American Orthotic & Prosthetic Association

**Ensuring High Quality Lower Extremity Care for Veterans**

**Testimony by the**
**American Orthotics and Prosthetics Association**
**Before the House Veterans' Affairs Subcommittee on Health**

**May 2, 2017**

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.

## 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.

To be fair to the VA, I do see some things changing, slowly, in some places. The VA is a large ship, and it is difficult to turn quickly. 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

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**

If I may, I'd like to turn 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. Nation-wide, 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.