

# OPTIMIZING CARE FOR VETERANS WITH PROSTHETICS: AN UPDATE

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## HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON VETERANS' AFFAIRS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

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JULY 31, 2012  
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## **OPTIMIZING CARE FOR VETERANS WITH PROSTHETICS: AN UPDATE**

**TUESDAY, JULY 31, 2012**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON VETERANS' AFFAIRS,  
SUBCOMMITTEE ON HEALTH,  
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 4:40 p.m., in Room 334, Cannon House Office Building, Hon. Ann Marie Buerkle [Chairwoman of the Subcommittee] presiding.

Present: Representatives Buerkle, Roe, and Michaud.

### **OPENING STATEMENT OF CHAIRWOMAN ANN MARIE BUERKLE, SUBCOMMITTEE ON HEALTH**

Ms. BUERKLE. The Subcommittee will come to order. Good afternoon and welcome to today's Subcommittee hearing: Optimizing Care for Veterans With Prosthetics: An Update. Today's hearing is a continuation of a discussion we began almost 3 months ago when this Subcommittee heard from veterans with amputations, members of our VSOs, and officials from the Department of Veteran Affairs to review the VA's capability of delivering state-of-the-art prosthetic care to our veterans with amputations and the impact of the VA's planned prosthetic procurement reforms. These reforms will, among other things, take prosthetic purchasing authority away from the prosthetic specialists and transfer it to contracting officers.

As our veterans so eloquently described in May, prosthetic care is unlike any other care that VA may provide, and when we make the mistake of treating it as such, no less than the daily and ongoing functioning and quality of life of our veterans is at stake. I was very troubled to hear from our veterans such strong opposition to the proposed reforms, arguing forcefully that they would lead to substantial delays in care for veterans with amputations and clinical judgments regarding veterans' needs being overridden by individuals with little or no experience in prosthetic care.

In mid-June, following our hearing, I sent a letter, along with Ranking Member Michaud, to the Secretary, requesting that the Department respond to a number of questions and provide certain materials regarding the strategy, plans, and criteria used to develop, consider, design and evaluate the proposed reforms as well as the pilot programs that preceded them.

Our goal was to understand the analysis VA employed to develop the reforms and what was behind the decision that they were the

best idea for our veterans, especially those who have experienced loss of limb as a result of service to our Nation.

Sadly, the Department's response, which came a week after the deadline requested in our letter, did not provide the information or the level of detail we asked for, and did nothing to assure me that the plan would be effective or that our veterans' concerns were unfounded. To the contrary, a close review of the materials VA provided leads me to believe that the reforms were developed without careful and thorough consideration.

It leads me to believe that they were developed without sufficient input from our veterans themselves, our veteran service organization advocates, or other stakeholders. It leads me to believe that they were developed and implemented after being tested for a very short period of time at a small number of locations, with very limited feedback. It led me to believe that they were developed without adequately measuring their impact on patient care. It led me to believe they were developed without safeguards in place to ensure that our veterans' and clinicians' wishes are respected and timeliness goals are met.

It is concerning that VA would move forward with instituting such large-scale changes that so directly impact our veteran patients in this way. If my concerns are groundless, and I truly hope they are, I want the VA in explicit detail to explain why.

During our last hearing, our veterans and VSOs spoke very loud and clearly. Now it is time for the VA to do the same.

[The prepared statement of Ms. Buerkle appears on p. 18.]

Ms. BUERKLE. Again, I thank you all for joining us this afternoon. Our Ranking Member, Mr. Michaud, is on the floor. We will give him an opportunity to provide remarks when he returns.

Now I would like to invite our first and only panel to the witness table.

Joining us from VA is the Honorable Under Secretary for Health, Dr. Robert Petzel. Dr. Petzel is accompanied by Philip Matovsky, the Assistant Deputy Under Secretary for Health, Administration Officers; Dr. Lucille Beck, Chief Consultant of Rehab Services, Director of Audiology and Speech Pathology, and the Acting Chief Consultant for Prosthetics and Sensory Aids Service; and Ford Heard, the Associate Deputy Assistant Secretary for the Office of Acquisition and Logistics.

Thank you all very much for being here.

Dr. Petzel, thank you for your service to our veterans and for taking the time out of your schedule to be here this afternoon to address what we consider an extremely important issue on behalf of our veterans. I look forward to hearing your testimony.

You may proceed at this time. Thank you.

**STATEMENTS OF HON. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, UNITED STATES DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY PHILIP MATOVSKY, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH, ADMINISTRATIVE OPERATIONS, VETERANS HEALTH ADMINISTRATION, UNITED STATES DEPARTMENT OF VETERANS HEALTH, LUCILLE BECK, PH.D., CHIEF CONSULTANT, REHABILITATION SERVICES DIRECTOR, AUDIOLOGY AND SPEECH PATHOLOGY, ACTING CHIEF CONSULTANT, PROSTHETICS AND SENSORY AIDS SERVICE, VETERANS HEALTH ADMINISTRATION, UNITED STATES DEPARTMENT OF VETERANS AFFAIRS, AND FORD HEARD, ASSOCIATE DEPUTY ASSISTANT SECRETARY, OFFICE OF ACQUISITIONS AND LOGISTICS, UNITED STATES DEPARTMENT OF VETERANS AFFAIRS**

**STATEMENT OF HON. ROBERT A. PETZEL, M.D.**

Dr. PETZEL. Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, I want to thank you for the opportunity to speak about the Department of Veterans Affairs prosthetics procurement reform. Thank you, Madam Chairwoman, for introducing the people that are accompanying me.

VA testified before this Subcommittee and the Subcommittee on Oversight and Investigations in May, 2012. We did this regarding our efforts to maintain the high quality of prosthetics VA provides to veterans while instituting reforms to improve compliance with the Federal Acquisition Regulations and the Competition in Contracting Act, and to improve our management of government resources.

In follow-up to these hearings, the chairwoman and Ranking Member submitted a letter to VA on June 21, requesting a response by July 6 that would offer additional information about these reforms. On July 12, VA submitted information to the Subcommittee to begin to address the Subcommittee's request. I apologize that submission was late and that it was not sufficient to address your concerns.

Yesterday, at the Subcommittee's request, we formally submitted additional information to provide a narrative account of our efforts, and we believe this will better meet your needs and provide for some further understanding. If you still have additional questions, we would be happy to respond.

You also have asked for an update on the actions the Department has taken to reform the prosthetics procurement process since May 21 in the hearing. On May 23, 2012, VA issued a memorandum to the field advising them that it is VA's policy that those engaged in the ordering of biological implants must comply with the FAR and VA acquisition regulations. That memorandum states that the VA official performing the purchasing activity is to comply with a physician's prescription.

Furthermore, in response to your advice to transition our warrant program with deliberation and caution, we extended the date for finalizing this transition from July 1 until September 30, 2012. This transition continues with ongoing communication and coordination within the VISNs to ensure that procurement services are

not disrupted. We are closely monitoring the staffing levels for our contracting organizations, the workload levels, and most importantly, the timeliness of procurement actions. If we find that we have insufficient resources to complete this transformation, we will extend the timeline to allow for a smooth transition.

Finally, you asked me to address the potential impact these reforms could have on veterans. As we testified in May, we do not believe that veterans will be adversely impacted in any way. Indeed, this change should result in no visible effect for veterans. We believe that our reform efforts are acceptable to the major service organizations.

Two proposals appear to have raised interest. First of all, our plans to standardize the purchasing of prosthetics and other devices; and secondly, our plan to transition procurement decisions to warranted contracting officers. On the first plan, many of the products VA purchases are already on contract in some way, shape, or form. They are either going to become a part of a veteran or they are going to be a critical part of their daily lives. We understand the critical value these devices offer and the independent clinical judgment of our providers will remain and must remain fully intact.

A contracting officer will not have the capacity to override a physician's order. This aspect guides a decision-making process of our leadership and will be preserved in our policies and in our procedures. Clinicians, in consultation with veterans, will decide what devices we procure. Our reforms are designed only to modify how we procure them. When products are generally available and interchangeable, competitive procurement may be appropriate. We are hoping that in the long term we can develop a catalog that will facilitate more cost-effective purchasing in those instances.

On the second plan concerning the transition of procurement decisions, I, again, emphasize that this is only changing how we purchase, not what we purchase. By shifting to contracting specialists, we can ensure that we secure fair and reasonable prices for the products while still delivering the personalized state-of-the-art care that has been earned by these veterans.

In conclusion, VA has been engaging in prudent and appropriate reform to improve the business processes governing the procurement of prosthetic devices for veterans. We take great care to ensure that these changes improve the accountability of these purchases while maintaining the high quality of care and clinical decision-making critical to veterans health care. Clinicians determine the prosthetic needs of veterans as a part of their clinical care, and VA procures the devices necessary to achieve personal clinical outcomes. Our reform efforts will not disturb this arrangement.

We appreciate the opportunity to appear before you today to discuss this important program. My colleagues and I are prepared to answer your questions.

[The prepared statement of Dr. Petzel appears on p. 19.]

Ms. BUERKLE. Thank you very much, Dr. Petzel.

I will now yield myself 5 minutes for questions. I guess my first question, as I am listening to your testimony today, as well as in the last hearing, is could you just briefly explain to me what prompted this change?



Dr. PETZEL. Certainly, Madam Chairwoman. The reform of VA's procurement processes really began more than 2 years ago, and they started at the Department level with the procurement of equipment, with the procurement of pharmaceuticals. This is a systemwide effort to ensure that we have professional, certified contracting people doing the procurement. We have been criticized in the past by organizations such as the IG for not having a professional procurement force and for not following in all instances the Federal regulations or VA's acquisition regulation.

So the effort, in no way, is directed specifically at prosthetics. This began, as I say, with equipment. It has moved into pharmaceuticals. Prosthetics is really the last area of procurement within VA where we have not had certified warranted procurement officers doing the majority of the procurements above \$3,000.

Ms. BUERKLE. Thank you. When I hear words like "equipment" and "pharmaceuticals" and then "the development, possibly, of a catalog," what you are talking about in those instances are so very different from the testimony we heard in the last hearing regarding the personal nature of a prosthetic. Amoxicillin is amoxicillin. A thermometer is a thermometer. But a prosthetic is unique to that person and to his needs or her needs. That is my concern with this process, that it will become just like any other procurement. This is a very different process. I think this is what concerns the VSOs and concerns the veterans. This is a uniquely personal service that we have to give to that veteran. What I am hearing here when you talk about cataloging purchases concerns me greatly.

Dr. PETZEL. Madam Chairwoman, we absolutely agree with you. This is the most personal of work that the VA does. Crafting and fitting a prosthetic limb to an individual that has lost an arm or a leg is a very personal process. The reforms that we are talking about in terms of procurement will not interfere with that process. The physician orders the prosthetic. And that order can be very specific. The prosthetist works with the patient to determine where the best place is to purchase that. As you know, we have 600 contracts in the private sector, and not all, but most of our procurement occurs in the private sector.

In the process of transitioning and during the pilots, we audited the orders that the physician had written; we audited the purchase contract, what was actually purchased; we looked at the timeliness between when that order was placed and when it was actually purchased; and we looked at the satisfaction, particularly of the prosthetist and the physicians, as to whether or not the needs of that veteran, as they described them, were met. And in the pilots we found that that was true; that that worked very well.

The only misjudgment that we made in the pilots is that we expected a higher level of productivity from the contracting officers than we actually found, and we had to revise the number of contracting officers that we felt we needed because we felt that the four contracts per day that they originally were going to perform was more than was doable; that 2.5 is a better example. But, otherwise, the pilots indicated that things went very well.

Ms. BUERKLE. Can you talk to us about the pilots? How many pilots were done? Over what period of time were the pilots conducted? Which VISNs were included in the various pilots?

Dr. PETZEL. Yes, Madam Chairman, we can, and I would like to turn to Mr. Matovsky to give you some of the details about the pilots.

Thank you.

Mr. MATOVSKY. Thank you, sir. We conducted three pilots, one of them in VISN 6, which is North Carolina, parts of Virginia, parts of West Virginia; VISN 11, which is Indiana—I am going to test my geography here—parts of Michigan as well; and then VISN 20, which is the Upper Northwest on into Alaska. We selected them because they were a broad representation, some of them highly rural, some of them very large and growing. We also ran them from the period of January through the end of March, for 3 months. I believe one of them scooted into April.

We tested two different processes. So one process utilized fully the ECMS, or Electronic Contract Management System, to place the order and another one in VISN 6 used a slightly different process. That is the basis for it.

We tested the onboarding of our staff, the training of our staff, the communication and the collaboration with the prosthetist, the prosthetics purchasing agent, and then the contracting management staff. As Dr. Petzel indicated, we did conduct some audits. For instance, we looked at the technical appropriateness of the contracting action. But more importantly, we looked at what percentage of the time did the contracting officer adhere to the physician's prescription. A hundred percent of the time, the contracting officer adhered to the prescription.

Ms. BUERKLE. Thank you. With that I will yield to the Ranking Member, Mr. Michaud, for any opening statement you might have and 5 minutes for your questions.

Mr. MICHAUD. Thank you very much, Madam Chair. I apologize for being late. I was managing the veterans bill on the House floor. This is the earliest I could get back.

**OPENING STATEMENT OF HON. MICHAEL H. MICHAUD,  
RANKING DEMOCRATIC MEMBER**

I want to thank everyone for attending this very important hearing. This afternoon is a follow-up. And I also would like to thank the chairwoman for her persistence in holding the Department accountable on issues such as prosthetics, not just for care, but also for procurement, which is so important for the veterans. Every veterans' needs are unique. VA should get this right.

We have learned during the last hearing on this issue in May about VA's proposed changes in the procurement of prosthetics. At that hearing, there was a high degree of concern expressed among some of our witnesses as to the effectiveness of these changes. We are alarmed by the possible negative impacts on patient care, including substantial delays in care and clinical judgments regarding veterans' needs being overridden by individuals with little or no working knowledge of prosthetic care. And we sent a bipartisan letter to the Secretary outlining our concerns and soliciting answers to several of our questions.

This is the third hearing in a handful of months on this particular issue, and I remain committed to working with the very dedicated staff at the Department of Veterans Affairs and the advo-

cacy community to assure that our veterans are getting the best care that we can deliver in a timely way. In this joint effort and joint challenges this Subcommittee stands ready to help.

And I read through your testimony and I just have a few questions, if I might. In your testimony you said: We believe that many of our reform efforts are acceptable to all concerned parties. When you say “we believe,” have you worked with the VSOs and the veterans to find out what their concerns are?

Dr. PETZEL. Congressman Michaud, we have. Since the May hearing, there have been multiple meetings with the service officer representatives. I have a breakfast monthly with six of the largest service organizations. We made a presentation and a discussion at that breakfast earlier in July. And then just a day ago, on Monday, at a conference call with the service organizations—the American Legion, VFW, PVA, the DAV, Amvets, and the Blind Veterans of America—to discuss what we want to do. And I can say that there was no objection at that meeting and at that conference to our proposed reforms.

Mr. MICHAUD. Thank you. My next question actually is two, but it is a related issue. Is the VA central office instructing VISNs to restrict access to contract prosthetics or orthotists? If not, what about the VISNs? Are the VISNs restricting access to contracts for prosthetics for veterans who rely on those prosthetics?

Dr. PETZEL. Congressman Michaud, our policy that is this is a veteran’s choice. That we have, as I mentioned earlier, 600 contracts. Most of the prosthetics actually are fabricated and fitted by private vendors. Our policy very clearly states that there must be available in every one of the medical centers a list of the contractors, and this must be explained to the veteran, that they have a choice in doing that.

The practice that I think you may be hearing about from some of the vendors is that around the country, how this interaction occurs is variable. In some instances, in rural areas, where we do not have prosthetists that do fitting, et cetera, people from the outside, from the private sector, are invited into the prosthetics clinic and are actually involved in the discussions with patients because we don’t have the personnel to do that. At our larger medical centers where we have a large cadre of prosthetists, it would be less likely that the vendors would be invited in to participate in the clinic because we have the personnel to do that. But if there is a connection between a patient and a prosthetist, that individual is invited in and is welcome to come to the clinic and welcome to be a part of whatever activities are involved in our prosthetic clinic.

Mr. MICHAUD. Thank you. My other question. As you know, we invest a significant amount of funding into the VA for fabricating prosthetics. Do you believe it is more cost effective for the VA to consolidate prosthetics fabrication internally within the VA, or is it more cost-effective to continue to rely on contracts?

Dr. PETZEL. Congressman Michaud, let me first say that I think it is essential that the VA retain the capacity to fabricate and to fit prosthetic limbs. We must be able to do that. And quite frankly, in years passed, I think that our capacity to do that had really slipped. And I must say that over the a last 7 or 8 years, the VA has improved its capacity to do both fitting and fabrication.

The question about whether or not the VA can do it less expensively than the private sector I think remains unknown. The IG had a limited amount of data to look at and made a statement that it was less costly to do it within the VA than it was in the private sector. But I think we would all have to agree that there was not all of the sufficient data to make that comparison. My personal belief is that it is more cost effective, but we need to have all the data to say that definitively.

Mr. MICHAUD. I see I am running out of time, so thank you very much, Madam Chair.

Ms. BUERKLE. I now yield to the gentleman from Tennessee, Dr. Roe.

Mr. ROE. Just a couple of very quick questions. The idea, the reason for doing this was back to what the IG, is that right, Dr. Petzel, is trying to standardize the procedures, not only in this but in other areas in contracting that the VA does? Am I right on that?

Dr. PETZEL. To standardize procurement, not procedures per se, but to professionalize and standardize the way we procure material. We have been criticized, as I said, in the past by important groups of people, including some congressional committees, on our procurement strategies. This systemwide effort was to try and professionalize that, yes.

Mr. ROE. So I guess what the chairwoman said is correct. There is obviously a prosthetist sitting right to your left. That is a very individualized therapy. And I know as a physician, this has to be tailored per person. I am sure there is some standardization to it, and this is not going to, in any way, slow that process down or make that process not as effective or available to our veterans. Am I correct on that?

Dr. PETZEL. Yes, sir, you are correct.

Mr. ROE. And so a patient will be able to come into the clinic, and that patient won't know the difference. The time won't make any difference. There is not going to be a difference in timeliness. The fact that it costs more than \$3,000, that is not going to deflect the time; that that veteran that comes in that needs a limb or a prosthetic device is going to get that device?

Dr. PETZEL. Yes, sir, that is correct.

Mr. ROE. I think that is extremely important. Secondly, once you have cataloged this, is there a way to go outside? In other words, here is what is in our catalog. If the doctor and the prosthetist look at this patient and say, This is what they need, it is not right in this little book right here, can they get that? Because this technology is changing faster than cardiac stents are changing. It is amazing the technology now on prosthesis. As that new technology occurs, it is like these things right here, as soon as you buy it, it is out of date.

And so I see the same thing in prostheses. People are doing amazing things with this. Once it goes in the Sears and Roebuck catalog that Sears has, that the VA has, can that person get something from the new catalog or something brand new that happens?

Dr. PETZEL. Dr. Roe, absolutely. One of the nice things about the VA and the procurement regulations is 8123, which basically says that with the proper justifications, we do not have to do competi-

tive buying; that we can buy specifically what the doctor has ordered.

So while we may have a catalog of things that are appropriate in certain kinds of circumstances, the important part of all of this is the doctor writes an order, and we will procure for that patient, what the doctor has ordered.

Mr. ROE. So this is not going to negate new technology that occurs?

Dr. PETZEL. Absolutely not.

Mr. ROE. So our veterans can get the cutting edge. They are not going to get stuck in "it's not in the book, so you can't have it."

Dr. PETZEL. Absolutely not, Congressman. Just to give an example, there are two relatively new knees that were jointly developed by the VA and the Department of Defense, the X2 and the Genium. Those are absolutely cutting-edge technology for an artificial knee. They are available to any veteran who needs and wants that kind of a prosthesis.

Mr. ROE. So it is one thing to have all the colonoscopes look exactly like. That was one of the issues when I first got here. We had that issue that came up. This is a little different than that. I guess the other question I have, and then I will have no more is that you said that you don't believe that the veterans will be negatively impacted. Will they be positively impacted by this? Will this improve? I know the VA feels like it will be positively impacted, but will the veteran be positively impacted by this, or will they even know the difference?

Dr. PETZEL. First of all, Congressman, they should not know a difference. It should be absolutely transparent to them. But there are a couple of things that I think will happen that will, even if they don't notice it, improve prospects, I expect that once we get this up and running and under our belt that we are going to cut down on the procurement time, on average. That is number one.

Number two is that any money that might be saved by getting a fair price—and that is not our intention, but if that should happen—is money that can be put back into the system to provide more care to more veterans.

Mr. ROE. One quick question. When will we know that? When will you evaluate that and know when it goes in and up and running, a year from now? Or 2 years from now?

Dr. PETZEL. Congressman, I think there are going to be two different kinds of valuation. One is that in an ongoing fashion we have to monitor the things that we described before: Timeliness, was a physician's order actually followed 100 percent of time, was there a level of satisfaction that was appropriate on the part of the patient, the provider, the doctor, and the contracting officer, and certain other technical things about the contract. That is going to be an ongoing process.

When we have been into this, say, for a year or 6 months, we will have to look, and we will, look at the overall process and see what it has accomplished and see if indeed we are doing overall a better job of purchasing than we were doing before. So there will be two levels of evaluation.

Mr. ROE. Thank you. I yield back.

Ms. BUERKLE. Thank you. I am going to yield myself five minutes for a second round of questioning, if that is okay. Just a couple of things. First of all, I am concerned about a 3-month pilot that you mentioned and whether or not that is going to give us the scope of the situation, and whether or not this is working. It seems to me that 3 months is a very short period of time. And I will let you address that question in a minute.

In your opening testimony, you talked about the potential if we find insufficient resources to have been allocated after you implement the changes. What period of time are you talking about to evaluate that?

Dr. PETZEL. Madam Chairwoman, let me answer first the second part of your question. What I was saying is, if in a network or at a facility we do not have sufficient, well-trained contracting personnel to do this, we won't do it until we have the resources we need in contracting to do this in a timely, professional fashion. And that will occur as we begin to extend this into the other networks.

So if there is a network, whatever that might be, where two or three of the facilities do not have sufficient people, we won't institute this in those two or three facilities until we have the appropriate, adequate trained personnel. That is that I meant to say.

The first part of your question, and I will ask Mr. Matovsky to comment on this in a minute, is, were the pilots of sufficient length?

There was a run-up period of preparation in terms of training, et cetera. So this was 3 months of actual doing the work. And yes, we think we got a good feel for how this worked, what the issues might be, and what the potential problems might be.

Mr. Matovsky, do you want to make any comment about the length of the pilots?

Mr. MATOVSKY. We continued running them after the duration. So the official time period, we wanted 3 months, but we continued running them. As we have concluded, we then standardized the process for ordering in VISN 6 so that it conformed to VISN 11 and VISN 20. And we saw improved performance by using that new process. And we really saw it stabilize as well. So our best performing month in terms of average timeliness was July, across the board.

So it was the official time period for the pilot, and then as it was there and running, we left it running and observed how it was running.

Ms. BUERKLE. Do you know in that period of time how many actual transactions there were; how many prosthetic devices were obtained or tried to be procured?

Mr. MATOVSKY. I do know that. I am not going to find it in my notes right now. And we can provide it for the record. But we do know the specific numbers, yes, ma'am.

Ms. BUERKLE. I do want to address a much broader concern, and that is the question of leadership within the VA with regard to prosthetics. As I read through the introductions, and I read Dr. Beck's introduction, the many hats that you wear, I am concerned that you are acting in multiple capacities, and there is not one person focused on prosthetic procurement and the whole prosthetics issue within the VA.

If you could speak to direction of leadership for the VA? Is this something Dr. Beck will take on herself and then someone else will relieve her of some of the other duties? It seems like Dr. Beck is wearing many hats, I am concerned with regard to the level of leadership.

Dr. PETZEL. Thank you, Madam Chairman. You are absolutely right, she is wearing a lot of hats. Very talented, incredibly energetic lady, but she has a lot of things that she has to do.

I want to ask Dr. Beck to comment in a minute about leadership in prosthetics. But I do want to commend the job that she has done since she has been in that role. There really has been a palpable change for the better in the way we do our prosthetics. I think that Lu has done really a fabulous job.

The bench is not as strong as we would like to have it in prosthetics, so that we can turn most of the operating parts of prosthetics over to someone else.

I would like you to make a comment about that, Dr. Beck.

Ms. BECK. Thank you, Dr. Petzel, and thank you, Madam Chairwoman, for your concern. I have had a lot of support from my leadership, up to Dr. Petzel, as I have taken on this initiative. We have developed a plan to have a comprehensive office of rehabilitation and prosthetics. In that office, we will have a national program director and a large staff devoted to prosthetics and sensory aid service so that we will be managing the clinical practices, the procurement and contracting, their regulatory issues, and the development of all of the programs. So we have a plan that is just in the approval stages now that will give us the resident resources and expertise and leadership roles in the prosthetics office.

One of the important things that we are doing, and I think one of the veterans service organizations talked about this in their testimony, is that prosthetics and sensory aids is a very dynamic service. It is an important clinical support service to all of the programs in VHA. And so it touches almost every provider, from our primary care teams to our rehabilitation teams to many of our specialists. And for that reason we are linking prosthetics to rehabilitation services so that we can assure that we have the proper collaboration and coordination under the direction of Patient Care Services, which is responsible for all of the clinical activity in VA.

Dr. PETZEL. So just to elaborate for a minute, Dr. Beck would be responsible for rehabilitation services and prosthetics in the larger sense. There will be specific leadership in prosthetics and an office and the staff necessary to administer that program appropriately. And that plan, as I understand it, is coming shortly to my desk.

Ms. BUERKLE. That was going to be my next question; what would be the expectation for implementation of that plan?

Dr. PETZEL. Very soon. I hesitate to give you a specific date, but I understand the request for people in the organizational chart is on its way to me. We will review that, and as soon as it is signed off on, the process of hiring those people and beginning to do that will begin. So the process will certainly begin shortly. I can't predict how long it will take to hire the right person, but we will begin shortly.

Ms. BECK. I would just like to reinforce that. We currently have many very excellent people in the prosthetics and sensory aids

service who are working everyday with me to accomplish all of our goals, and also to say that in rehab services, we have defined leadership and subject matter expertise for each of the offices. So our physical medicine and rehabilitation office has a physician leader. So the leadership, as Dr. Petzel says, in prosthetics and sensory aids service will be devoted to the clinical support services that we are doing in prosthetics and sensory aids.

Ms. BUERKLE. Thank you very much. Just briefly, and then I am going to yield to the Ranking Member. You mentioned that yesterday you had a conference call and that you have been in touch with the veterans service organizations. As you recall, at the last hearing there were grave concerns, and in my opening comments, I expressed the concerns the VSOs have. In one of the questions you just answered, you talked about this ongoing process and you talked about timeliness and physicians' orders and the contracting officers. But, again, there is no contact, there is no connection, there is no ongoing—there doesn't seem to be ongoing communication with the veterans service organizations, with the veterans themselves. It is one thing to do this operation and to look at it objectively, and to look at a plan on paper, but the most important ones we need to hear from are the veterans who are requiring this service, because that is what is key here.

Dr. PETZEL. Thank you, Madam Chairman. Two responses to that. One is I have ongoing meetings with veteran service organizations. We do two things: Every month I have a breakfast, 2-hour meeting with the leaders of the six largest service organizations. Then every quarter we have a bigger meeting, again, about 2½ hours, with a broader range of service organizations. And we will keep in touch with them through this. It is important to all of them, but particularly the Disabled American Veterans, the PVA, and the Blinded Veterans. Prosthetics is an essence of the service that the members of those organizations need.

In terms of the veterans, Troy Elam, who was present, by the way, on the phone call, who had testified earlier, I think said it at the first hearing, and I had not really heard anybody articulate it quite as well as she did. And that is, that we have to have, as part of our ongoing look at this transition, we have to have a mechanism for asking the veterans what they experienced, not just with this transition, but with prosthetics itself.

Perhaps Dr. Beck could just briefly comment on the instrument that we are going to use.

Ms. BECK. Yes. Thank you, Dr. Petzel. The instrument we are going to use is called uSPEQ. That is an acronym for the Stakeholder Participation and Experience Questionnaire. This is a national benchmarked questionnaire that is used by the Committee on Accreditation for Rehabilitation Facilities, which is a national organization that accredits rehabilitation facilities. We have recently received approval from the Office of Management and Budget to use that survey to gather information about satisfaction, and we have arranged a contract which is now in place with CARF, the acronym for Committee on Accreditation of Rehab Facilities, and we are beginning the training of our staffs around the country so that they will be able to implement the utilization of this question-



naire, not only for amputation and prosthetics care, but for many elements of the rehabilitative care that we provide in VA.

One very important aspect of this is that it is a valid survey. Data are collected from all facilities all over the country, not just VA facilities, and we are able to benchmark our care with the care that is provided across the country related to rehabilitation. So that is important for us. And it is patient satisfaction. And so it asks the patient what they think.

Ms. BUERKLE. And if I could respectfully suggest, in addition to the organizations that you are communicating with, that you would include the newer organizations: The Wounded Warrior Project, the IAVA. It seems to me they should be included in this discussion and their feedback should be obtained as well.

Dr. PETZEL. Yes. Thank you.

Ms. BUERKLE. I yield now to the Ranking Member.

Mr. MICHAUD. Thank you very much, Madam Chair. In answering Mr. Roe's question about procurement time, you said it will cut down on procurement time. Do you have any idea how much time it might cut down on the procurement time?

Dr. PETZEL. I would, Congressman Michaud, have to ask Mr. Matovsky if he has any thoughts on that. I don't.

Mr. MATOVSKY. As we were watching the pilots as they were running in the most recent month in VISN 20, for instance, our average timeliness was down inside of 3 days to procure, which was pretty quick. I think the other thing that we would expect to find, frankly, and it came out of these pilots, was a collaboration between logistics and prosthetics so that we could better tune the inventory management process as well. We will see how that goes. We will study that.

But what that would allow us to do is it would allow us if we have better visibility into our inventory avoid a stock-out situation. A stock-out situation is where we run out of something. And I think that is where we really have the benefit of being able to have greater visibility into what we have available and what kinds of inventory control points would allow us to have a situation where we are managing at a minimum inventory level. We are seeing that in VISN 20 in the Upper Northwest, sir.

Mr. MICHAUD. Thank you. The OIG in their recommendations recommend that some VISNs contract out between three and five. When you look at VISNs that are actually contracting out with the private sector providers more than the three or five that was recommended, does that show that there is a greater demand among the veterans community to go to the private sector, or is that because veterans pretty much in the rural areas are accessing those, therefore you have a lot of contracts with private providers? Or, is the need continuing to increase dramatically?

Dr. PETZEL. Dr. Beck, could you take that?

Ms. BECK. Thank you, yes. The contracts have been established to provide access, to be sure there was access close to the patient's home or close to the veteran's home. And that is the reason for the large number of contracts that we have had.

Mr. MICHAUD. Thank you. My last question is in reviewing your testimony, Dr. Petzel, you stated that VA is instituting more audits of purchases to ensure that we are getting the best value for our

dollars when we procure prosthetics or other devices. Can you tell me how many more audits you are doing now compared to before, who is performing those audits, and who is analyzing those audits as well as the types of measurements that you are using for those audits?

Dr. PETZEL. Let me, in a general sense, respond, Congressman, then I would ask Mr. Matovsky to provide some detail. The things that we are going to be looking at are the things that I mentioned earlier, was the product that was ordered and delivered, the product that the physician ordered. In other words, what is the consonance between what the physician ordered and what was obtained?

Timeliness will be an ongoing audit. Satisfaction from the point of view of the patient, the physician provider, the prosthetist, and the contracting officer will be an ongoing audit. In the cases where we use 8123 where we don't have to be competitive, was there an adequate justification for a noncompetitive acquisition, et cetera. Those are the things that we in an ongoing way are going to audit. In terms of how frequent we are going to be doing that, I would turn to Mr. Matovsky for a comment about that.

Mr. MATOVSKY. We will be running those every month on a cycle. We run within VHA two systems of audits that occur every month and then the Department, under Mr. Heard, has another audit that comes in and reviews. Ours is probably a little bit more tactical than the Department's.

We look at primarily two things: First, where there is a justification for other than full and open under FAR part 6 using 8123, did the contracting officer comply with the prescription? That is number one. Number two, we are looking at other elements that are procurement reform-oriented. Is there an adequate work-up for the justification? Was there a price negotiation performed? Et cetera. And those are the things that we are looking at.

Over time, I think where we would see additional efficiencies, at this point theoretical; again, the most important thing, did we conform to the 8123 justification? But over time, looking at things where we are buying many things repeatedly without a covering contract using 8123, do we have an opportunity to structure an agreement there. And I think those are the ones that we would look at over time.

But to your question, every month it cycles through the VISN level contracting manager, every month it cycles through the VHA system of national audits. I review every month in detail one of our VISN's contracting results. This is one of those results I now review. Mr. Doyle, who is here, also reviews through his system the audit results.

Mr. MICHAUD. Thank you. I have no more questions. Thank you.

Ms. BUERKLE. I am going to yield myself another 5 minutes, and then if Mr. Michaud has other questions, he may ask them. We keep talking about the contracting officer. What is a contracting officer?

Dr. PETZEL. I would ask Mr. Heard if he would, please, Madam Chair, to answer that question.

Ms. BUERKLE. And if you could speak to their qualifications, their training, and the agreement they have. Because initially, I

heard there would be a 100 percent compliance with the physician order for the prescription. Now I am hearing that is going to be monitored. Does the contracting officer have any discretion, or why wouldn't he adhere 100 percent of the time the physician's prescriptions for which a prosthetic device is being prescribed for the veteran?

Mr. HEARD. Sure. Madam Chair, we have to look at the acquisition workforce first to determine what their qualification skill-sets are. Going back to 2000, the Clinger-Cohen Act that went into place actually professionalized the acquisition workforce by putting a positive education requirement in place. That positive education requirement for a GS-12 or below is either a degree in any field of study at an accredited college, or 24 hours of business. At a GS-13 and above, it requires both an undergraduate degree and 24 hours of business. The Clinger-Cohen Act also required experience and also training to be an integral part of that acquisition professional contract specialist requirement.

The actual warranting of a contracting officer, that is a delegation. A delegation is based on a need defined by the head of a contracting activity. In the VA, there are six heads of contracting activity. For Veterans Health Administration, which oversees all of the hospital acquisitions, including prosthetics, that HCA is Norb Doyle, who is here. Norb is designated by the senior procurement executive for the Department of Veteran Affairs, Jan Frye. The warranted contract individuals that are identified based on a need have to show and demonstrate their experience, their education, and training.

Training is also a very elaborate criteria requirement that was identified by OMB back around 2007, called the Federal Acquisition Certificate in Contracting. Those individuals climb to a level of FACC level 3. Again, a very rigorous, robust education training requirement, a curriculum identified by the Federal Acquisition Institute. Once you are certified, you are eligible for a warrant at various levels.

Our level 1 warrant holders probably have the lesser amount of training, but they can be warranted up to \$150,000. That is commensurate with the simplified acquisition threshold. So these are warranted individuals that are warranted on behalf of the Federal Government to act as an agent to procure on behalf of the Federal Government to ensure that contracts are awarded with a fair and reasonable price, to seek competition, to comply with the FAR and the VAR.

Prosthetics is a unique requirement. We are really identifying special needs for our veterans. Those requirements can be anything, as we talked about today, artificial limbs, but also products that are also commercial in nature, which could be walkers, canes, and crutches. Some of those are available commercially. They are obtained off Federal supply schedules. But then the others are really very specific to the surgery that is required for a veteran or other therapeutic requirements.

Ms. BUERKLE. So why wouldn't there be automatically 100 percent compliance with a physician's order? Why is that even a concern? You are talking about someone with a bachelor of science degree who maybe has 24 hours of business classes, that they have

discretion to override or to not comply with the physician's order with regard to the prosthetic?

Dr. PETZEL. Madam Chairwoman, I can just take that for a moment, first, and then we will see if either Mr. Heard or Mr. Matovsky have anything to add.

The issue there is fair and reasonable price. That is their only responsibility in that case, would be to ensure that in purchasing that specific thing that the physician has ordered, that we are getting a fair and reasonable price. And that might entail negotiating with that provider—with that prosthetic provider.

Ms. BUERKLE. So I guess I am concerned, because if there is a prosthetic available that is maybe less money, are we looking at the quality, are we looking at the prosthetic itself, or are we just negotiating a price about the same—

Dr. PETZEL. We are negotiating, in this case, a price, Madam Chairwoman, around the specific thing that the physician has ordered. That is what determines what we buy. The contracting officer's responsibility is to see that we get a fair price for it. But when he is not going to be, or she is not going to be buying something different because it is less costly. Again, we look at what was the physician's order, and that is what we buy.

Ms. BUERKLE. So you would expect 100 percent compliance with the physician order?

Dr. PETZEL. Absolutely.

Ms. BUERKLE. Do you have any further questions?

Mr. MICHAUD. No. That is a good way to sum it up. I think it is very important that the physician is the one who decides, so I do want to thank you, Dr. Petzel, for all that you are doing to help our veterans, as well as the other three panelists here today for your efforts in this regard, so thank you very much.

Ms. BUERKLE. I thank the Ranking Member, and I also want to thank the panel for being here this afternoon. I, again, would just like to ask, I think it is very important that we get as many veterans' service organizations involved in this discussion, as many perspectives as possible. You know, what you have mentioned, with all due respect, is great, but I think we have got additional veterans' service organizations that need to be included in this discussion and to make sure there is nothing more important than the veterans and making sure when they come home without a limb because they have served this Nation, that they have what they need, that they are not dealing with some contracting officer who has got some discretion to give him less of a device than he deserves. So that is all of our concern here—that we get our veterans exactly what they need.

We heard the last time from veterans who talked about—we are talking about—the ability of someone to walk his daughter down the aisle. We are talking about intensely personal prosthetics and an intensely personal segment of the care that our veterans need, so there is nothing more important.

And while we are all concerned with regard to costs, that we make sure our veterans who have served this Nation get exactly what they need so they can return to their maximum potential after they have sacrificed so much for this Nation.

With that, I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and to include extraneous material. Without objection, so ordered.

Before I close the hearing, I would like to make a request that you submit to this Health Subcommittee and to the Veterans' Affairs Committee the plan that you are talking about. We would like to see that to make sure that the veterans' best interests are served.

Dr. PETZEL. We will do that, Madam Chairwoman.

Ms. BUERKLE. Thank you, again, to our witnesses for being here, to our audience members, and to the Subcommittee members, to my Ranking Member, for joining in today's conversation.

This hearing is now adjourned.

[Whereupon, at 5:33 p.m., the Subcommittee was adjourned.]

## A P P E N D I X

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### Prepared Statement of Chairwoman Ann Marie Buerkle

Good morning and welcome to today's Subcommittee on Health Hearing, "Optimizing Care for Veterans with Prosthetics: An Update."

Today's hearing is a continuation of a discussion we began almost 3 months ago when this Subcommittee heard from veterans with amputations, members of our veterans service organizations (VSOs), and officials from the Department of Veterans Affairs (VA) to review VA's capability of delivering state-of-the-art prosthetic care to veterans with amputations and the impact of VA's planned prosthetic procurement reforms.

These reforms will, among other things, take prosthetic purchasing authority away from prosthetic specialists and transfer it to contracting officers.

As our veterans so eloquently described in May, prosthetic care is unlike any other care that VA provides and, when we make the mistake of treating it as such, no less than the daily and ongoing functioning and quality of limb of our veterans is at stake.

I was very troubled to hear our veterans voice such strong opposition to the proposed procurement reforms, arguing forcefully that they would lead to substantial delays in care for veterans with amputations and clinical judgments regarding veterans needs being overridden by individuals with little to no experience in prosthetic care.

In mid-June—following our hearing—I sent a letter, along with Ranking Member Michaud, to the Secretary requesting that the Department respond to a number of questions and provide certain materials regarding the strategy, plans, and criteria used to consider, develop, design, implement, and evaluate the proposed reforms and the pilot programs that preceded them.

Our goal was to understand the analysis VA employed to develop the reforms and what was behind the decision that this was the best idea for our veterans, especially those who have experienced loss of life as a result of service to our country.

Sadly, the Department's response—which came a week after the deadline requested in our letter—did not provide the information or the level of detail we asked for and did nothing to assure me that the plan would be effective or that our veterans concerns were unfounded.

To the contrary, a close review of the materials VA provided leads me to believe that the reforms were developed without careful and thorough consideration. It leads me to believe they were developed without sufficient input from veterans themselves, veteran service organization advocates, or other stakeholders.

It leads me to believe that they were developed and implemented, after being tested for a very short time, at a small number of locations, with very limited feedback. It leads me to believe they were developed without adequately measuring their impact on patient care. It leads me to believe they were developed without safeguards in place to ensure veterans and clinician's wishes are respected and timeliness goals are met.

It is concerning that VA would move forward with instituting large-scale changes that so directly impact veteran patients in this way. If my concerns are groundless—and I hope that they are—I want VA, in explicit detail, to explain why.

During our last hearing, our veterans and VSOs spoke loud and clear. Now it is time for VA to do the same.

Again, I thank you all for joining us this afternoon. I now recognize our Ranking Member, Mr. Michaud for any remarks he may have.

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**PREPARED STATEMENT OF HON. ROBERT A. PETZEL, M.D.**

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee: thank you for the opportunity to speak about the Department of Veterans Affairs' (VA) prosthetics procurement reforms. I am accompanied today by Mr. Philip Matkovsky, Assistant Deputy Under Secretary for Health for Administrative Operations, Veterans Health Administration (VHA); Dr. Lucille Beck, Chief Consultant, Rehabilitation Services, Director, Audiology and Speech Pathology, and Acting Chief Consultant, Prosthetics and Sensory Aids Service, VHA; and Ford Heard, Associate Deputy Assistant Secretary, Office of Acquisition and Logistics.

VA testified before this Subcommittee and the Subcommittee on Oversight and Investigations in May 2012 regarding our efforts to maintain the high quality of prosthetics VA provides to Veterans while instituting reforms to improve compliance with the Federal Acquisition Regulation (FAR), the Competition in Contracting Act, and to improve our management of government resources. In follow-up to those hearings, the Chairwoman and Ranking Member submitted a letter to the Department on June 21, 2012, requesting a response by July 6, 2012, that would offer additional information about these reforms. On July 12, 2012, VA submitted information to the Subcommittee on Health to begin to address the Subcommittee's request. Our interest was in responding as quickly as possible to your request, and we regret our submission of July 12, 2012, did not sufficiently address your concerns.

You also have asked for an update on the actions the Department has taken to reform the prosthetics procurement process since the May hearings. I am pleased to report that on May 23, 2012, VA issued a Memorandum to the field advising them that it is VA's policy that those engaged in the ordering of biological implants comply with the FAR and VA Acquisition Regulation (VAAR). This Memorandum provides further information and guidance to staff to ensure they understand our objectives and procedures. That Memorandum states that the VA official performing the purchasing activity is to comply with a physician's prescription when it is indicated. Furthermore, in response to your advice to transition our warrant procurement program with deliberation and caution, VA extended the date for finalizing this transition from July 1 until September 30, 2012. This transition continues with ongoing communication and coordination with the Veterans Integrated Service Networks to ensure that procurement services are not disrupted. We are closely monitoring the staffing levels for our contracting organizations, the workload levels, and most importantly, the timeliness of the procurement actions.

Finally, you asked me to address the potential impact these prosthetics procurement reforms could have on Veterans. As we testified in May, we do not believe that Veterans will be adversely impacted in any way. We believe that many of our reform efforts are acceptable to all concerned parties. For example, VA is instituting more audits of purchases to ensure that we are getting the best value for our dollar when we procure a prosthetic or other device. We also will begin tracking our purchasing trends to identify when and where we can enter into negotiated contracts. Further, we are streamlining and standardizing elements of the procurement process to reduce variation and accelerate purchases so Veterans can receive their devices and equipment faster.

The proposals that have raised interest are our plans to standardize the purchasing of prosthetics and other devices, and our plan to transition procurement decisions to warranted contracting officers. On the first plan, many of the products VA purchases are either going to become a part of a Veteran or will be a critical part of their daily lives, helping them walk, work, and interact with their families. We understand the critical value these devices offer, and the independent clinical judgment of our providers will remain fully intact. This aspect guides the decision-making of our leadership and will be preserved in our policies and procedures. Clinicians, in consultation with Veterans, will decide *what* devices we procure. Our reforms are designed only to modify *how* we procure them. When products are generally available and interchangeable, competitive procurements may be appropriate, and we are hoping that in the long term we can develop a catalog that will facilitate, more cost effective purchasing decisions.

On the second plan, concerning the transitioning of procurement decisions, I again emphasize that this is only changing how we purchase, not what we purchase. By shifting to contracting specialists, we can ensure that we secure fair and reasonable prices for products while still delivering state-of-the-art care.

In conclusion, VA has been engaging in prudent and appropriate reform to improve the business processes governing the procurement of prosthetic devices for Veterans. We take great care to ensure that these changes improve the accountability of these purchases while maintaining the high quality of care and clinical decision-making critical to Veterans' health care. Clinicians determine the prosthetic needs of Veterans as a part of their clinical care, and VA procures the devices necessary to achieve personal clinical outcomes. Our reform efforts will not disturb this arrangement, which will remain the centerpiece of prosthetics care in VA. We appreciate the opportunity to appear before you today to discuss this important program. My colleagues and I are prepared to answer your questions.



**Deliverables from the United States Department of Veterans Affairs**

**Date:** August 23, 2012

**Source:** Hearing Deliverables

**Inquiry from:** HVAC Health

**Context of Inquiry:** During the HVAC Health prosthetics hearing three deliverables were noted:

There were three deliverables from yesterday's prosthetics hearing:

1. How many prosthetic devices were procured during the pilot?
2. Please forward the new organizational plan to merge prosthetics and rehabilitation.
3. Please provide a timeline for how long it will take to complete the new organization.

**Response:**

**Question:** How many prosthetic devices were procured during the pilot

**Response:** The table below provides this information.

It is important to recall that only those purchases above \$3,000 will transition to a VHA Contracting Officer. There are roughly 90,000 prosthetics transactions executed per year that are greater than \$3,000.

**Table: Number of Prosthetics Purchases made by VHA Contracting Officers**

	VISN 11	VISN 20	VISN 6	Totals
January	57	131	145	333
February	122	149	224	495
March	263	174	299	736
<b>Subtotal</b>	<b>442</b>	<b>454</b>	<b>668</b>	<b>1,564</b>
April	268	166	194	628
May	283	207	358	848
June	226	273	314	813
July ( <i>partial month</i> )	149	150	272	571
<b>TOTAL</b>	<b>1,368</b>	<b>1,250</b>	<b>1,806</b>	<b>4,424</b>

**Question:** Please forward the new organizational plan to merge prosthetics and rehabilitation

**Response:** Veterans Health Administration (VHA) has aligned Prosthetic and Sensory Aids Service (PSAS) with the Office of Rehabilitation Services (ORS), to become the Office of Rehabilitation and Prosthetic Services. The reason for this change is to align both prosthetic and clinical programs together in order to optimally coordinate and deliver programmatic services, policies, and guidance for medical equipment/items and medical rehabilitative services that promote the health, independence, and activities of daily living for Veterans and Servicemembers. This realignment of existing VHA resources will further improve management and oversight of prosthetic purchasing, inventory control, and clinical coordination in order to better utilize appropriated resources. The cost of this realignment is budget neutral, the newly aligned office will remain within VHA Office of Patient Care Services, and the administrative processes (e.g., budget, HR, planning and programming, etc) for PSAS and ORS will be completely aligned by September 30, 2012.

Please see the attached document for a summary of the plan to merge prosthetics and rehabilitation.

**Question:** Please provide a timeline for how long it will take to complete the new organization

**Response:** The Office will be completely aligned by September 30, 2012.

**Summary of Plan to Merge Prosthetic and Sensory Aids Service and Office  
of Rehabilitation Services**

**Health Subcommittee, House Committee on Veterans' Affairs**

**Deliverable from July 31, 2012 Hearing**

Prosthetic and Sensory Aids Service (PSAS) is core to the mission of VA and affects millions of Veterans and Servicemembers on a short-term, long-term, and ongoing basis. PSAS should be realigned to most effectively support clinical services and engineer optimal programmatic policies, guidance, and regulations to advance the full continuum of health care practices in VHA. The Office of Patient Care Services will merge with the Office of Rehabilitation Services (ORS) and become the Office of Rehabilitation and Prosthetic Services in the Office of Patient Care Services.

This alignment will improve management and oversight of prosthetic purchasing, inventory control, and clinical coordination in order to better utilize appropriated resources. Transition of PSAS under ORS, with appropriate staffing, will position VHA to most effectively accomplish that mission. The Prosthetic and Orthotic Program will be aligned as a separate clinical section under ORS.

The Office of Inspector General (OIG) recently completed reviews, and Congress has subsequently held hearings regarding concerns about oversight and management of procurement, inventory management, and prosthetic services in VHA. Consequently, the pressing need for improved management, coordination, and alignment of PSAS within clinical services has become increasingly important.

The transition of PSAS to a national program office under ORS will:

- Establish and improve processes for providing prescribed and clinically appropriate, state-of-the-art prosthetic devices, sensory aids, and equipment in the most economical and timely manner;
- Manage national contracting processes for prosthetic devices including strategic sourcing;
- Maintain a system of information management for procurement requests; and
- Align standards of care and clinical practices and PSAS purchasing.

PSAS does not currently have the appropriate organizational structure or staffing to support clinical services aligned with programmatic policies. If PSAS is realigned with ORS, the resulting programmatic re-engineering of regulations and policies, contracting processes, clinical prescription practices, budget accounting, information technology, and realignment of key staff will: (1) leverage pre-existing infrastructure and resources and (2) identify and mitigate vulnerabilities.

Dr. Lucille Beck, Chief Consultant, will lead this realignment and the Office of Rehabilitation Services will become the Office of Rehabilitation and Prosthetic Services (OR&PS). Implementation of this realignment will commence, with initial organizational restructure completed within 30 days. Personnel recruitment actions will be initiated to fill existing personnel vacancies. The existing PSAS budget will be realigned under OR&PS, with accountability fully transitioned by the beginning of fiscal year (FY) 2013.

The success of this realignment will be monitored through a number of strategic outcomes, including: improved timeliness in providing prescribed items to Veterans; increased numbers of national contracts and compliance with contracts; compliance and accuracy in recording and tracking serial numbers of critical items (e.g., surgical implants); accurate budget execution to ensure appropriate allocation for specific purpose funds (i.e., prosthetic items, devices, and equipment) and balance of expenditures to obligations; and implementation of data accuracy monitors to track and compare issuance codes for consistency across national averages. Further, programmatic policies, regulations, and processes for prosthetic services will be aligned with those of clinical services to improve consistency and continuity of services to Veterans—from clinical prescription, to procurement, provision, and verification of receipt of appropriate prosthetic items.

