shining example of their success at quality improvement for all forms of foot care but especially in the elderly Veteran. The ability of the podiatrists to recognize and manage problems related to the foot is not duplicated by any other group of health care providers. Their perspective in this field is exceptional. Their critics have often said that "all the VA needs to do is hire some health technicians who can be trained to provide nail care, orthopedic surgeons are capable of providing care for the remaining foot issues as they occur". Nothing can really be farther from the truth. Podiatrists understand the biomechanics of the foot and all of the various factors, which can produce local tissue injury. Their ability to manage each of these issues by directly attacking the source of the problem rather than treating sequellae is invaluable.

I hope my comments in the above text show the strong support that myself and my Vascular Surgery colleagues have for improving the compensation package for VA Podiatrists. If I can be of any further assistance in their behalf, please do not hesitate to contact me.

Clifford J. Buckley, MD, FACS

254–931–0818

LAWRENCE B. HARKLESS, DPM

RE: COMMENTARY ON HR 1058, VA PROVIDER EQUITY ACT

My name is Lawrence B. Harkless, DPM, FACFS and I am providing a voluntary statement in support of efforts to improve compensation for podiatric physicians and surgeons that are employed by the Veterans Health Administration. I am qualified to comment on this issue because of my personal experience and observations on the role provided by qualified podiatrists in caring for patients who have problems related to the lower extremities, and especially their feet.

By way of background, I am a Board certified foot and ankle surgeon and have been serving for the past ten years as the Founding Dean and Professor of Podiatric Medicine and Surgery at Western University of Health Sciences in Pomona, California. For my over thirty-year career I have served as a professor in the Department of Orthopedics and Podiatry Division Chief, and Director of Residency for Podiatric Medicine at the University of Texas Health Science Center, San Antonio, Texas. This also included staff privileges at the Audie Murphy VA Hospital where I was an attending physician during my thirty-year career. I have had the unique opportunity to serve the county hospital population in addition to the veteran's population of the San Antonio community and beyond. I also served on a Special Medical Advisory Group (SMAG) that advises the Secretary of the VA from 1995–2001.

During my entire career of working at UT and Audie Murphy VA it IS my own opinion that podiatric physicians and surgeons have been undercompensated and undervalued in comparison to their peers, and to their role in providing comprehensive care for the feet and lower extremities of veterans. The VA continues to have

trouble recruiting and retaining experienced podiatric providers due to low compensation. The VA can recruit young providers out of residency but once they become Board certified and more experienced, they leave the VA for the private sector. Several of my former residents, who were destined for academic careers, have not taken VA positions due to this low compensation. Our veterans deserve better.

The ability to attract and retain experienced podiatric providers has affected access. With a projected increase of over 400,000 additional veterans coming into the system, the VA will continue to struggle with access unless the VA can offer better compensation for podiatric physicians. Legislatively capped VA clinical podiatrists in nearly 58% of the regions receiving locality pay have reached the legislatively capped rate of pay for the executive schedule which has resulted in significant reduction in pay over the past decade for many of highly productive and experienced providers.

The Center for Medicare and Medicaid Services (CMMS) is already defining podiatrists as physicians under Title XVIII. The VA's definition is from the 1976 Title XXXVIII Omnibus Bill, and it is an outdated thirty-year old law. Podiatrists share the same inpatient/outpatient on call and rounding responsibilities as any other physician's profession.

The VA is central to residency education and training for podiatrists. It trains more podiatric medical residents than any health system. It's important to attract the best and brightest as they will provide leadership in education, research and service to the next generation of podiatrists who will care for the veterans. Moreover they will have an impact with interprofessional teams in improving foot health for the veteran population.

Podiatry has the most important role in keeping America walking. Their knowledge and skills in the management in foot problems in the areas of diabetes, aging and arthritis are noteworthy. Congress now finds itself with the opportunity to make long needed improvements in the VA health care delivery system, and I hope my testimony will encourage the House to do the right thing for our veterans and America.

Sincerely,

Lawrence B. Harkless, DPM

LBH:mb
PVA

PARALYZED VETERANS OF AMERICA (PVA)

Chairman Wenstrup, Ranking Member Brownley, and members of the subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to offer our views on VA specialized services for lower extremity conditions. PVA represents the voice of approximately 60,000 veterans in the U.S. who live with paralysis of the lower extremities due to spinal cord trauma, multiple sclerosis, amyotrophic lateral sclerosis, and other dysfunctions. We are grateful to be part of this discussion.

Loss of lower extremity function related to the spinal cord often includes loss of other functions, such as genitourinary, digestive, and reproductive. It may also be accompanied by chronic nerve pain, muscle spasticity, muscle atrophy, and skin breakdown. For this reason, medical professionals who are trained in spinal cord injury medicine are best equipped to provide medical care for this population of mobility-impaired veterans. Paralyzed veterans are the largest cohort of veterans who rely of specialized services in VA and have the fewest alternative choices for care and long term institutionalization. The overwhelming majority of paralyzed veterans suffer lower extremity loss of use (exceptions include central spinal cord, which only affects the upper extremities, and some veterans with regressive MS). They rely on prosthetic devices such as wheelchairs, power chairs, power-assist chairs, patient lifts, auto adaptive equipment, home adaptive equipment, and other mobility solutions.

No one is more affected by provider shortages than those veterans with complex injuries who rely on VA to treat their specialized needs. Unfortunately, VA has not maintained its capacity to provide for the unique health care needs of severely disabled veterans-veterans with spinal cord injury/disorder, blindness, amputations, and mental illness-as mandated by P.L. 104–262, the "Veterans' Health Care Eligibility Reform Act of 1996." As a result of this law, VA developed policy that required the baseline of capacity for Spinal Cord Injury/Disease System of Care to be measured by the number of available beds and the number of full-time equivalent em-

ployees assigned to provide care.VA was also required to provide Congress with an annual "capacity" report to be reviewed by the Office of the Inspector General. This reporting requirement expired in 2008, and was reinstated in last year's "Continuing Appropriations and Military Construction and Veterans Affairs Appropriations Act for FY 2017." This report, a critical tool of oversight, should be made available to Congress by September 30 of this year. However, we have serious concerns about VA's plan to re-implement this requirement.

Additionally, VA Prosthetics has been problematic for quite some time in a number of ways. The gap between policy, where the Prosthetics National Director resides, and operations, under which the facility prosthetics office operate, has created sweeping inconsistency in how prosthetics policy is implemented. Individual facilities are allowed to enact or interpret policies that make it difficult for some veterans with lower extremity impairment to get needed devices in a timely matter. Resolving local problems is difficult because the National Prosthetics Office has no authority over the field prosthetics office, who report to the respective VISN.

New prosthetics policies are being developed without the substantive input of external stakeholders. While stakeholders have been invited to participate in workgroups and on the Federal Advisory Committee for Prosthetics & Special Disabilities, the input from these groups rarely if ever affect the policy being developed (e.g. Clothing Allowance policy is still exclusive and punitive for those veterans who seek a second clothing allowance; power chairs are still not considered a factor in damaged clothing despite the consensus of the workgroup that argued otherwise, etc.).

Existing prosthetics policies have not been properly followed in many locations, particularly in the area of customized wheelchair choice and backup wheelchair provisions. Some prosthetics offices allow for loose interpretations of policy that make it more difficult to get the mobility device that s/he chose and was supported by physician/therapist prescription. Documented cases of injury due to the issuance of ill-fitted mobility devices and the lack of a viable backup in the event a veteran's primary mode of mobility becomes damaged have not been thoroughly addressed by VHA leadership.

PVA supports H.R. 1058, the "VA Provider Equity Act," bill to clarify the role of podiatrists in the Department of Veterans Affairs. Podiatrists at VA are currently classified among optometrists and other allied health professionals, rather than among physicians and dentists. The VA pay scale incorrectly differentiates podiatrists from other physician providers. The resulting salary discrepancies are significant and create further challenges for VA in the recruitment and retention of podiatrists. With an aging population of veterans, the demand for podiatrists is growing. Parity in pay among other physicians will allow VA to better resource the health care system to meet the needs of veterans. This legislation provides the VA with tools needed to address current and future demand. In order to transform the culture and timeliness of care, Congress must enable VA to quickly hire a competent workforce with competitive compensation that ensures VA is a first-choice employer among providers.

Thank you for the opportunity to present our views on these issues.