

LIFE AFTER LIMB LOSS: EXAMINING VA AMPUTEE PROSTHETICS CARE

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C O N T E N T S

WEDNESDAY, NOVEMBER 20, 2024

	Page
OPENING STATEMENTS	
The Honorable Mariannette Miller-Meeks, Chairwoman	1
The Honorable Julia Brownley, Ranking Member	3
WITNESSES	
PANEL I	
Mr. M. Christopher Saslo, DNS, APRN-BC, FAANP, Assistant Under Secretary for Patient Care Services/Chief Nursing Officer, Veterans Health Administration, U.S. Department of Veterans Affairs	4
Accompanied by:	
Dr. Joel Scholten, Executive Director, Physical Medicine and Rehabilitation, Veterans Health Administration, U.S. Department of Veterans Affairs	
Dr. Ajit Pai, Executive Director, Office of Rehabilitation and Prosthetic Services, Veterans Health Administration, U.S. Department of Veterans Affairs	
Mr. J. Drew Craig, Design Chief, Enterprise Measurement and Design Directorate, Veterans Experience Office, U.S. Department of Veterans Affairs	
PANEL II	
Mr. Jose Ramos, Vice President of Government and Community Relations, Wounded Warrior Project	18
Mr. Matt Brown, U.S. Army Veteran, The Independence Fund	20
Ms. Ashlie White, Chief Strategy and Programs Officer, Amputee Coalition	22
APPENDIX	
PREPARED STATEMENTS OF WITNESSES	
Mr. M. Christopher Saslo, DNS, APRN-BC, FAANP Prepared Statement	35
Mr. Jose Ramos Prepared Statement	40
Mr. Matt Brown Prepared Statement	52
Ms. Ashlie White Prepared Statement	54
STATEMENTS FOR THE RECORD	
U.S. Government Accountability Office Prepared Statement	57
Mr. Scott Restivo Prepared Statement	64
The American Legion Prepared Statement	66

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

The subcommittee met, pursuant to notice, at 2:30 p.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meek [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meek, Bergman, Murphy, Van Orden, Luttrell, Brownley, Landsman, and Budzinski.

Also present: Representative Rouzer.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. Hearing for the Subcommittee on Health will now come to order. Today we will be discussing the Department of Veterans Affairs' (VA) Amputation System of Care (ASOC) and the services provided to veteran amputees. At VA prosthetics include a wide range of devices, from eyeglasses to hearing aids to prosthetic limbs. If I could manage to turn the page. Although our main focus today will be on amputee prosthetics, I want to highlight the VA's recent failures related to purchasing and budgeting for prosthetics. In July, committee staff visited the Rocky Mountain VA Medical Center in Colorado and discovered that thousands of prosthetic orders had been improperly canceled. As a clinician, I was appalled that this could happen and it is clearly unacceptable.

Earlier this month, I was informed that the VA's claimed budget shortfall for healthcare, which they argued was related to the cost of prosthetics, was a huge exaggeration. If the VA cannot even budget correctly for prosthetics and routinely cancels orders, how can veterans, especially those living with the visible wounds of war, trust that they will receive the prosthetics they need? We cannot and should not accept this as status quo. Prosthetic care is essential to the bedrock of VA's mission. This means assisting veterans with regaining functionality and working to improve their quality of life after limb loss as a result of their service in uniform. Each year, VA sees approximately 95,000 new amputations, primarily due to vascular disease or diabetes. However, VA also treats a significant number of post 9–11 veterans with combat related amputations.

As veterans' needs evolve, it is the VA's responsibility to provide the highest quality of care and advances in research to meet those

needs. VA services vary across its facilities, but its seven fully equipped regional amputation centers can offer comprehensive care from prosthetic fabrication to full inpatient rehabilitation. These centers should set the standard for world class care for prosthetics, and in many cases they do. VA's amputee care serves nearly 100,000 veterans annually, with many receiving exceptional care. However, the committee has heard of significant delays in veterans receiving their prosthetics.

For one example, one veteran recently told my team that he has spent over a year waiting for a functional prosthetic leg. For 10 of those months, as you can see here, he had to rely on duct tape to hold his prosthetic together. Since March 2023, he has been forced to travel out of State every 3 months for appointments. Despite these repeated trips, there is still no timeline for when he will receive his new prosthetic limb. Now, it should not take a congressional hearing for him to hear back from the VA or for the VA to respond to this veteran. He should receive the latest state-of-the-art updated prosthetic limb now, ASAP. Veterans depend on these devices for their daily lives and waiting for years for our prosthetic limb, socket, or terminal device is unacceptable. I expect we are going to hear similar stories today.

Like other VA offices, VA's amputation centers face understaffing and are often riddled with bureaucratic inefficiencies. These challenges, exacerbated by the Biden Harris Administration's poor leadership and staffing decisions, are uniquely devastating to veteran amputees. These bureaucratic delays not only impact veterans physical health, but they also take a toll on their mental well-being, resulting in more time in healthcare facilities and less time spent with their families enjoying life or advancing their careers. As a veteran and a physician, I know we can do better. In addition to these issues, veterans face barriers in accessing adaptive prosthetic limbs and terminal devices for sports and recreational activities. Devices that can be life changing. The committee has heard numerous stories of veterans being denied these adaptive prosthetics. That is why I recently introduced H.R. 9478, the Veterans Supporting Prosthetics Opportunities and Recreational Therapy Act or the Veterans Sport Act. This bill would ensure these adaptive prostheses and terminal devices are defined as clinically necessary for veterans living with limb loss.

I am committed to working with the VA to ensure we provide our veterans with timely, high quality prosthetic care that they deserve so that they have access to what they need to live the most fulfilling life possible and the most fulfilling work. During today's hearing, we will delve deeper into these issues, hear from witnesses and work toward common sense solutions. Thank you all for being here and I look forward to a productive discussion on this critical topic.

Before I introduce the witnesses on our first panel, I ask unanimous consent that our colleague, Representative David Rouser be waived on for this hearing. Hearing no objection. We will move forward. I now will yield to Ranking Member Brownley for any opening remarks you may have.

**OPENING STATEMENT OF JULIA BROWNLEY, RANKING
MEMBER**

Ms. BROWNLEY. Thank you Chairwoman Miller-Meeks and thank you to our witnesses for being here today. Veterans living with amputations deserve access to the most comprehensive pre and post amputation care that VA can provide. I am looking forward to hearing from our VA witnesses on Panel One about how they currently provide this care and areas of improvement and advancements that they are seeking. I am also looking forward to hearing from our Panel Two witnesses about their own experiences and experiences of those they represent with VA care.

Veterans with amputations from any cause must receive well-coordinated and comprehensive care from providers including their physicians, physical and occupational therapists, prosthetic providers and mental health providers. It is crucial that we support the provisions of all these types of care to ensure that every veteran receives the unique combination of these services needed to meet their medical and personal goals. While I understand that not every VA facility has the capacity to manufacture prosthetics, I look forward to hearing more about how VA is working to build in house capacity while continuing to work with contracting and vendor partners, improve communication with providers in the community, and ensure it is providing wraparound services for veterans in its care.

I am especially glad to hear of the work VA is doing to both prevent disease progression to avoid amputation as well as to the advances in technology and treatment options available for those who do receive amputation. This includes VA programs like the Preventive and Amputation in Veterans Everywhere or PAVE, a program that has been established at every VA medical facility and researched through the VA center for Limb Loss and Mobility. As we continue to advance our medical understanding of these diseases, they can lead to the need for amputations. I am sorry, that would lead to the need for more amputations. We must continue to improve the care we are providing our veterans.

It is also clear we are living in a time of exciting advancements for prosthetic options. With the use of telehealth technology, VA providers can be more connected than ever to ensure veterans and other providers are communicating about veterans' prosthetic needs. Additionally, with advances like 3D printing, we have more control than ever over how and where VA can manufacture prosthetics and ensure a proper and effective fit. I look forward to hearing more about how VA is already using this technology and how it can be expanded upon. This will be especially important for women veterans who make up a small but growing number of the total patients with amputations that receive care at VA.

As U.S. Government Accountability Office (GAO) notes in its statement for the record for this hearing, women veterans have reported facing difficulty in finding properly fitting prosthetics as they are generally sized for men. However, the ability to 3D print prosthetics that are designed to fit their bodies and accommodate their clothing and shoe options will be revolutionary for women veterans. I am also grateful to Mr. Ramos and Mr. Brown for being here and willing to share their experiences and expertise, as well

as Mr. Restivo who has submitted a statement for the record. I find this committee's work is most impactful when we can hear a variety of veterans experiences with the care VA provides and identify common ground where those services and care can be improved. I look forward to continuing that today.

Finally, I welcome hearing from our witnesses at the Amputee Coalition about its work to support VA's amputation care. Having the support of a community of individuals who understand the challenges of living with any physical change is crucial, including for veterans living with amputations. I am glad the Coalition can provide that through its Peer Visitor Program and National Support Group Network, and I am looking forward to hearing more about the types of support that we can expand upon. Thank you again to our witnesses and for being here and I yield back.

Ms. MILLER-MEEKS. Thank you Ranking Member Brownley.

I would now like to introduce the Panel One witnesses testifying before us today. We have Dr. Christopher Saslo, Assistant Undersecretary for Health Patient Care Services at the Department of Veterans Affairs. Accompanying Dr. Saslo representing the Department of Veteran Affairs are Dr. Joel Scholten, Executive Director of Physical Medicine and Rehabilitation, Dr. Ajit Pai, Executive Director, Office of Rehabilitation and Prosthetic Services and Mr. Drew Craig, Design Chief, Enterprise Measurement and Design Directorate, Veterans Experience Offices (VEO). Dr. Saslo, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF M. CHRISTOPHER SASLO

Dr. SASLO. Good afternoon, Chairwoman Miller-Meeks and Ranking Member Brownley and members of the subcommittee. I appreciate the opportunity to address the subcommittee today regarding VA's amputation system of care. Joining me today as you heard is our Executive Director for the Office of Rehab and Prosthetics, Dr. Ajit Pai. I am also accompanied by the Executive Director of Physical Medicine and Rehab, Dr. Joel Scholten and Mr. Drew Craig, who is our Design Chief for VA Enterprise, Measurement and Design Directorate. My colleagues and I are pleased to share how VA cares for veterans with limb loss. Overarchingly, the department employs an interdisciplinary team based approach focused on maximizing each veteran's functional ability and independence. Each amputation procedure presents unique challenges which requires specialized follow-up care. VA is committed to building on our record of excellence when addressing amputation related needs of our veterans. We provide lifelong specialty care benefits which includes ensuring access to advanced prosthetics and instructor rehabilitative services. VA's amputation system of care connects the Nation's heroes to the expert services as close to their home as possible.

In Fiscal Year 2024, the amputation system of care provided care to 18,387 veterans through 38,122 encounters that included 7,896 virtual visits. The roughly 18,000 veterans we cared for represents a significant 12.5 percent increase in our prosthetic health delivery over Fiscal Year 2023. Further, new patients experience a low average wait time of 26.5 days. Patient satisfaction remains high in Fiscal Year 2024 with the 95 percent of our veterans reporting feel-

ing respected during clinic visits and 92.8 percent reporting satisfaction with their inclusion in care delivery. The Amputation System of Care model emphasizes lifelong care which centers on the whole health of each veteran including physical and mental well-being. Key pillars include preoperative education so that they know what to expect throughout their wellness journey.

VA performs annual assessments thereafter as part of the Whole Health approach which incorporates peer support and adaptive supports. We also offer comprehensive training for providers, specialists, patients, caregivers and families. The U.S. Department of Defense (DOD) and VA continue to collaborate to ensure seamless, high-quality care for service members and our veterans. VA and DoD utilize the Extremity Trauma and Amputation Center of Excellence to advance discovery and clinical practice. In service to veterans' whole health, the department creates new mutual educational programming and has created a network of amputation rehab coordinators. In conjunction with the DoD, VA's Office of Advanced Manufacturing allocates resources to develop and manufacture U.S. Food and Drug Administration (FDA) compliant advanced medical devices. In recent years, VA has made significant prosthetic advancements. We modernized our workflows through the implementation of 3D technology and through increased use of our telehealth visits.

Other current innovations include a 3D printed foot system to enable veterans to wear shoes of any size type and heel height. VA is also testing a prosthetic system which allows users to feel touch through their prosthetics. The next gen prosthetic devices utilize advanced algorithms to produce real time measurements which improves functionality. Surgical advancements includes the ERTL technique, targeted muscle reinnervation and FDA approved osseointegration implantation. VA's groundbreaking research includes a multi-site study which tests an internally developed bone anchored prosthetic docking system. At VA, we do much of our work to create positive veteran outcomes from within. However, we also rely on private sector partners to advance our mission of care. The network of veterans service organizations aid VA in caring for veterans experiencing delays or challenges with amputation related care and we continue to learn at every opportunity.

Chairwoman Miller-Meeks, Ranking Member Brownley thank you again for your opportunity to provide remarks on VA's holistic approach to amputee care. Our commitment to ensuring that all veterans receive the solutions and respect they deserve remains steadfast. My colleagues and I are ready to address any questions you may have on how we can advance our mission.

[THE PREPARED STATEMENT OF M. CHRISTOPHER SASLO APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you very much, Dr. Saslo. As has been my protocol, I will defer my line of questioning to the end. I now recognize Ranking Member Brownley for 5 minutes for any questions she may have.

Ms. BROWNLEY. Thank you. Thank you, Madam Chair. Dr. Saslo, the GAO's statement for the record for this hearing identified that one of the issues facing VA researchers in this area, particularly

for women veteran research, is recruitment, giving the smaller population. Can you expand on how VA is addressing this challenge?

Dr. SASLO. Yes, ma'am. I will start off, and then I will turn it over to my colleagues. We have a number of ways that we continue to advance the research of our female veterans. Of course, you mentioned the Rehabilitation and Engineering Center for Optimizing Veteran Engagement and Reintegration (RECOVER) center, which we look at our 3D printed foot. We also have done a number of research studies since 2017. We have actually completed seven studies. We have five that are ongoing, and we have one that is a new study. We can actually offer that into submission for the record to actually go over all the different studies that we have been working through. I will turn it over to Dr. Pai and Dr. Scholten.

Dr. SCHOLTEN. Thank you, Dr. Saslo. I would also add that VA uses the electronic health record so we can identify and recruit subjects not only from the site where the research is being conducted, but we can actually recruit nationwide to improve the pool of applicants and increase the number of females in the study. The Office of Research and Development also includes funding support for travel and some of these studies where there is a harder time to recruit individuals, so they will include the travel piece within the research budget. Finally, the Office of Research and Development also has developed the Women's Enhancement recruitment process, which is a toolkit that all researchers can use so we can increase the number of female participants in all of our research studies.

Ms. BROWNLEY. Can we have the new research that Dr. Saslo referenced written into the record?

Ms. MILLER-MEEKS. Without objection.

Ms. BROWNLEY. I wanted to—so you know, in reading my staff report here, that 73 percent of veterans who need prosthetics is because of diabetes and not because of injury, which is just a shocking statistic to me. I will just say that it seems as though the VA should be so razor focused on diabetes to prevent them ever having to come over to your department to get some form of prosthetics. I think with women, I have to assume that. I think the women population is about 20 percent in that area. In terms of veterans who have received prosthetics. I have to—my sense is that women are more likely to need a prosthetic because of injury and not diabetes since they are younger. You know, they are younger and we did not have women fighting in Vietnam, for example, and so forth. If you agree with that assumption, then I am very interested in this new study that you are talking about. Is there anything more that you can be doing for women who need to receive a prosthetic because of an injury? Is there anything more? I know the 3D printing I think, is a big one. I would be interested to know kind of what the women's satisfaction level is within the VA in terms of those who receive a prosthetic. If you could just talk a little bit more.

Dr. SASLO. I will just comment on the fact that as you heard me mention earlier, our satisfaction stories overall are very high. However, to your point, we continue to look at how we can focus our efforts on our growing population female veterans, as you mentioned. As they are a younger population and our fastest growing

population, I will turn it over to Dr. Scholten, who may be able to address a little bit further.

Dr. SCHOLTEN. Yes, unfortunately, I do not have the breakdown of VA trust scores, female versus male in the amputation clinic, but we do make every effort to outreach to of female veterans with limb loss. We have. We actually rely very heavily on our Veteran Service Organization (VSO) partners to encourage female veterans to engage with VA and engage with the amputation—

Ms. BROWNLEY. If you guys, I only have 17 seconds left, but if you could talk a little bit about what the VA is doing with regards to diabetes and addressing that so that we can reduce this percentage of veterans who need a prosthetic.

Dr. SCHOLTEN. We have a complete diabetes management team and our Patient Aligned Care Teams (PACT) implement that with veterans. As you mentioned before, the PAVE Score or the PAVE program helps with prevention of amputation. There is a whole health approach essentially for the prevention, for the wellness and the diabetic management in order to prevent amputation care.

Ms. BROWNLEY. Thanks.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley. The Chair now recognizes Dr. Murphy for 5 minutes for any questions he may have.

Mr. MURPHY. Thank you, Madam Chair, and thank you all to the witnesses for coming today. I think your assumption that older veterans that are primarily female, I just think seeing a lot of older patients myself, generally diabetes is worse in older individuals and as far as the amputation risk, it is much higher then. You know, guys, I serve on this committee because I am not a veteran, but one out of ten of my constituents are and I am increasingly now just frustrated upon frustrated upon frustrated about delays, missed appointments, not being able to get referrals. I just want to pull my hair out. I had a long call with one of them yesterday who was at his wit's end and bounced around VA's gets referred back and forth. You get sent to community care. The community care doctor cannot send you to an appropriate referral. They have to bounce you back to your primary person who may or may not really get to that. The VA has lost yet another opportunity to provide excellent care to our veterans.

When it goes on with prosthetics, this is difficult time. I mean, I get it. It is not only a change in your ability to ambulate or to pick up something, it is also just a change in your entire mental calculus on how you view yourself. Delays just in these type of instances where you have veterans delayed in wheelchairs for extended period of times, not ambulatory, not able to get things back. I am reading about the difference between the philosophy of DoD versus veterans and how veterans actually prefer DoD because they want to get their life back and get back into action, if you will, is really something, I think a particular note. Just if I can get a few questions, Dr. Saslo, can you tell me how the VA is ensuring that individuals with lower limb loss who are confined to wheelchairs due to malfunctioning prosthetics, legs sockets, how do they receive timely repairs? How do they receive replacements that restore their mobility? Do you have any statistics that tell me about timeliness?

Dr. SASLO. Well, I will start off with the timeliness piece, sir, and that is that our access itself actually falls below the target of 28 days, where our access metrics show an ability to get veterans into care within 26 days. While that is not ideal——

Mr. MURPHY. Can you define into care?

Dr. SASLO. Getting into an appointment?

Mr. MURPHY. Okay.

Dr. SASLO. While that is not ideal, we certainly want to try to make sure that our veterans mobility is addressed as quickly as possible. I do not know if, Dr. Scholten, you would like to address it a little further.

Dr. SCHOLTEN. Sure. I am not sure I can speak specifically to the sub cohort of individuals you are referring to that have had a challenge with their prosthetic device or their wheelchair. We have done extensive work to and we are launching a wheelchair repair contract which will help improve access for veterans and the speed and efficiency to get wheelchair repairs made. We encourage for any veteran with limb loss that is engaged with their amputation team they have the ability to communicate by phone, by secure message, and any way possible to try to connect with the team and allow for the appropriate appointment to occur in a timely manner.

Mr. MURPHY. Does the VA monitor anything of any complications that can occur from delays? You know, you delay a wound, you get cubitus ulcers, you get some other things for people sitting in wheelchairs and et cetera, et cetera. Does the VA monitor any of that? That is a quality measure that the private world does.

Dr. SCHOLTEN. I do not have any specific information on that question.

Mr. MURPHY. Can you guys tell me briefly about training that our prosthetic staff at the VA gets, how they deal with these cases? What kind of individuals are training our veterans?

Dr. SASLO. Sure. Dr. Pai.

Dr. PAI. Yes, happy to answer that. We have robust training programs for rehabilitation therapies, whether they are physical therapy, occupational therapy, as well as for Certified Prosthetists and Orthotists (CPO). We have the most robust training programs for certified prosthetists, orthotists in the country. We have 15 sites that train 26 trainees annually. The majority of these individuals are recruited then for VA employee employment down the line. We can use these programs as our pipeline.

For physical therapy, we have 54 training programs not specific to amputee care, but in general, over 900 trainees and the majority of 80 percent of physical therapy trainees are recruited down the line for VA employment.

Mr. MURPHY. You know, I get that the world. I was in a physical therapy office in the civilian world in my district, I do not know, six, 8 weeks ago. Very difficult to find physical therapists, as with any healthcare official or position these days. I will tell you, I just am getting more and more and more frustrated to hearing from our veterans that they cannot access a system that is built for them. There are frustrations, and it is not just with this particular committee meeting, of access to community care, access overall. I will tell you, I am hopeful that in the next administration, the new veteran secretary is going to really shake up the VA to determine that

we are doing things costly, I mean, cost effectively and efficiently, and most importantly, providing quality and timely care to our veterans. Guys, I just, you cannot sell a product that is not working for the people to whom it is supposed to be purchased. By whom it is supposed to be purchased. Thank you, Madam Chair. I am going to yield back.

Ms. MILLER-MEEKS. Thank you, the chair now recognizes the gentlelady from Illinois for whatever questions she may have.

Ms. BUDZINSKI. Thank you, Madam Chair. Thank you to our Ranking Member and thank you to the panelists for being here on a very important topic today. Taking a look at amputee prosthetic care for our veterans. I wanted to pick up just on what Ranking Member Brownley was talking a little bit about specifically around our women veterans. The GAO report on prosthetics for female veterans. One issue that was raised by veterans was the lack of commercially available prosthetic options that VA providers can use to meet women's needs. My question is for Mr. Saslo, what steps has the VA taken to work around these challenges present in the prosthetics market generally and specifically for women veterans? As a second question, how do these challenges differ by type of limb loss, such as lower versus upper limb loss?

Dr. SASLO. I will be happy to start, but one of the things I want to emphasize is that, as Dr. Scholten mentioned earlier, we really do rely on our electronic health record to really look at how we can match the needs of our specific veteran population to how we can best address treating them. One of the things I think is also important to recognize is that we partner very aggressively with our Office of Research and Development in looking at how we can develop those recruitment processes in order to be able to study our female veterans as well as the rest of our population. One thing I will say is that we recognize that lower limb loss is a much higher prevalence than our upper limb loss. I think we have done a great deal of research when it comes to how our upper limb loss can be addressed, especially in our female veterans. I will talk to, I will let Dr. Scholten talk a little bit more about that.

Dr. SCHOLTEN. I would just add that each individual, each veteran is treated as an individual, so they are assessed and provided an individualized plan of care. That, of course, would include which type of amputation they have experienced, as well as what are their goals, what were their recreational activities, pre-amputation, as well as things they are interested in doing post amputation. The VA has also partnered, as Dr. Saslo mentioned, with our research partners. As a result of that, I did want to reemphasize that the RECOVER program, which is out of the Minneapolis VA, they have created a 3D printed custom ankle, custom printed foot system so you can adjust the heel height to accommodate whichever shoe you want to wear. We have made some significant advancements to provide some unique customization for prosthetic devices for females. There is certainly a long way to go. There is not a lot commercially available, but we are hoping to rely on the innovation of our VA staff to help move the needle forward.

Dr. PAI. Add to that, at the Denver VA, they are working specifically on upper extremities, so different size hands for women Veterans and at the Tampa VA they are looking at the prosthetic—

they call it a brasthesis or sports bra for women with upper limb needs.

Mr. CRAIG. Yes. I just wanted to add, we recently completed a deep dive into amputee and adaptive driving in the Veteran Experience office. Two of the things that we came away clearly hearing as bright spots was that veterans truly appreciate the way they are treated as individuals, which is not something we normally hear when we are out doing our research and also the passion of the providers. I mean, I can imagine how it would be pretty easy to be very passionate about this, but that is two of the bright spots. I think it goes to what you were asking.

Ms. BUDZINSKI. Thank you. Thank you. If I could just. With the time I have remaining, I wanted to shift gears to rural health and accessibility. Mr. Saslo, I understand the VA's amputation system of care operates as a tiered system with four levels of care into which each medical facility is classified. How does the VA ensure that care is consistent across its medical facilities, particularly in rural areas where we know in districts like mine, we just have fewer providers.

Dr. SASLO. I think the really great part is that as the amputation system of care not only has a regional amputation centers, but they also have the polytrauma amputation network. It is across the entire country where it is a very comprehensive training program that is done every year. We work with not only the facilities, the providers, but we also make sure that there are opportunities for us to learn from our community partners. The other thing that I think we are very proud of is our mobile prosthetics, which we have. It is a rural funded prosthetics process. We have 15 sites in 11 states, including 32 of our Community-Based Outpatient Clinics (CBOC). We are looking at expanding to another five sites just in Fiscal Year 2025. I think there is an awful lot of opportunity. We have served over 4,200 veterans using that process with over 6,000 visits.

Ms. BUDZINSKI. I will yield back. Thank you.

Ms. MILLER-MEEKS. Thank you. The Chair now recognizes General Bergman for 5 minutes for any questions he may have.

Mr. BERGMAN. Thank you, Madam Chairwoman. Thanks for all of you for being here. I am going to ask a question that I do not expect an answer to because inside you will know what your answer is and not necessarily to be talked about now, is the VA being reactive or proactive on the majority of the time? Okay. The answer is sometimes you got to be either, you know, each different. Okay. Proactivity tends to lead toward less need to be reactive, if that makes, you know, any kind of sense. Having said that, Dr. Saslo, how does the VA ensure its prosthetists? That is a tough one to roll off the tongue. Prosthetists stay informed about the latest advancements in prosthetic limb technology and innovation?

Dr. SASLO. Thank you for the question. I think, as we mentioned a little bit earlier, there is a lot of training that goes on not only from a national, but a regional. We also use the concepts of having the three regional amputation centers that our physical medicine rehab have fellowships on. We try to make sure that we make training as available as we can.

Mr. BERGMAN. I know, I think you, probably because I walked in late, you might have already answered that in some way, shape or form.

Dr. SASLO. Yes, sir.

Mr. BERGMAN. Okay, so let me ask you a slightly different, from a different angle, is there any modeling and simulation that is used? If that was asked before, I apologize. To do what you do.

Dr. SCHOLTEN. I would just add that we work very closely with the Department of Defense to review all emerging evidence when it comes to amputation care and update our clinical practice guidelines every 5 years. In addition, we partner with DoD to have training opportunities to learn about the latest advancements in prosthetic technology as it emerges so that service members and veterans have access to the latest technology.

Mr. BERGMAN. Okay, well, I am not making a pitch for anything in particular here, but each year, Sunday after Thanksgiving through the Tuesday, but the show floor opens on Monday, Inter-service/Industry Training, Simulation and Education (I/ITSEC) Modeling and Simulation Conference takes place in Orlando. It is a place where obviously a lot of DoD folks go, and there is a lot of innovative technologies there and good panels, good education. I would suggest if somebody from the VA is not attending, it is like you are missing a chance to not have to rely on the DoD for what it might tell you is there. I would be proactive and send somebody down there. Dr. Saslo, what is Veterans Health Administration (VHA) doing to get real time feedback from the amputee patient population to take corrective action when necessary, and also address local facility level issues? What kind of real time feedback chain do you got going?

Dr. SASLO. In addition to the patient satisfaction surveys that we use, we also have a veteran experience that looks at how we can improve and what we have done. With that, I will turn it over to Drew because he is got some really great, robust information.

Mr. CRAIG. Yes, sir. Each of the outpatient journeys has a stop code that is associated with a particular type of clinic, and the stop code that is associated with amputation the scores are remarkably high among ease, effectiveness, emotional resonance and transparency, equity. The lowest score on this for this quarter is 83.5. That is graded on a liker score of 1 through 5. If they give us a 4, I trust I agree with the statement made or I strongly agree that we consider that an indication of satisfaction with that particular piece. 93 percent overall satisfaction and 89.4 percent in overall quality. These are assessed by ongoing. What triggers the survey is a visit to the amputation clinic and then the veteran receives a survey. It is not 100 percent, it is not a canvas, it is surveys. Out of this one this quarter we have received 384 responses from veterans who were seen for amputee issues.

Dr. SASLO. If I could just add on to that really quickly, we have a process called a completed post-delivery checkout where we look to try to make sure that the veteran actually has the opportunity to tell us that we have met their needs, what, how their fit is, what their performance is, what their comfort is. So far, that we have been successful in trying to address 81 percent of those. While our goal is always 100 percent, we have actually improved our scores

of being able to do those evaluations to 81. We continue to move that forward. Sir.

Mr. BERGMAN. Thank you, Madam Chair. I yield back.

Ms. MILLER-MEEKS. Thank you very much, General Bergman. The Chair now recognizes Representative Landsman for 5 minutes for any questions he may have.

Mr. LANDSMAN. Thank you, Madam Chair. Dr. Saslo, I just, in your testimony, you talked about the work that you all are doing to address the gaps in orthotics and prosthetic services. Including challenges, limited access. Including challenges like limited access in the Midwest. I represent the 1st congressional district in Ohio. That is southwest Ohio, and was hoping you could talk a little bit about some of the strategies. Just going into greater detail on what you all are doing to address those gaps. What we should be doing, where I should be doing to be helpful. It is to everyone. Starting with you, Doctor.

Dr. SASLO. Sure. I appreciate that. As I mentioned earlier, one of the things we are proud of is the fact that we do utilize our mobile prosthetics. We also have other mechanisms that we are trying to make sure, such as our in-house fabrication at 89 different sites. I do not know, Dr. Pai, if you would like to also address some of the opportunities.

Dr. PAI. Yes, certainly. Our prosthetists will oftentimes use scanning technology to get a sense of the limb that is needed to be fabricated. Right. If they do not have the fabrication lab onsite, then they can send that out to a centralized fabrication lab within VA that is in house. Then the limb is created there, the components, the socket that is fabricated, plus the different components are sent back to the facility. The prosthetists onsite can put that together and work with the veteran. They can make adjustments there at their location. They can also do those adjustments in those mobile prosthetic vehicles. It is called Mobile Prosthetic and Orthotic Care (MOPOC) that we have at those 15 sites. Then the other thing that we do quite a bit is virtual care. If, and maybe Dr. Scholten, you want to talk about virtual care from an ASOC standpoint.

Dr. SCHOLTEN. Sure. We have, as Dr. Pai mentioned, we have leveraged virtual care extensively in order to not only improve access, but also equity across all areas of the country. Really focusing on our rural areas, we have been able to expand our amputation clinic team. Now there are only nine VA sites that do not have a full team. Now a full team would be considered, may include some virtual team members that are beaming in to kind of participate with the veteran and the therapist or the provider that is with the veteran. We have, we are down to only nine sites that do not have a fully functioning team. We leverage our other VA capabilities of beneficiary travel in order to kind of—in order to allow access for veterans to get to the right level of care. In Fiscal Year 2024, we did perform almost 8,000 virtual care visits really to really emphasizing how we are reaching out to veterans.

Mr. LANDSMAN. Considering all that, very helpful. As we look at next year's budget or finishing this year's budget, which will most likely happen next year. What as it relates to these gaps which sound like are being filled or you all have strategies, is there any-

thing that I should be pushing for are those of us who represent Midwest districts should be pushing for to be helpful?

Dr. SASLO. I think, as I mentioned, you know, we are looking at the expansion of those mobile sites as well. The mobile sites being Fiscal Year 2025, the mobile prosthetics labs. One of the other things I think is also important is that we really do rely on our community partnerships as well. In those areas where VA cannot provide the fabrication or the prosthetic services, we try to make sure that our community partners are heavily engaged. The one thing that I think that we continue to work at evolving is how those partnerships can be strengthened in making sure that we are delivering the same type of care through our community partners as we do through the VA because we have recognized that there are some gaps in the way that our customer satisfaction exists and we have opportunities to improve that.

Mr. LANDSMAN. It is great. Thank you all. I yield back.

Ms. MILLER-MEEKS. I thank you very much Representative Landsman. The Chair now recognizes Representative Luttrell for 5 minutes for any questions he may have.

Mr. LUTTRELL. Thank you, Madam Chair. Well, good afternoon, gentlemen. Mr. Saslo, you and Mr. Scholten mention the electronic healthcare records and how that information shares, how you are gathering information. Just going to piggyback off of Mr. Landsman's statement and Ms. Budzinski statement, I think, because there seems to be a shortness when we are dealing with women veterans on the sizing, sizing scope and scale of their prosthetics. Now, I am very well aware that the electronic healthcare record system is broken. There is only six facilities out of 172 facilities in the continental United States that communicate to each other. My question is, maybe you can enlighten me on this. I am trying to get clarification on this as we kind of wade through these difficult waters. How are you aggregating enough data that you can share across multiple sites if only six sites are talking to each other?

Dr. SASLO. I am not sure where the six sites information is coming from, sir, but all of our—

Mr. LUTTRELL. I just talked to the Secretary today.

Dr. SASLO. All of our sites have the ability to draw data from across the entire enterprise.

Mr. LUTTRELL. Communicate to all 172 sites?

Dr. SASLO. Yes. The CBOC's as well, it draws from the electronic health record, depending upon the type of data you are trying to pull. It will go oftentimes by diagnostic code. It will actually look at the age, the demographics as a whole. Much of our data that we have through the Office of Prosthetics and Rehabilitation, actually we have individuals that work on that data aggregation and help us to drive the care that we are providing for it. I do not know, Dr. Pai, if you would like to expand on that a little bit more.

Dr. PAI. Yes, certainly. You are alluding to the disparate Veterans Health Information Systems and Technology Architecture (VistA) systems that are in our Legacy—

Mr. LUTTRELL. Yes. Yep. Correct.

Dr. PAI. All of that data does get pulled into our data bases, our national data bases that we were able to pull data from for, to ag-

gregate and to review on a national level. We can utilize that data to provide direction to our clinicians in the field or to our clinical programming.

Mr. LUTTRELL. From Washington State. All the way to the Bronx. You guys can communicate without any interruption?

Dr. PAI. Yes.

Mr. LUTTRELL. It is fascinating because I am going to take what you are telling me and, and I am going to go back to Mr. Elnahal, have the same conversation.

Dr. PAI. As a clinician, so I worked in a facility as a clinician for a number of years. During that time, I could look at. We could be able to pull in records from other VA's through our joint Legacy viewer or even through the Vista system.

Mr. LUTTRELL. Okay, is there a, for lack of a better term, is there an enclave that exists inside the VA when it comes to aggregating amputees data set data information that—because if I understand this correctly, and I have too many friends that are missing limbs, there is a series of stages that go along with. Once they lose their limb, they get their primary, secondary, tertiary, and then their final prosthetic. Is there an enclave in place that these data facilities that the VA facilities can access? If a veteran is in one of the remote places that says, hey, look, here is the next phase of evolution when it comes to the prosthetics for a below the knee amputee, this is what our private industry has implemented into the space. Then you reach out to the veteran and say, hey, look, phase 20 or whatever is ready to go. We have it for you.

Dr. SCHOLTEN. Thank you for that question. We have some capability, but we cannot get down to the granularity that you are speaking of about the specific subtype of amputation and the potential prosthetic device or evolution of a prosthetic device that might be necessary. What we do have is we have our FLOW 3 system, which allows us to track on an individual veteran level, the process of their prosthetic prescription and then all the way through to delivery and checkout process. We can monitor that timeline. We do not necessarily have a way to kind of retrospectively go back and identify every veteran with a specific type of amputation that might benefit from a new prosthetic.

Mr. LUTTRELL. You would think in 2025 we might have that capability with artificial intelligence and machine learning. Is this one of those spots that the VA is kind of behind?

Dr. SASLO. I think when it comes to using the use of AI—

Mr. LUTTRELL. I am trying to. I am just—

Dr. SASLO. No, sir.

Mr. LUTTRELL. I am just trying to make this easier on our veterans. It seems like we may be behind the eight ball a little bit when it comes to advances in technology for the VA and helping our veterans out.

Dr. SASLO. We recognize the use of AI is actually propelling us in healthcare to be able to do a better job. I do not know that we are there yet.

Mr. LUTTRELL. Okay. Madam Chair, I want to thank you.

Ms. MILLER-MEEKS. Thank you, Representative Luttrell. The Chair now recognizes Representative Rouzer for 5 minutes for any questions he may have.

Mr. ROUZER. Thank you, Madam Chair. I appreciate that very much. I have got a witness that will come up in the next panel, but my question is for you all now that I have the opportunity. Thank you. It seems to me that in so many cases, you have veterans that need prosthetics or whatever the issue may be, that everybody seems to be treated as a number, you know, on somebody's desk. I recognize the inherent difficulties with the bureaucracy, et cetera. When these veterans come in and they need help and they need care, why do not we have a system where you assign somebody to see their case all the way through? You have all these check boxes, and they check this box, but then they have to wait 8 months to get to this box, and then another 8 months to get to this box or 4 months or whatever it may be. It just seems to me like it could be organized in a much better manner, and perhaps it takes more personnel to do it this way. After all, they are our veterans. I mean, you have got a Congress that is willing to invest in these things. Any comment on that or any thought on that? Has that ever been discussed where you basically have a caretaker in the sense of guiding them through the bureaucracy and make sure that their case does not fall through the cracks?

Dr. SASLO. I think it is really important to recognize that the whole concept behind the amputation system of care really does rely on an interdisciplinary team. Sometimes that case manager for that particular veteran may be a prosthetist, it may be the clinician, but we are also looking at how we can maximize the care delivery and the continuity that you are speaking to using the concepts of care coordination, integrated case management. For those patients that are high risk, high visibility, what we are trying to do is to identify someone who takes that ownership of that veteran's care from start to finish. I do not know if, Dr. Pai, if you would like to address the additional pieces of ASOC.

Dr. PAI. Yes, so care coordination is paramount in this population. We want to ensure that we are able to provide our veterans with that type of service. Right. Sometimes. I know our offices work with your office and the network, and we want to ensure that we are hearing when there are issues like that and there are gaps, because then we want to try and fix them. We did hear from, and I do not know if Mr. Craig, if you want to talk about the VEO discussion with veterans on post 9-11, but that was something that we heard from veterans that would allow us to do better in the future.

Mr. CRAIG. Yes. Our research that I spoke about earlier focused on post 9-11 combat amputees and their experience between DoD and VA and private sector. One of the things that certainly came out of that research was that they do need someone to help them navigate the system so that they do not get put in line behind others who may not have as big a need just based on when they were signed up for an appointment. A number of our research projects for different populations have borne that out. That is something veterans desire.

Dr. SASLO. If I could just add one other thing, and that is to your point, I think we do have the opportunity to refine that. I think that we, as we have other navigators for specialized types of care

like our cancer navigators and things like that, we have the opportunity to refine that even more.

Mr. ROUZER. Well, I think there is a number of cases out there that you do not even know about because veterans, they just give up. You know, they at least ought to be able to get their phone call returned when they call. I mean, it is very, very frustrating for every Member of Congress and Madam Chair, I have probably taken more time than I should have been allocated. I will yield back and wait for my opportunity to introduce our witness.

Ms. MILLER-MEEKS. Thank you very much, Representative Rouzer. I now yield myself 5 minutes for any questions I may have. Dr. Saslo, I have heard reports of veteran amputees being denied adaptive prosthetics. How many veterans have been denied adaptive prosthetics in the past year? What justification is VA providing for these denials or Dr. Scholten.

Dr. SCHOLTEN. Thank you for that question. I will go ahead and take that. We certainly do not, we do not have the number of, when you say veterans that have been denied prosthetics, we do not have that number. Each veteran is seen and provided an individualized plan of care. That care plan is based on the veterans desires to engage in the community and also their medical comorbidities and other psychosocial factors. Our amputation teams are encouraging veterans to participate in recreational activities. We are able with our prosthetic regulations to provide any device provided it is FDA cleared that is in clinically indicated for a veteran. While that development of that individualized care plan allows us for those items, even though they are recreational type items, to be clinically indicated to enhance their community participation.

Ms. MILLER-MEEKS. My staff has been in contact with a veteran who has been waiting all year for a prosthetic leg. He was told by the Nashville Veterans Affairs Medical Center (VAMC) that his delay was due to a backlog of 4,000 prosthetic devices. Do you think this is acceptable?

Dr. SCHOLTEN. I do not. I do not.

Ms. MILLER-MEEKS. What immediate steps is the VA taking to address this significant backlog?

Dr. SCHOLTEN. I would be happy to hear get some information about that specific veteran case.

Ms. MILLER-MEEKS. Thank you. Is the VA leveraging community care and third-party vendors to alleviate this backlog? Is there anything preventing the VA from outsourcing more effectively to ensure timely prosthetic care and access?

Dr. PAI. I am happy to answer that question. While I specifically do not know, or I cannot answer specific to the you said Nashville or Tennessee backlog. In general, we do leverage community vendors, providers that are prosthetists. We work very closely with them. About 2/3 of prosthetic limb fabrication is provided out in the community. Our clinical teams are the amputation team that Dr. Scholten has described, they work in concert with those community providers. Oftentimes when a veteran is there getting their prosthetic limb or getting their therapy, our clinical team has teamed in with telehealth so that they can ensure that the veteran is getting the care that they deserve.

Ms. MILLER-MEEKS. To better understand the scope of this issue, I would like a list of every VA medical center that currently has a prosthetic backlog. To be specific, I would exclude glasses, hearing aids, scleral shells. I am speaking of limb prosthetics, arms, legs, hands, et cetera, broken down by item type by December 20th.

Dr. Saslo, you mentioned earlier about the whole health approach and the annual assessment. We know that the majority of amputees come from vascular disease or peripheral vascular disease or peripheral arterial disease, which could be diabetes or other types of peripheral arterial disease or PAD. We also know that the life expectancy or mortality once one has been diagnosed with PAD is quite significant above 50 percent. My question is, given that you have a whole health approach and an annual assessment, is the VA screening for PAD with a simple device such as an ankle brachial index test?

Dr. SASLO. Yes, thank you for that question. I think one of the examples I think is really important is what we are doing with regards to our remote temperature monitoring and our sensory Podiometric Smart Map that allows us to actually identify veterans that are at risk. We also have things called the siren socks or the Orbix insoles. We are taking every advantage that we can to identify early diagnoses so that we can do prevention. One of the things that we have been able to be successful with is actually reducing the number of ulcerations based upon some of these uses by about 15 percent. We have actually seen a reduction of about 37 percent in our amputations and admissions to hospitals of about 10 percent. I think it is really important that this is just one set of tools that we use when it comes to addressing peripheral artery disease.

Ms. MILLER-MEEKS. In the 2019 Rand report, and this is coming off of some of the other questions, the US Army noted that for all individuals sustaining combat amputations, the goal is to return them to the highest level of activity they wish to achieve. In contrast, the standard of care at the VA focuses on returning amputee patients to a community ambulation level. I certainly understand that with the majority of amputees in VA care being elderly and from vascular disease. It enables them to perform basic activities of daily living, not to the highest level of activity they wish to achieve. Should not the VA hold itself to the US

Army standards, particularly for post 9–11 service connected amputees to ensure they can function to their highest potential? Or do we need to legislate that there is a priority given to returning young amputees back to a full life daily activities?

Dr. SASLO. We completely agree that we want to return people to the full extent of their activity of daily living, which is one of the reasons why we really have been trying to push for our veterans to get the equipment that they need to be as flexible as they can be. One of the things that I think reflects that is the number of adaptive sports programs that we have that helps to highlight what the capabilities are for those veterans that may be seeking to improve their quality of life.

Ms. MILLER-MEEKS. Thank you so much. On behalf of the subcommittee, I want to thank all of you for joining us today. You are now excused, and we will wait for a moment as the second panel comes to the witness table.

[Recess]

Ms. MILLER-MEEKS. I would now like to introduce the panel to witnesses testifying before us today. We have Mr. Jose Ramos, Vice President of Government and Community Relations at the Wounded Warrior Project. We have Ms. White, Chief strategy and Programs Officer at Amputee Coalition. Then I am going to recognize Representative Rouzer to introduce our third witness.

Mr. ROUZER. Well, thank you, Madam Chair and Ranking Member Brownley, I greatly appreciate you having this hearing today. It is a great honor for me to introduce Mr. Matt Brown. He is an army veteran that currently resides in my district. It is an honor to represent him. Mr. Brown served in the United States Army as a member of the 82d Airborne, assigned to Fort Bragg, or what is now known as Fort Liberty, North Carolina. After active duty, Mr. Brown continued his service in the Maryland National Guard before moving to Wilmington and founding Energize Group Dental Marketing. A very successful businessman. Today, the committee will hear firsthand from him about his very, very frustrating experience dealing with the Fayetteville VA Medical Center while acquiring his or trying to acquire his prosthetic.

My team and myself have worked very diligently to get his case resolved, and it almost took an act of Congress just to get him elsewhere to actually receive the prosthetic that he needed. He will go into much greater detail, but it really is a very disturbing set of facts that he reveals. He is not the only one. He is representing probably thousands and thousands of other veterans who are facing the same issue. I greatly appreciate you allowing him to come and testify. I appreciate it much. Mr. Brown, thank you for your service. Thank you for your tireless efforts to advocate for not only yourself, but all the veterans that need the help and that they deserve. I yield back.

Ms. MILLER-MEEKS. Thank you. Mr. Ramos, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF JOSE RAMOS

Mr. RAMOS. Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the Health Subcommittee, thank you for today's hearing. I want to begin by saying that every day, Wounded Warrior Project has the privilege of working with our VA partners, and we get to see the amazing work they do and the dedicated staff who are committed to caring for our Nation's veterans. Our organization has been serving wounded warriors across the country for more than 20 years, interacting with thousands of warriors daily and helping them lead healthy, fulfilling and empowered lives. Since the beginning of the global war on terrorism, Wounded Warrior Project has been at the bedside of just about every single combat amputee, close to 1,800 of us. Today, we continue to serve these warriors through our adaptive sports and independence programs, just to name a few.

While I serve as Vice President of Government and Community Relations. I would like to share my story as an amputee. In 2004, while serving on my third combat tour as a Navy Corpsman attached to a Marine sniper team, I was severely injured when a rocket hit our position and instantly severed my left arm. Shortly

after my recovery, I was fitted with a prosthesis. I felt whole again and quickly became dependent on it or some other type of adaptive device to live a fulfilling life. I have tried three times to transition from DoD to VA for my prosthetic needs and three times I have left believing that my care is better left to DoD. I have experienced getting wrong prosthetics a right hand when I am missing my left hand. VA has told me that I am better off going to DoD for my care. VA providers not knowing about the latest cutting-edge technologies and VA changing its policies to make it harder to get adaptive devices. Roughly 20 to 30 percent of post 9–11 combat amputees decide to stay with DoD for their prosthetic needs. While many have successfully transitioned to VA, relying mostly on community providers, too many have also experienced challenges and at times experiences trying to use VA.

You would think that someone like myself, with over two decades of being an amputee who understands the system better than most veterans out there because of the work I do that I would not face or that would fare off a bit better. On this last attempt, which started in late 2022, I decided to go all in. I did so because my prosthetist, who had been my prosthetist with DoD for the last 18 years, became a VA community provider. I figured should be seamless. From the start, I felt like I had to fight what I truly needed, something I have never experienced at DoD. I felt like the system was designed to work against itself and against my needs. For example, I dropped off a broken hand in late 2023 and it took 6 months to get it back. I finally received a functionable hand back in June 2024. While I waited, my other three hands broke down and now I am choosing to go back to DoD for my replacements.

I cannot wait months. Not having a working prosthetic is not simply impacting physical abilities, but as you have heard before, it impacts mental health too. I firmly believe that VA is committed to serving our Nation's veterans and I see that every single day. For VA to truly be the best in the country, there are areas where improvements are urgently needed, especially when it comes to the care of our most severely disabled warriors. I believe that VA should be the world's premier place for amputee care and prosthetics. However, my personal experience tells me that there is still room for improvement. As we highlighted in our written testimony, VA can take at least four steps to become best in class for amputee care.

First, recognize the unique needs of amputees rather than grouping amputees and prosthetic limbs with other prosthetic users such as those who use hearing aids, wheelchairs or even hip implants. Just different. Second, increase the hiring of prosthetists and expand in house fabrication capabilities within the VA to ensure that veterans get timely expert care. Third, promote and support holistic, healthy lifestyles for amputees by providing necessary adaptive equipment to help veterans stay active without forcing them into rehabilitation programs that may not be needed. Finally, provide increased funding to support and expand innovative programs like the Mobile Prosthetic Orthotic Care Program to reach a larger population of amputee veterans.

The VA has struggled to recognize that there is a large number of younger, more active amputees demanding more of their pros-

thetics. Veterans deserve the best care and with the right investment and commitment, the VA can and should become the global leader in prosthetic care for amputees. I thank you for inviting me to testify today and look forward to answering your questions.

[THE PREPARED STATEMENT OF JOSE RAMOS APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Ramos. Mr. Brown, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF MATT BROWN

Mr. BROWN. Thank you, Chairwoman Miller and Ranking Member Brownley for inviting me to testify about my long and frustrating experience with VA prosthetic services at Fayetteville, North Carolina VA Medical Center. I am US Army veteran.

Mr. LUTTRELL. Hey buddy, you are 82d Airborne. You are the toughest son of a bitch in this room. All right. Hey, we are here for you, man. Suck it up. All right. You are amongst friends. Let us hear it.

Mr. BROWN. I am a US Army veteran who enlisted in 2009 and sustained traumatic brain injuries and spinal fractures from an airborne training operation at Fort Bragg, North Carolina. I left active-duty service in 2011, transitioning to the Maryland National Guard. I was honorably discharged in 2015. I have always been very active. Running, doing martial arts, scuba diving. I was diagnosed with bone cancer in May 2021. My life has forever changed. When I was still a young man, a family and thriving business. Much of my self-worth was derived from my physical abilities. To the extent of the cancer, my concerns concerning my about having my surgery at the VA center. I was given a community care referral to Duke Medical center in Raleigh, North Carolina. In summer of 2021, my left leg was amputated above the knee in August 2021 at Duke. After the surgery, I was in a wheelchair for 7 months. My first VA treatment appointment was on November 18th, 2021. VA claims they gave me a martial arts prosthetic within 28 days and a state-of-the-art leg system within 53 days of this appointment. Neither of those worked.

I learned later that remaining in a wheelchair post amputation for as long as I did can inhibit physical and mental recovery. I had no idea it would take the VA 2 years to get me a proper prosthetic. I would have to advocate aggressively for myself at every turn, eventually seeking help from Representative Rouzer, Senator Tillis, the Independence Fund and this committee staff. My experience with the VA over those 2 years were bewildering and demoralizing. The staff at the local VA hospital consistently failed to communicate well about my care, follow through on my care coordination and expedite requests for prosthetics. All of the community vendors who responded to the VA request to produce the proper fitting leg socket for me did their best. Some told me the acquisition process at VA was slow and sometimes they would not get paid promptly by the VA. This would only add to the stress of not being able to resume my normal activities outside of a wheelchair.

In October 2022, I heard about a special socket the VA had provided to another amputee, the Quattro Variable Volume Socket. Given my level of physical activity and the changes in blood flow

residual limb, I thought this system would be my answer. I asked the VA to obtain one, but they never followed through to acquire it. The request sat idle and eventually expired. I had to start all over again. I continued to work with a local vendor to obtain a properly fitting socket. During those months I was using a prosthetic ankle. I visited the vendor for routine maintenance in September 2022. The vendor told me they had to repossess it because the VA had not paid them. I left the vendor without the ankle and had to temporarily use an older ankle that was not flexible for the next year. VA continued to pursue the same types of sockets. I continued to tell the VA that I needed a different type of socket, basically the Quattro.

This Groundhog Day process was extremely frustrating for me and my family. I was stuck in a wheelchair for 6 months and missed out on many personal activities. In October 2023 I was so frustrated with VA prosthetics after a socket they acquired from a vendor broke while I was overseas, I contacted Congress Rouzer staff for help. They tried to get VA moving, but Congress was still slow. After 2 months of congressional inquiry, I reached out to the Independence Fund's case work team in Charlotte. Their team and Congressman Rouzer's staff joined up and pressed VA for answers. In December 2023, VA finally agreed to shift my prosthetics care to Richmond, Virginia. I was assigned to a VA prosthetics doctor there. He assessed my needs for a different type of socket so I could get out of the wheelchair and travel more easily for my business and participate in sporting activities with my wife and friends.

The Richmond VA doctor worked with me and local vendor to give me an interim that will fit well. It was not until May 2024 that VA finally purchased and delivered the Quattro socket I am using here today. I have lost 34 pounds since getting the socket. I am a new person today. This only happened because of continued pressure on VA from Congress and the Independence Fund. Looking forward, it is clear to me that VA needs a deep dive into what they address and process everyday amputees needs for prosthetics, especially ones like mine, and deliver them timely. The entire experience can be overly bureaucratic, sluggish, often impersonal and sometimes uncaring.

I know VA has testified that the cost of these recreational limbs is a concern, but very honestly, these experts do not realize what it is like to be confined to a wheelchair, unable to swim or run, carry your child and then ignore unseen costs, long delays like mine, like mental health anguish I went through and the related cost VA paid for additional mental health visits I needed over these 2 years. The VA has also testified that all these services are already being provided. Yet I and other amputees are proof that commitment is not being honored and followed by local VA staffs and supported by a responsive acquisition system.

There are lifelong future cost savings for VA when veterans can obtain the prosthetics they need to live active, fulfilling lives. We are not looking for special treatment. We just want to live our lives as independently as possible. I appreciate the time you have given me today and look forward to your questions.

[THE PREPARED STATEMENT OF MATT BROWN APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Brown, for making the trip here to Washington, DC to share your story and your testimony with us. Ms. White, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF ASHLIE WHITE

Ms. WHITE. Good afternoon, Chair Miller-Meeks, Ranking Member Brownley, and the distinguished members of the VA Health Subcommittee. My name is Ashley White. I am the Chief Strategy and Programs Officer for the Amputee Coalition, and I am testifying today in that capacity. Thank you so much for the hearing and this opportunity. The Amputee Coalition is a 501c3 organization established in 1986 to provide support, education and advocacy for the over 5.6 million individuals living with limb loss or limb difference in the United States. The Amputee Coalition provides information, referral, healthcare, navigation services, peer support and community engagement programming through its operation of the National Limb Loss Resource Center, which is funded through a cooperative agreement under the Administration for Community Living in the Department of Health and Human Services.

At the heart of the Amputee Coalition's mission is our peer support programs. The organization was founded from a peer support program. Our goal is to make sure that no one goes through this journey alone. We believe that support comes in many forms and can make an incredible difference in recovery and rehabilitation. Through an annual contract with the Department of Veteran Affairs, our organization provides technical support, print and digital resources, certified peer visitor training as well as train the trainer training and helps facilitate the amputation systems of care Peer Support Program. No one is in a better position to understand the experience of living a life with an amputation or supporting a person with limb loss than someone who has traveled that journey. A well-trained peer can offer encouragement and information. An individual navigating the start of their own journey can better understand, absorb, process and accept. A peer reviewed study published in 2022 noted that peer support interventions showed promise in addressing suicide risk.

As noted in a recently published GAO report, over 93,000 veterans living with limb loss receive care through the VHA annually. Beyond combat related injury from serving in the Armed Forces. Limb loss can also be the result of complications due to diabetes and peripheral arterial disease. The VA reports that most of its patients living with limb loss treated by amputation systems of care suffer from one of these conditions. The previously mentioned GAO report also highlighted as Chair Miller-Meeks mentioned and as others have testified today that the amputation specialty clinics through which many of the veterans receive limb loss receive care related to their limb loss are staffed by an interdisciplinary team. This interdisciplinary team model is the gold standard and one that we at the Amputee Coalition wish all Americans facing limb loss could have access to throughout their continuum of care.

Recognizing that some veterans living with limb loss may experience mobility challenges, virtual amputation clinics also exist to access care from a VA medical center. This opportunity provides vet-

erans living with limb loss the ability to connect to a provider from various locations including at home, a VA clinic or a community prosthetic partner. This is also not the standard of care offered to most available to most civilians and we commend the efforts to the VA to make care more accessible for those living with limb loss. Acknowledging the successes of the VA care model, it is also important to note some of the challenges and potential areas for improvement.

Healthcare access challenges faced by individuals experiencing limb loss in rural America continue to be a concern for the Amputee Coalition. The GAO report confirmed that 28 percent of Medicare beneficiaries who receive received amputations live in rural areas, but only 20 percent of all Medicare beneficiaries live in rural America. While the report did not provide this data for the veteran population, one cannot ignore that rurality, it plays a role in access to coordinated health care. While the VA employs many certified prosthetist orthotists for its various clinics, much of the prosthetic care received by veterans is still provided by community Orthotics and Prosthetics (O&P) provider. The reports we receive highlight from veterans highlight differences in communication processes between clinics within the VA and those in a community setting that vary from facility to facility.

Creating more streamlined, coordinated channels of communication between community providers and the VA clinical teams is vital to ensure that care remains coordinated when an individual is receiving prosthetic services outside of the VA setting. Our partners and provider groups, also representing the orthotic and prosthetic field have also expressed their concerns about the Orthotics and Prosthetics workforce pipeline, and it is my understanding that the National Commission on Orthotic and Prosthetic Education is in the process of initiating a study to look specifically at those workforce shortages.

While the VA remains an attractive employer for CPOs, the Amputee Coalition is concerned with the recent reports of attrition that are coming out of these Masters of Orthotic and Prosthetic programs, especially since There are only 13 programs at graduating Master's level O&P providers.

In closing, the Amputee Coalition expresses its gratitude for the opportunity to be a trusted partner in serving our Nation's veterans every single day. We value our partnership with the VA and are committed to supporting efforts to improve prosthetic care and the mental health and well-being of those veterans who have or are at risk of experiencing amputations.

[THE PREPARED STATEMENT OF ASHLIE WHITE APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. White. We will now proceed to questioning. As is my protocol, I will defer my questions until the end. I will now recognize Ranking Member Brownley for 5 minutes for any questions she may have.

Ms. BROWNLEY. Thank you Madam Chair, and thank you all for being here. Mr. Brown, thank you for your service to our country and the courage to come up here and share your story. I want to understand the period of time that you kind of went through this horrible experience. It sounds like. It sounded to me like it was a

2-year period from the time that you wanted to get out of that wheelchair and get a prosthetic to the time that you finally got one that worked for you. Is that roughly right?

Mr. BROWN. It is pretty accurate. It was about 2 years. There was—it was like, there is a loyalty more to the bureaucracy than the end user, the patient. I was like, I am the person using it and it is like you get up in the middle of the night to go to the bathroom and your leg falls off by the bathroom and you fall and you say this thing keeps falling off in public, it is falling off. They replicate into the same socket all over again. I knew what my problem was. I did my own research and I said, this is the solution. I knew another veteran who is a friend of mine in Colorado who got that socket and I was not able to. The whole time I was asking for a running blade so I could start running. I started exercising again. I am a really active guy. There was a lot of things and it took about 2 years total from beginning to end to get it. I just got it this past June, so I am still—

Ms. BROWNLEY. The running blades, did you get those?

Mr. BROWN. I have the running blade. One issue with the running blade is you have to do a running clinic to learn how to run. I still, since I have got my running blade, have not been able to get to a running clinic. They were like, there are two we could possibly send you to. One is in Washington State and one was over here. There was not really a way to facilitate training and teach me how to run. Here is this item, but there is no support on how to use the item. I am kind of using my personal trainer at home to try to figure it out on my own, which I do not know if it is the safest, but I want to run with my wife, so.

Ms. BROWNLEY. How many prosthetics were you given before you got the one? I cannot remember what the name of it, but it is what, the Quattro?

Mr. BROWN. Yes.

Ms. BROWNLEY. Yes. How many? How many tries?

Mr. BROWN. The socket. I do not have the number in front of me, so I do not want to be inaccurate. If I had to guess off top of my head, we probably had 10 to 14 tries of the socket, but it was all different variations of the same attempt.

Ms. BROWNLEY. And, but, so, but you had, I mean, sort of at least 6 months into it, you had done your research and you knew what was going to be best for you. It took and you still had to go through a lot of—

Mr. BROWN. There was a lot of not understanding my needs. Like no one, like they talked a lot about team care when they are up here. The team, I am not sure, I have never saw the team. I saw a person that was a prosthetist who was 70 years old who was out of touch and did not care. He just, he did care, but he just did not want to read through it. The one problem I had was I am a Brazilian Jui-Jitsu black belt. I train a lot, I wrestle and when I would come off the mats my leg would not fit anymore. I said I need something I can adjust. A friend of mine that is a black belt who is also a veteran in another State got this from you. I would like this. It was, what we actually found out was the purchase order actually had been cut to the vendor and it sat there for a year and no one told us. Then I called the vendor like, can you help me with

this? Like we had your purchase order for a year and now it expired. At some point it got authorized and we had not even known.

Ms. BROWNLEY. Thank you. Again, thank you Mr. Rouzer for, you know, getting involved and making it happen. Sadly, I apologize for the VA and their inability to satisfy you as a veteran and as an important patient in their care. So. Again, thank you. Thank you very much for being here. Ms. White. I wanted to ask you. I absolutely am a firm believer in peer support programming and peer support groups and how effective they can be for veterans with a variety of different kinds of issues. I am just wondering. I tend to spend a lot of time on women because I do not feel like women veterans get the attention that they deserve. I am wondering how many women have you served and do you believe that the women that you have served that a woman to woman peer group is the best option moving forward?

Ms. WHITE. Thank you for the question, Ranking Member Brownley. With respect to the number of women served by the Amputee Coalition, our support programs operate through the amputation systems of care. About 14 percent of the individuals who come directly to the Amputees Coalition's information referral centered. Those are direct calls to us, about 14 percent of those are veterans, and only about 2 percent of those are women. A very small—

Ms. BROWNLEY. Veterans and non-veterans.

Ms. WHITE. Veterans and—sorry. Yes, yes.

Ms. BROWNLEY. I got it.

Ms. WHITE. If you look at that, those numbers that are directly served by our organization, not through the partnership that we have with the amputation systems of care, It is a small number, but I do believe that many women are going to community support groups. There are nearly 300 community support groups that we help facilitate. They are affiliated with us, but they are actually operated by individuals who live in those communities. I believe that many women are going to those community groups and they are finding support, whether that is through a civilian who has a similar level of limb loss or a person who has a very similar experience to them and may also be a veteran. I think they have access to both support groups in their communities as well as through the VA system.

Ms. BROWNLEY. Very good. Thank you for that and thank you for what you do, because it sounds like what you do is really important to servicing our veterans and having success with limb loss and all the wraparound issues and support that they need to have the highest quality of life that they certainly deserve. Thank you for that. I am over my time. I apologize and I yield back.

Ms. MILLER-MEEKS. Thank you for yielding. Thank you, Ranking Member Brownley. The chair now recognizes Representative Luttrell for 5 minutes for any questions he may have.

Mr. LUTTRELL. Thank you, ma'am. Mr. Brown, Mr. Ramos. We try to unpack the suitcase on this. We understand that. We understand the varying levels of difficulty trying to get the quad for your leg and then what is your arm. Obviously, here is the tricky part. Who did you call? Who said no? Where did it go from there? I would like to have names so I can personally address this issue at the granular level. You know, veterans are veterans, we will

come—we have this just. We just love to come. Just to say things are going bad. I got it. You know, but we need to know exactly where we need to touch this. I am going to ask both of you, when you talk to your—at what level, who you are speaking with and where are they going and where is it dying? Where are the barricades and the barriers existing so we can get in there and try to clean it up. Mr. Ramos, you can go first, and I will go to Mr. Brown.

Mr. RAMOS. I think you asked a really good question. I think the challenge is there is not a single person that you can really reach out to. To be very honest with you, I think the system collectively, the way VA defines prosthetics and amputees generally sits under PSAS or the Office of Prosthetic and Sensory Aid Services. That truly is more of an acquisition logistics and procurement process. It is funded in that way. The prosthetists and prosthetic limbs all reside underneath that. One of our recommendations here is we got to kind of separate and stop talking about prosthetics as the same as hearing aids and eyeglasses. I think that is the challenge, I think for the both of us reaching out to our providers, our community providers. I mean, similar story for me was a lapse of time as it relates to the purchase order being submitted and not being sent to the provider. Not knowing.

Mr. LUTTRELL. It seems like a series of communication breakdowns because you are—I do not mind, I have got a brain fart here. Your system was sitting there waiting to get. The paperwork is waiting to go and it just, it died on the vine, correct?

Mr. BROWN. Yes. The communication breakdowns I could not have asked for. I could not hope for a better question from you, Representative Luttrell. My local VA, this is going to sound unbelievable to you that the phones have been broken for several years. I cannot call in and make an appointment. I heard a lot of talk today about satisfaction scores from the VA officials. You can make studies and package data up and paint a picture. There is a Key Performance Indicator (KPI) or standard that all of us in this room, civilian, veteran, any industry value, it is universal and it is a Google rating. The Google rating for my facility is like 3.5 stars. If you read those reviews, for years we have been complaining with no feedback loop to help, that we cannot call in and make an appointment. We have to drive in to make an appointment. I challenge all of you, take your phones out, Google Wilmington, North Carolina VA Hospital and read the reviews. You can go back four or 5 years and everyone is on there complaining, we cannot call in. To this day, I still cannot call in to make an appointment. I have to drive in.

A fundamental patient care is communication. If we take this KPI like we can package up all these KPIs, right? That is the standard of excellence for the world. I just challenge you in your districts, go look at the Google ratings and read the reviews. They are generally not good because of this. Then on the level of the granular level, my prosthetists, he verbally told me there needs to be five of me here, and there is one, and I am 68 years old, and his name was Thomas Ray, generally a nice guy that cares, but he was not equipped to handle this. His boss, Damon DeLoache, was just out of touch with the whole process. On the fundamental level,

when I was waiting for my prosthetic, I could not call in to get a status update.

Every Thursday, the prosthetist visited my local VA center. I would take my wheelchair, throw it in my truck. I would only been an amputee a few months now. I would drive to the VA center, sit in my wheelchair, wait in the lobby to hope that he would walk past me to ask for an update. If we cannot handle the fundamentals of patient communication, like calling in. I had—I am kind of a little bit of aggressive guy with some stuff. I figured out who the director of that building was. I found her picture and I waited around for her. Her name was Debbie. I addressed her. I said, you are the director, right? She said, yes. I said, the phones are broken. She goes, oh, I quote, I know they have been broken. They have been broken for years. I just do not know who to call.

Mr. LUTTRELL. Okay, next steps for me is going to find out, because there are multiple sites, so I need to find out who the prosthetist is calling at the next level and where that goes to get everything activated and how it comes back down inside the organization to clean up this problem set. The gentleman that I am going to discuss that with are sitting directly behind you, which I think you should have gone first in this hearing. That would have given us extra ammunition, if you will, to have discussions with the VA staff, or VA leadership. Thank you and Chair, I yield back.

Ms. MILLER-MEEKS. Thank you very much, Representative Luttrell. The Chair now recognizes Representative Rouzer for 5 for any questions you may have.

Mr. ROUZER. Thank you. I would be happy to yield some more time to my colleague, Mr. Luttrell, if he wants to follow up. You had a good line.

Mr. LUTTRELL. I could sit here all day. When—I would like to dig in with you, Mr. Brown, because when your case was moved out of the Wilmington VA, where does that land? At what site?

Mr. BROWN. We end up at Richmond, Virginia.

Mr. LUTTRELL. Wilmington goes to Richmond.

Mr. BROWN. Yes, so we moved out of the Fayetteville or Veterans Integrated Service Network (VISN) 6 to Richmond. The doctor who received me was Dr. Joseph Webster, who is an awesome clinician. He was an angel for me. He got me my leg back. He was compassionate. He was awesome. It was the opposite experience of what I experienced in Fayetteville. We had to move my care all the way to Richmond, Virginia to get me past this 2-year ordeal.

Mr. LUTTRELL. Can you explain to me at kind of a deeper level why? The people behind you are listening and I need them to hear this, which I am sure they have heard it multiple times, but they are going to hear it right here in front of Congress. I want to know why and where the communication, not most of the communication, but the movement of taking care of our amputees at Wilmington seems to be lost. Then you have to go to North Carolina. You have to go to Richmond.

Mr. BROWN. Yes, go to Richmond. Just to give you an idea, like the level of distrust that develops so rapidly, I actually had to start like recording my doctor's appointments to document things because of me requesting things verbally and not having them. What happened is I would request something. I would wait a long period

of time for an appointment with a prosthetist. I would request something and then he would say, oh yes, we are working.

Mr. LUTTRELL. Do you have the paperwork that you received from the VA that says why this got canceled with a name on the bottom of it?

Mr. BROWN. No.

Mr. LUTTRELL. That is tragic.

Mr. BROWN. Yes, I do not. I never really could. Like, so I was asking the prosthetist, like, when am I going to get this Quattro socket? Every time it was a kick the can down the road. It was a very vague answer. He was the only prosthetist for our region. He swore there needed to be five, there was only one. He went out with COVID for 3 months and he finally called me back 1 day and he said this to me. I work in healthcare, in dental, so I am very familiar with Health Insurance Portability and Accountability Act (HIPAA) laws. My company handles a lot of personal information and we are really compliant with that. He said on the phone to me, he said, Matt, I am home with COVID and my dining room table is covered with patient paperwork that I am trying to get through while I am out sick with COVID. My first reply was, that is a HIPAA violation. My information cannot be in your home. It is like there is a deliberateness you do things with when you want to achieve. What I will tell you is in VISN 6 Fayetteville system, that deliberateness does not exist for excellence. Just look at the Google reviews. We give the reviews. It is all under four stars.

Mr. LUTTRELL. Mr. Ramos, your turn.

Mr. RAMOS. I think this frankly highlights the necessity to really evaluate what DoD does versus what VA does. I will say, and I will tell you why I say that is, unfortunately, my brother in arms here does not have the luxury to be next to an Military Treatment Facility (MTF) center of excellence to just walk in and get the assistance they need. Right? We should strive collectively to ensure that the VA is the center of excellence. I am not saying we need to build a center of excellence in every single district, because that is not possible. There is not many amputees, but, dang it, every single active duty or post 9–11 combat veteran will tell you exactly if they want to go to the best care for amputee care. They are going to fly to Brooke Army Medical Center (BAMC), they are going to fly to Walter Reed, or they are going to fly to the Center for Intrepid. Right? By the way, they are going to pay out of their own pocket to get there. Nonetheless, and VA should have the same, exact same thing, and we just do not.

Mr. LUTTRELL. When the question is asked why the VA does not have the same model as the DoD, what is the response you get from those that you are engaging with?

Mr. RAMOS. We talk a lot about the ASOC system or kind of the amputee system of care. I will tell you, until I started working with Wounded Warrior Project, I did not know it existed. We have seven sites, and I think collectively the culture is we have the systems in place. I am not saying that it is not in place for maybe older geriatric patient population. It is just not responsive to a young active population who is beating the crap out of their prosthesis and trying to live a fulfilling life. When I turn 70, I am still going to continue to do what I do. I have four hands because I break them

fast. I break them fast because I am an active individual and their system is not responsive to meet my needs, to meet his needs. It is just not designed that way.

Mr. LUTTRELL. How long can you stay with the DoD? Do you ever have to transition away from DoD to the VA?

Mr. RAMOS. You do not. I do fear part of why I have come to the VA system to give it a try is I fear that at some point, DoD says, hey, you know what? You are a veteran. Go to the VA. The answer is DoD looks at us also kind of a way to ensure that they continue to maintain their expertise in dealing with combat patients based on what is happening across the globe. We have not been asked to no longer come back, but that is always been a concern. Right now, as far as I know, now it is a different situation for him because he is not a service connected, combat disabled veteran that went through the system, but I do not. That is why I am going back to DoD, to be very honest.

Mr. LUTTRELL. Okay. I yield my time.

Mr. ROUZER. Yes, my time has expired.

Ms. MILLER-MEEKS. Thank you. Thank you, Representative Luttrell and Representative Rouzer. The Chairwoman now yells herself 5 minutes for questions she may have. Mr. Ramos, and I think you brought this up, but how did your experience with the DoD prosthetic care compare to care provided directly by the VA? Were there noticeable differences in quality or timelines?

Mr. RAMOS. I think what would be helpful is to kind of maybe give you a comparison of the two different experiences in systems generally. Right. At DoD, the prosthetist and the clinic or the amputee care clinic are jointly co located. Right. When I go talk to my primary provider, my prosthetist is there or easily accessible and we can talk about here are my challenges. Okay, got it. Here is a prescription. Then go and execute. Now if I need something that is modified on the spot, they can build out. If it is something that needs to get sent out to either rebuilt or new, they do that right there. Then I get it in a matter of weeks. Right.

With VA, for example, the VAMC here in DC, they are not co located as a matter of fact, two different, complete different spaces. I first have to make a visit with my primary clinician and then get that prescription approval that then gets sent to my community provider. Now I have to make an appointment with my community provider, drive down to Bethesda, and actually go through the process of kind of working with the prosthesis. That individual then now has to wait for the purchase order to come in to them so that they can go and execute on the actual prosthetic delivery or fixing. Then from there I have to either go back to the community provider and make sure that it is the right prosthetic in this case, because I have experienced having the wrong one been delivered to me now. Then eventually that is what the process looks like.

It is really a almost instant fixing of addressing need, approval of an execution versus coordinating different meetings, different appointments, getting approvals, waiting, and then eventually getting your prosthesis.

Ms. MILLER-MEEKS. Yes. That difference in the care that you receive and you perceive may in fact be a difference in mission between the DoD and the VA. Certainly we have heard a lot about

the populations and the type of population that we are dealing with as a veteran population, as an active duty DoD population. To me, what I am hearing loud and clear is that there needs to be a segregation of prosthetic limbs from other sensory type of prosthetic devices. That is, when you were here, I was adjusting my prosthesis, my glasses, but glasses, hearing aids, scleral shells, facial implants, even wheelchairs. These types of devices need to be segregated and have an amputee prosthetic office that directly deals with that within the VA, and then second, perhaps also segregating the populations. No one wants to say that. It is not politically correct to say that. Although I am almost 70 years old, I would say I am an active 70 year old.

Nonetheless, a person's needs who is retired and not working is certainly different than a person who is working and raising a family and trying to support a family. Mr. Brown, did anyone from the—so you were diagnosed with the cancer, you are at the VA, you know you are going to have treatment for your cancer, you are going to have an amputation. Did anyone from the VA's Amputation System of Care team engage you before your amputation or how long after your amputation?

Mr. BROWN. Earlier there was a conversation about proactive versus reactive. Me and wife are really proactive people. We knew this was coming. We knew for about 3 months my leg was being amputated and I proactively contacted the VA. No one reached out to me. The extent of the team experience they speak of was I went there, sat down with that prosthetist and what I was told was it was a very short conversation. I was in this chair maybe 5 minutes. The VA is world class when it comes to prosthetics, was the claim and that whatever you need, you are going to get, there are no problems. It was a great expectation. Me and wife felt good about our decision.

Then the amputation happened and then it was kind of like the best analogy I can use is it kind of felt like a used car salesman. I was told this awesome, rosy story. Then the moment it was time to facilitate care, I had to wheel myself to the VA on Thursdays to hope to bump into this individual to get an update. I was never given a timeline or expectation. There was no team experience.

Ms. MILLER-MEEKS. Yes, I can certainly understand that. Waiting for the stump to heal. There are a ton of questions I would have about all of this process. One of the things I also heard, and let me say that having been in the military, both enlisted as a nurse, as a doctor, worked at the VA, relatives at the VA, family members, I can assure you that the people behind you have not heard of your story because that is how bureaucracies work. What happened at the Wilmington VA probably stayed at the Wilmington VA instead of that being ratcheted up the chain of command to where the people who can actually implement policy changes and make those individuals work to the best of their ability do not get that information.

We also heard from Dr. Saslo and Dr. Scholten that the scores that were received and feedback reports had very high scores, 88 percent clinical prosthetic patients at the Fayetteville VA Medical Center are happy. As I listen to that, if someone did not take the proactive approach to go and study what socket, what terminal,

what prosthetics, if you are a woman, do you have a prosthetic that is going to adapt to the different type of shoe that you are wearing, to the different type of activities that you are engaged in, whether you are working or non-working, whether you are lifting children? If they do not take the proactive approach to do that, how do they know what is available? If in fact they are getting state-of-the-art care? How can you determine whether or not you are satisfied? All you can determine is you are satisfied with what you were given, but not what the range of options are available to you, or even if there is adaptive prosthetic devices.

Based on your experience, Mr. Brown, and conversations you have had with other veteran amputees, do you believe that statistic accurately reflects the quality of care and trust at Fayetteville or the experience other veterans may have?

Mr. BROWN. No, I do not think it is anywhere near accurate. I sit in the waiting rooms with the other amputees in the prosthetics department and you know, the amputee community, the veteran community is small. The amputee veteran community is smaller, especially in our region. It is real easy for us to find all each other. I started like a little WhatsApp chat with all my fellow amputee friends and asked them, how long are you waiting for this? How long are you waiting for that? The experience is pretty uniform. When you lump in major limb amputation with eyeglasses and compression socks, it is easy to get a positive review of questions you loaded up to get the metric you want as a survey you sent. When you are asking someone about compression socks versus a complex item like a leg that replaces your—creates your ability to be mobile.

When I heard the in Fiscal Year 2024, the satisfaction rate was like 95 percent. That is not accurate. Going back to the Google rating, like I mentioned earlier, that is the world's standard for excellence. I personally started looking at the facilities in my area and they all were well below four stars, most near three stars. I think that is a KPI that no one is looking at, that the whole world embraces as the standard for excellence. I think that needs to be looked at because these facilities do not have good ratings. That is a clean feedback loop from us to you. No one in leadership, I think, has ever looked at that. No one thinks anyone is looking at it.

Ms. MILLER-MEEKS. Well, thank you very much. Ranking Member Brownley. Do you have any closing remarks?

Ms. BROWNLEY. I just want to say I really appreciate having this hearing. I have been on the committee, I think, for 12 years, and I am not sure that we have had a hearing on this. Thank you for bringing it forward. I have learned a lot, and I think I have got a pretty clear idea. I think that the Chairwoman's just sort of laid it out, too, in terms of where we need to go on this, in terms of trying to make it better. The VA should, when it comes to prosthetics, they should be the very best. They should be on the cutting edge. They should be world class, and, you know, they should be leading the pack across the country. I think there is probably the VA is doing a good job across the board in certain places, but, you know, not everywhere. I think someone talked about, you know, rural America, too, where it is even a greater challenge.

I just think we need to kind of really work on this to make sure that we are providing, you know, our veterans who have served our country. You know, losing a limb is—I cannot imagine. I honestly, I cannot imagine what that would be like. I do understand how impactful it can be if things are not working for you, both physically and mentally. Anyway, I think we have got some work cut out for us, and I appreciate you having the hearing, Madam Chair. I yield.

Ms. MILLER-MEEKS. Well, thank you very much, Ranking Member Brownley. I thank all of our members who are here today. I especially thank the VA. I know that some of these comments were probably not something that you particularly wanted to hear because it sounds like you are truly trying to give state-of-the-art care to all of our veterans, especially our veterans with amputee and limb loss. I would like to thank our witnesses on Panel Two Mr. Ramos, Ms. White and Mr. Brown for being here and for your courageous testimony. Not easy to come all this way and bring that forward and that we do need to do a better job of holistically looking at our veterans and our veteran population.

I would like to thank everybody for their participation in today's hearing and for the great discussions we have had on this important topic. I would agree that we have a roadmap for where we need to go and how we need to assist the VA in order to treat you better to the highest level of your functionality and activities of daily living. As I have stated before, ensuring that our Nation's veterans receive the highest quality of care is my top priority as Chairwoman of the subcommittee and holding the VA accountable and providing proper oversight is the job that we on this committee have been tasked with.

I am committed to working with my colleagues and the department to ensure that high quality care is delivered to our veterans. I look forward to continuing these efforts to working with all stakeholders involved.

The complete written statements of today's witnesses will be entered into the hearing record. I ask unanimous consent that all members have five legislative days to revise and extend their remarks and include extraneous material. Hearing no objection. So ordered. I thank the members and the witnesses for their attendance and their participation today. This hearing is now adjourned.

[Whereupon, at 4:16 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of M. Christopher Saslo

Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee on Health. Thank you for the opportunity to testify before you today to discuss VA's Amputation System of Care (ASoC). Joining me today is Dr. Joel Scholten, Executive Director, Physical Medicine and Rehabilitation (PM&R); Dr. Ajit Pai, Executive Director, Office of Rehabilitation and Prosthetic Services; and J. Drew Craig, Design Chief, Enterprise Measurement and Design Directorate, Veterans Experience Office (VEO).

At VA, we are dedicated to addressing the diverse needs of Veterans with amputations throughout their lifetime and ensuring access to rehabilitation services, specialty benefits and services, and advanced prosthetics. Our comprehensive approach focuses on providing tailored care, cutting-edge technologies, and ongoing support to improve the quality of life for Veteran amputees.

Overview

VA's ASoC offers a comprehensive, integrated care model for Veterans with amputations or those who are at risk of amputation. This holistic approach emphasizes Veteran-centric care through a multidisciplinary team, including PM&R physicians, physical and occupational therapists, prosthetists, mental health clinicians, and various other specialists. ASoC's core philosophy revolves around providing lifelong care through coordination, collaboration, and education.

Amputations present unique challenges and complexities for Veterans requiring specialized services and support throughout their lifespan, including pre-amputation care, post-surgery, rehabilitation, prosthetic prescription and training, and lifelong follow-up. The Veteran's care journey begins with pre-prosthetic care and preparation. Whenever possible, the ASoC team engages with Veterans and their families before surgery. This proactive approach allows for crucial education on post-operative care, home preparation, equipment needs, and future prosthetic plans. It ensures a smoother transition for Veterans returning home and assists families in making necessary preparations.

Once the Veteran's residual limb has healed, the prosthetic fitting and training phase begins. The prescription process considers the Veteran's goals, prior functional level, and medical history. Fitting may occur within the VA system or with community prosthetists with the VA team collaborating to ensure the prosthesis meets the Veteran's mobility needs. The subsequent training process is intensive and requires commitment from the Veteran, their family, and the care team. This initial rehabilitation phase can extend more than a year post-amputation.

Post-prosthetic rehabilitation services involve close monitoring, especially during the first year. The team anticipates and responds to changes in the Veteran's limb and strength and makes necessary modifications to the prosthesis and rehabilitation plan. Veterans typically return to the Amputation Specialty Clinic multiple times in the first year after amputation to ensure the prosthesis supports the Veteran in achieving their functional goals.

Long-term follow up and maintenance are crucial aspects of the ASoC model. VA recommends annual assessments for all Veterans with major amputations to ensure continuity of care and lifelong management. ASoC adopts a Whole Health approach that incorporates peer support, support groups, and adaptive sports to help Veterans reintegrate into the community.

Adaptive sports programs play a significant role in the rehabilitation process. VA uses health care practitioners to refer patients to recreation therapists who educate Veterans and families about adaptive sports and leisure activities. They also aid Veterans with renewing pre-injury leisure activities, introduce adaptive equipment, teach new skills, and facilitate community integration. Adaptive Sports programs adhere to specific regulations for equipment provision and can have a profound impact on Veterans' well-being. They help Veterans restore functional capabilities, boost self-esteem, and improve overall quality of life. Recreation therapists, working

with Veterans in adaptive sports programs, partner with the ASoC team when specialty prosthetic limbs are required to participate in a sport.

Through this comprehensive approach, ASoC provides a continuum of support from pre-amputation through long-term care, ensuring Veterans receive the highest quality of care and support throughout their journey.

Recent Data

During Fiscal Year (FY) 2024, the Veterans Health Administration (VHA) surgery programs performed over 8,000 amputations, which is a 7.7 percent decrease from Fiscal Year 2019. Toe/foot amputations were most common (69.7 percent), followed by below-knee (19.9 percent) and above-knee leg amputations (15.3 percent). A trend toward more distal (further away from the body) amputations in Fiscal Year 2024 suggested a preference for tissue preservation.

Veterans undergoing amputations were predominantly male (98 percent) with a mean age of 70 years. They often had complex comorbidities, which included diabetes (87 percent), peripheral vascular disease (82 percent), and ongoing tobacco use (over 50 percent). Notably, most VA amputations result from chronic diseases rather than combat or trauma. Only 119 of the over 8,000 Fiscal Year 2024 amputations were performed on Veterans with Operations Enduring Freedom, Iraqi Freedom, or New Dawn designations.

DoD and VA Partnerships

The Department of Defense (DoD) and VA have established a robust collaborative framework to ensure seamless care for Service members and Veterans, particularly in amputation and limb trauma. This interagency partnership is exemplified through various initiatives and programs designed to enhance patient care, streamline processes, and foster innovation.

One cornerstone of collaboration is the Extremity Trauma and Amputation Center of Excellence (EACE), which is a congressionally mandated joint effort that focuses on advancing care for individuals with limb trauma or amputations. EACE ensures consistency and efficiency across both agencies and demonstrates a commitment to providing the highest quality care for those who have sacrificed for our country.

Another significant area of cooperation is the development and updating of Clinical Practice Guidelines (CPG). VA and DoD regularly join forces to create evidence-based guidelines that improve patient care for Veterans, Service members, and civilians. These interagency workgroups have made substantial progress in developing guidelines for upper and lower limb amputation rehabilitation, which ensures standardized care practices based on the latest research. CPGs for upper and lower limb amputation are publicly available on the VA/DoD Clinical Practice Guidelines webpage (<https://www.healthquality.va.gov>). VA clinicians are informed of CPG updates through a variety of educational forums, such as webinars, community of practice calls, and email distribution to clinical providers.

The collaboration extends to logistical support with VA's Denver Logistics Center (DLC) providing comprehensive supply chain management for various VA programs. Notably, DLC grants DoD orthotists and prosthetists access to its contracted orthotic and prosthetic components, which facilitates timely procurement and enhances care delivery. This cooperation is further strengthened by mutual participation of DoD and VA providers in each other's educational programming, thereby fostering knowledge exchange and professional development.

To ensure a smooth transition of care for Service members, ASoC implemented a network of 25 Amputation Rehabilitation Coordinators across the country. These coordinators assist Service members with amputations in their transition to the VA system. Additionally, they help coordinate care for Veterans who receive ongoing treatment in both systems.

The Office of Advanced Manufacturing (OAM) currently executes a Joint Incentive Fund (JIF) grant to align advanced manufacturing between VA and DoD. A major component of this work was developing a shared Quality Management System (QMS) that adheres to U.S. Food and Drug Administration (FDA) requirements and allows for the development and manufacturing of certain medical devices within VA and DoD, thus facilitating easy sharing of products and ideas. With the shared QMS and medical devices, transitioning Service members can expect to receive continuation of care and similar prosthetics services between DoD and VA.

Research and Innovation

Since 9/11, technological advancements revolutionized care delivery and prosthetic devices. Additionally, VA improved communication between Veterans and their clinic teams through platforms like MyHealtheVet, My VA Images, and VA Video Connect. These tools allow Veterans to share their home and community environments

with providers, which enables a better matching of prostheses and rehabilitation plans to optimize independence. VA's Office of Healthcare Innovation and Learning also has been instrumental in implementing cutting-edge technologies. By adopting 3D scanners, printers, and digital software, VA developed a digital prosthetic workflow and seamlessly integrated new hardware and software.

Prosthetic devices have benefited from micro-computing and design improvements. Lower limb prostheses now use advanced algorithms and real-time measurements to react to user movements, which reduces the risk of falls. Power-generating foot and knee systems can actively propel users forward. Upper limb prostheses also have advanced systems that can identify muscle activity patterns to replicate desired movements more accurately and prosthetic hands that can move individual digits for increased precision.

The human-prosthesis interface has seen advancements through various surgical techniques including Ertl technique, Targeted Muscle Reinnervation (TMR), and bone-anchored external prostheses. The Ertl technique is a surgical procedure in which a tibiofibular bone bridge is established with the intent of creating improved distal weightbearing. The TMR procedure aims to alleviate phantom limb pain and improve muscle control over myoelectric prostheses by intentional placement of nerves within selected muscles. Veterans now have access to osseointegration (OI) surgery creating direct skeletal attachment for the prosthetic limb. Nine Veterans have received OI surgery, either in VA or through a community provider, since the inception of the program in January 2022. VA is carefully monitoring the demand for this procedure to ensure Veterans have access to this innovative surgery.

Ongoing research and development initiatives continue to push the boundaries of prosthetic technology. VA has funded a new research center with a focus on prosthetics, which brings the total number of VA Rehabilitation Research and Development Centers in amputation care and prosthetic technology to three. Current projects include a 3D-printed foot system to enable women Veterans to wear shoes of any size, type, and heel height; testing fully implanted neuro-prosthetic systems that enable users to feel touch through their prosthetic as if it were their own limb; improving clinical measures for upper-limb amputees; and developing shared decision-making tools for amputation level and prosthetic component selection. Research is also underway to improve prosthetic attachment methods. This research includes a multi-site study which tests a VA-developed bone-anchored prosthetic docking system, develops women-specific above-elbow prosthetic suspension systems, creates new variable-compliance below-elbow prosthetic arm sockets based on athletic shoe technology, and tests the effects of an adjustable above-knee socket on asymmetry, residual limb movement within the socket (socket pistoning) and comfort/satisfaction in female and male Veterans.

Procurement and Manufacturing

VA balances efficiency with individual patient needs by following a structured approach to procuring and manufacturing prosthetics. Manufacturing challenges often stem from limitations in local resources, particularly in rural areas. To address these challenges and manage the device lifecycle, VA's regulations (38 C.F.R. §§ 17.3200–3250) prioritize repairing existing items unless replacement is clinically necessary or more cost-effective. Decisions regarding limb repair or replacement involve discussions between the clinician, Veteran, and Prosthetic and Sensory Aids Service (PSAS) representative.

Case studies from the Denver VA Medical Center (VAMC) and Fayetteville VAMC highlight ongoing efforts to improve prosthetics services. Key improvements include aligning surgical implant handling with VHA Directive 1081.01(1), Procurement of Surgical Implants; enhancing Durable Medical Equipment contractor stocking; and addressing staffing shortages. These efforts have yielded tangible results, such as reducing open consults and eliminating delayed orders. The Fayetteville VAMC does not fabricate limbs. All prosthetic limb requests are referred to vendors for fabrication or procurement. The latest Veteran feedback report stated that 88.8 percent of clinical prosthetics patients expressed trust in their prosthetics team at the Fayetteville VAMC.

The Office of Advanced Manufacturing is collaborating with various VA offices and external organizations to develop an end-to-end digital prosthetic workflow. This digital workflow aims to improve efficiencies in device delivery, reduce facility space requirements, and enhance communication across the VA enterprise including expanding capacity for community-based outpatient clinics (CBOC) and rural sites. The workflow also offers opportunities to improve procurement transparency, standardize care, and better understand the lifecycle of devices Veterans use.

Acquisition Process

The prosthetics acquisition process within the VA system presents strengths and challenges. When VA providers handle artificial limb provision internally, the process is generally more streamlined due to effective collaboration between the Orthotic, Prosthetic, and Pedorthic Clinical Services (OPPCS), ASoC, and PSAS teams. This approach minimizes potential bottlenecks and creates a smoother experience for Veterans. However, when necessary, community fabrication is available. Involving community prosthetists requires additional steps. For items over \$10,000, purchase requests must go through Contracting Officers, potentially delaying the delivery of artificial limbs. This process contrasts with the internal VA process, where such delays are significantly less frequent.

Quality of Care

The ASoC's integrated care model exemplifies a patient-centered approach that emphasizes streamlined, coordinated amputation and prosthetic care. In Fiscal Year 2024, VA saw 18,387 unique Veterans with 38,122 encounters in amputation clinics, which included 7,896 virtual care encounters to enhance access to specialty amputation care. This multidisciplinary strategy offers numerous benefits, including improved care coordination, cost savings, and continuity of care. Follow-up appointments provide opportunities for more in-depth evaluations and strikes a balance between comprehensive care and specialized attention.

Prosthetic limbs are provided for Veterans through both internal capabilities and referral to community prosthetic providers. Approximately one-third of prosthetic limbs are fabricated within the VA system while two-thirds are provided by community prosthetic providers.

To ensure high-quality prosthetic limb procurement, VA promotes an interdisciplinary post-delivery prosthesis checkout visit, going above the industry standard. In Fiscal Year 2023, for all Veterans receiving a limb through VA, 76 percent completed a post-delivery prosthesis checkout. Full Fiscal Year 2024 data are not yet available.

Veteran satisfaction remains a top priority, as evidenced by continuous monitoring efforts using data from VEO's Veteran Signals (VSignals), a survey platform used to measure Veterans' trust in VA. In Fiscal Year 2024, results showed 95.4 percent of Veterans felt respected and comfortable during their Amputation Specialty Clinic experience, and 92.8 percent reported feeling the health care team included what matters most to the Veterans in their plans for what to do next in managing their health and well-being. ASoC proactively enhances patient experience through annual satisfaction evaluations and is currently collaborating with VEO to develop a Veteran Journey Map for the Amputation Specialty Clinic.

To improve service delivery and provide more equitable care to rural Veterans, ASoC is exploring digital workflow infrastructure to extend prosthetic services beyond VA medical centers into outpatient clinics and Mobile Prosthetic and Orthotic Care units. Furthermore, ASoC leverages digital prosthetic workflows to enable collaboration across clinical services, and OAM is exploring ways to overlay different imaging modalities with patient anatomy and prosthetic devices. This approach aims to facilitate communication between surgery, wound care, rehabilitation, and prosthetics, ultimately yielding prosthetic devices that fit well, are comfortable, and prevent friction-related pressure wounds.

ASoC demonstrates an unwavering commitment to providing Veterans with high-quality prosthetic devices and care services through a multifaceted approach to standards, quality control, and patient satisfaction. This dedication is evident in the organization's ongoing efforts to refine and implement evidence-based practices, which includes the forthcoming Lower Limb Amputation CPG that is set to release in December 2024, and a meticulous "check out" process for prostheses to ensure devices meet patients' needs in terms of fit, performance, and comfort.

Training and Education

To enhance care quality, promote innovation, and empower those affected by limb loss, ASoC and its associated programs offer comprehensive training and education initiatives for providers, specialists, patients, and families. For health care professionals, ASoC provides annual regional trainings, a Monthly Education Series, and annual Peer Support Training in collaboration with the Amputee Coalition. Three Regional Amputation Center sites offer established PM&R physician Amputation Fellowships for specialized physician training, while the OPPCS National Program Office complements these efforts with monthly Virtual Education Sessions, annual in-person training, and the VA Prosthetic and Orthotic Residency Program.

VA continues to develop training materials for implementing new technologies in prosthetic services and funds nearly 300 PM&R physician residency positions annually. In addition, VA supports Orthotics and Prosthetics (O&P) education through

various initiatives, which includes funding residency positions, participating in trainee recruitment events, and providing resources for non-competitive hiring flexibilities. To further enhance the quality of care for Veterans with limb loss and other related conditions, VA also sponsors numerous physical therapy and occupational therapy residency and fellowship programs across various specialties.

Veterans and their families also benefit from ASoC collaboration with the Amputee Coalition. This collaboration includes development of a workbook on sex and intimacy after amputation, as well as a robust Certified Peer Support program with over 25 trained VA Clinician Trainers and more than 40 VA Certified Peer Visitors.

VA also leverages its relationships with Veterans Service Organizations (VSO) to better understand the Veteran experience. VSOs inform us of Veterans who are experiencing delays or challenges with their amputation-related care, which allows VA to address Veteran-specific issues and perform service recovery. These challenging scenarios are used as training examples during national forums. VSOs have been invited to participate as faculty during our regional amputation training conferences to support education efforts and ensure the Veteran experience is adequately represented.

Future Improvements

VA is actively addressing gaps in its O&P services and facing challenges such as limited access in the Midwest and among insular islands despite mobile care units. While weighing in-house production against outsourcing, VA aims to improve service delivery by streamlining procurement processes and hiring additional staff in areas of limited access.

To modernize its prosthetic workflow, VA aims to implement an end-to-end digital process to allow for better storage, reproduction, and research capabilities. This plan includes expanding access to 3D printing technologies and streamlining electronic systems nationwide. VA also introduced the Prosthetic Sock Management Tool, a patient-centered education tool to aid in education and management of prosthetic sock use.

Conclusion

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee on Health, thank you for the opportunity to testify today to update you on VA's holistic approach to amputee care. Our system encompasses innovative technologies, specialized care, and unwavering support to ensure Veterans with amputations receive the highest quality of care and services possible. Our commitment to ensuring that all Veterans receive the care, support, and respect they deserve remains steadfast. My colleagues and I are prepared to answer any questions you may have.

Prepared Statement of Jose Ramos

Wounded Warrior Project
 4899 Belfort Road, Suite 300
 Jacksonville, Florida 32236
 ☎ 904.296.7350
 📠 904.296.7347

**WOUNDED WARRIOR PROJECT**

**Statement of
 Jose Ramos
 Vice President, Government & Community Relations**

On

“Life After Limb Loss: Examining VA Amputee Prosthetics Care”

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

November 20, 2024

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee – thank you for inviting the Wounded Warrior Project to share its perspective on the issues that post-9/11 combat amputees requiring prosthetics are facing with the Department of Veterans Affairs (VA). My name is Jose Ramos, and I am the Vice President of Government and Community Relations at Wounded Warrior Project. In 2004, while deployed to Iraq as a Navy Hospital Corpsman attached to a United States Marine Corps Sniper team, I became a casualty of war and lost my right arm below the elbow. As an amputee who is heavily dependent on prosthetics and adaptive equipment, I bring over 20 years of personal experience on this issue.

For 20 years, WWP has been dedicated to our mission to honor and empower wounded warriors. In addition to our advocacy before Congress, we offer more than a dozen direct service programs focused on connection, independence, and wellness in every spectrum of a warrior's life. These programs span mental, physical, and financial domains to create a 360-degree model of care and support. This holistic approach empowers warriors to create a life worth living and helps them build resilience, coping skills, and peer connection. Our reach extends to more than 200,000 veterans who are being served in various ways across the United States.

According to our 2022 Annual Warrior Survey, about one in 70 WWP warriors indicated amputation as a service-related injury (1.4%), and 3.5% indicated they have a prosthesis. Among those with a prosthesis, 23.1% are amputees, like myself, as a result of post-9/11 military service.¹ WWP provides several impactful programs and services for these warriors, including our Physical Health & Wellness and Mental Health programs. At WWP, we understand well the intertwined connection between physical and mental health and its significant impact on quality of life. Additionally, WWP's Adaptive Sports program provides veterans with certain

¹ WWP 2022 Annual Warrior Survey, <https://www.woundedwarriorproject.org/media/y1whpx4h/wwp-2022-annual-warrior-survey-full-report.pdf>

DUTY ★ HONOR ★ COURAGE ★ COMMITMENT ★ INTEGRITY ★ COUNTRY ★ SERVICE

woundedwarriorproject.org



conditions, including amputations, the ability to participate in modified athletic opportunities designed for their individual abilities.

We recognize and appreciate the great work VA has done as well to help this population of veterans. VA demonstrates its commitment to improving the health and well-being of our nation's amputee veterans by providing high-quality care and support to this population every day. There are certain areas of improvement that can further strengthen VA prosthetic care to help veterans rebuild function and reintegrate back into the community more quickly and effectively. To that end, we recommend that VA take several key actions to provide amputee veterans full restoration of normal human function and empower them to live fulfilling lives.

1. ***Separate Characterization for Amputees:*** Recognize the unique needs of amputees and provide specialized care, rather than including them with other prosthetics users.
 - a. ***Establish a Dedicated Amputee Prosthetics Center for Excellence at VA:*** Institute an Amputee Prosthetics Center for Excellence, independently led by VA, to provide care specifically for amputees.
 - b. ***Increase Hiring of Prosthetists within VA:*** Bolster VA's capacity to provide timely and effective medical care for amputees by hiring more prosthetists.
 - c. ***Fabricate Amputee Prosthetic Devices In-House at VA:*** Source needed prosthetics internally to improve standardization and timely delivery of services.
 - d. ***Unify Management of Amputee Prosthetics Services at VA:*** Prioritize amputee care at VA through assuming in-house departmental responsibility for handling prosthetics, reducing the need to refer veterans to the Department of Defense (DoD) and community providers.
2. ***Customized Care Plans:*** Develop tailored care plans to meet the unique needs of each amputee, recognizing individual challenges and requirements. Implement proactive and personalized healthcare plans for amputees to address their specific health needs effectively.
3. ***Holistic Health Maintenance:*** Promote and support holistic healthy lifestyles for amputees, ensuring they remain active and healthy. This includes providing necessary adaptive equipment without forcing enrollment in rehabilitative programs.
4. ***Pilot Programs:*** Provide increased funding to support and expand the Mobile Prosthetic and Orthotic Care (MoPOC) program and other essential services for veterans. Extend the reach of the MoPOC services to urban areas to benefit a larger population of veterans.

By implementing these recommendations, VA can significantly improve its provision of amputee prosthetics care and improve veteran quality of life and mental health.

SEPARATE CHARACTERIZATION FOR AMPUTEES

The Department of Veterans Affairs (VA) Prosthetic and Sensory Aids Service (PSAS) is the largest and most comprehensive provider of prosthetic devices and sensory aids in the world. In fiscal year (FY) 2023, more than 55 percent of the veterans treated across the Veterans Health

Administration (VHA) received 21.7 million prosthetic devices, items, and services.² VA's website highlights that, "although the term 'prosthetic device' may suggest images of artificial limbs, it actually refers to any device that supports or replaces a body part or function."³ In fact, PSAS provides a full range of equipment and services to veterans, including artificial limbs as well as other items worn by veterans such as hearing aids; items that improve accessibility, such as ramps and vehicle modifications; and items surgically implanted in veterans, such as hips and pacemakers.

This generalized definition of "prosthetic device" has hindered VA's ability to care for veterans in need of amputee prosthetics who suffered amputation during or after their military service. The broad size and structure of PSAS leads to competing priorities, and unfortunately, does not prioritize amputee prosthetics. To address VA's primary challenges in providing prosthetics care to amputees, we are focused on the areas outlined below.

Establish a Dedicated Amputee Prosthetics Center for Excellence at VA

VA is a worldclass leader in providing mental and physical healthcare, including through emerging technology, and amputee prosthetics should be no exception. Between 2009 and 2019, the number of veterans with limb loss who received care at VA increased by 34 percent.⁴ In FY 2022, VA provided care to 97,095 amputee veterans; approximately half of those (44,171) had at least one major limb amputation (an amputation at or above the wrist or ankle).⁵

Despite the growing number of amputee veterans receiving care at VA, the Department does not have the infrastructure to adequately address the need for amputee prosthetic services for this group. Amputations have serious implications for the veteran and his or her family, including medical, physical, social, and psychological. Yet, amputee veterans are treated along with other prosthetic device users with very different needs, who may use PSAS for a hearing aid or eyeglasses. Without a Center for Excellence dedicated to amputee prosthetics services and independently led by VA, veterans often choose or are even encouraged to seek care elsewhere, such as at DoD or out in the community. These options to receive amputee prosthetic care outside VA provide a less holistic care experience, are less convenient, and for veterans who must use community care, are often more expensive.

Following the needs of veterans returning from Operation Enduring Freedom (OEF), Operation and Operation Iraqi Freedom (OIF), in 2008, VA established a formal Amputation System of Care (ASoC) to improve the quality and consistency of rehabilitation care for amputee veterans. This integrated system, housed under PSAS, provides specialized expertise through an interdisciplinary team approach. A limited number of ASoC facilities are located across the country which provide veterans with full continuum of care services, including surgical care,

² Department of Veterans Affairs. Coalition for Government Procurement, <https://thecgp.org/images/2024/05/2024-Spring-CGP-5.5.24-version-2.pdf>

³ Department of Veterans Affairs. Prosthetic & Sensory Aids Service (PSAS), <https://www.prosthetics.va.gov/psas/index.asp>

⁴ Webster et al. "Ten-Year Outcomes of a Systems-Based Approach to Longitudinal Amputation Care in the US Department of Veteran Affairs." NIH. National Library of Medicine, <https://pmc.ncbi.nlm.nih.gov/articles/PMC7473733/>

⁵ CRS Report. "Department of Veterans Affairs Amputee System of Care: An Overview." July 18, 2024.

prosthetic fitting, rehabilitation, mental health support, and long-term care management for veterans who have experienced limb loss.⁶

ASoC includes four levels of care: Regional Amputation Centers (RACs); Polytrauma Amputation Network Sites (PANS); Amputation Clinic Teams (ACTs); and Amputation Points of Contact (APOCs). RACs provide the highest level of care and are required to have certain capabilities, including the ability to provide clinical expertise, to fabricate and repair prosthetic limbs on site, and to provide inpatient rehabilitation services. PANS provide a range of specialized prosthetic care services, and ACTs include amputation specialty teams. Despite providing the highest level of expertise, there are only seven RAC sites across the country, while there are 18 PANS and 101 ACTs, which provide more limited care options. Some states, especially those in rural parts of the country, do not contain any ASoC facilities.⁷

ASoC provides needed care and support, but VA does not have enough ASoC facilities, particularly RACs, to address the needs of all amputee veterans. While the number of ASoC facilities has grown overall since its establishment, and the number of PANS has increased from 15 to 18, the number of RACs is still seven, the same amount that were in existence when ASoC was first created. VA lacks funding to launch these comprehensive care sites in additional locations. When veterans cannot access amputation care or services at an RAC, VA often offers those services through contracted community providers.

WWP recommends that VA provide a separate and distinct characterization of prosthetics for amputees, including by establishing a separate Center for Excellence at VA for amputee prosthetics to improve provision of specialized care. We believe developing a separate Amputee Prosthetics Center for Excellence at VA would be best suited for serving the needs of this veteran population. Such a facility, similar to those which have been created for mental health, geriatric care, epilepsy, multiple sclerosis (MS), and Parkinson's at VA⁸ would allow VA to fabricate its own prosthetic equipment in-house and provide a veteran-centric approach to amputee prosthetic care. DoD facilities, such as the Walter Reed Army Medical Center (WRAMC), the Naval Medical Center San Diego (NMCSD), and the National Intrepid Center of Excellence (NICoE), may also serve as models.⁹ An independently-led dedicated center would enable VA to better focus on the unique needs of all amputee veterans and provide the specialized care that is greatly needed to maximize function and community integration.

Increase Hiring of Prosthetists within VA

VA's challenges to properly provide prosthetic services for amputees are a result of not only how VA defines "prosthetic" but also the funding structure for PSAS. Currently, the primary purpose of PSAS is to provide logistics and procurement for prosthetics, not clinical care. The size of the staff and budget reflect that VA's prioritization is procurement of prosthetic devices, while using outside sources – such as DoD or the community – to provide the actual

⁶ Department of Veterans Affairs. Rehabilitation and Prosthetic Services, <https://www.rehab.va.gov/asoc/>

⁷ Department of Veterans Affairs. Amputation System of Care (ASoC), <https://www.prosthetics.va.gov/asoc/>

⁸ Department of Veterans Affairs. Veterans Health Administration: Clinical Organizations, https://www.va.gov/health/landing_clinical.asp

⁹ Department of Defense, Centers of Excellence, <https://health.mil/Military-Health-Topics/Centers-of-Excellence>

care needed. Although a small amount of funding for clinical care is provided for PSAS, this funding is nested under procurement and logistics and is not enough to provide adequate clinical care for amputees, resulting in inadequate resources, including staff and equipment.

The lack of funding for and attention to clinical care often results in long wait times and an inconsistent standard of care, often leading to a perception among veterans that VA is neither knowledgeable nor prepared to meet their needs. WWP's 2022 Annual Warrior Survey revealed that 14.2% of warriors experienced an inability to get prosthetic-related medical care.¹⁰

VA does not have the ability to correct this funding imbalance between procurement and clinical care on its own. Congress must give VA the funding to build the capacity for in-house amputee prosthetic clinical care for veterans to expand amputee prosthetics at VA from primarily a procurement department into one with force-building capabilities. WWP recommends that Congress provide funding to bolster VA's capacity to hire more prosthetists to provide timely and effective care for amputee prosthetics. We also believe that this funding must be for dedicated clinical care and not stem from a procurement funding stream.

Fabricate Amputee Prosthetic Devices In-House

Veteran amputees often face significant wait times for VA prosthetic services, including appointments, approvals, fittings, and repairs, sometimes waiting 90 days or more. The timeliness of care is generally substantially faster at DoD facilities compared to VA. Experiences of WWP Alumni reveal that warriors who utilize both VA and DoD systems of care receive new, repaired, or replaced prosthetics faster from DoD. On average, DoD delivers new or replacement prosthetics to veterans in 28.8 days and repairs prosthetics in 29.8 days, while VA takes 87 days to deliver new or replacement prosthetics and 66.4 days for repairs.

Moreover, in November 2023, the *Denver Post* reported on several disturbing issues taking place at the VA Eastern Colorado Health Care System in Aurora, Colorado, including that the PSAS Chief directed staff to delete purchase orders and close consults prematurely; that some prosthetics orders remained untouched and pending for months; and that expired prosthetic implants were sitting on the shelf, and one was even placed in a patient.¹¹

We are aware that VA conducted a report substantiating these allegations and providing additional conclusions and recommendations, including that Aurora, CO, does not have adequate staff for the volume of work in PSAS. The VA Eastern Colorado Health Care System was asked to complete the review of inappropriately canceled orders, determine the ongoing needs of veterans, and make necessary purchases to fulfill the orders.

WWP is concerned with the events that took place at the VA Eastern Colorado Health Care System and encourages the committee to ensure such errors do not reoccur. We also

¹⁰ WWP 2022 Annual Warrior Survey, <https://www.woundedwarriorproject.org/media/y1whpx4h/wwp-2022-annual-warrior-survey-full-report.pdf>

¹¹ "Head of Aurora VA's prosthetics department canceled veterans' orders to eliminate backlog, ex-employees allege," *Denver Post*, April 18, 2024, <https://www.denverpost.com/2023/11/12/aurora-va-hospital-veteran-affairs-prosthetics-department-colorado/>

advocate for in-house prosthetic fabrication by VA to address these issues; this would standardize the process to help VA provide timely delivery of services and maintain adequate supplies to cover the needs of amputee veterans.

In some instances, VA prosthetic clinics do fabricate the needed prosthetic devices within an in-house facility. However, this is based on the available prosthetic limb components, and often a contracted community provider is responsible for fabricating all items required by a VHA prosthetic prescription. Currently, the seven RACs are the only ASoC facilities which are required to have the capability to fabricate and repair prosthetics on site. PANS and ACTs may have on site facilities or can choose to establish contracts with community providers.¹²

Additionally, while some Veterans Integrated Services Networks (VISNs) contractual performance work statements specify deadlines for the provision of prosthetic limbs from community providers, this is not required by all, leading to a lack of standardization and timeliness. When given an itemized prescription from providers, VA should be able to produce the necessary prosthetics in-house. Sourcing prosthetics internally will improve efficiency, reduce delays, and help ensure timely provision of needed items.

VA currently has the potential to source more prosthetics in-house by utilizing certain existing manufacturing labs through VHA's Office of Advanced Manufacturing (OAM).¹³ This office has the ability to assist veterans with amputations by leveraging innovative healthcare solutions. For example, OAM and its Central Virginia VA Health Care System opened a new advanced manufacturing lab in Richmond, Virginia in 2024. The newly-opened Richmond Office of Advanced Manufacturing (ROAM) and IDEAS Center has the capability to 3D print devices and ship them across the country as well as to design 3D products that can be printed in other VA facilities. ROAM's care team, made up of rehabilitation engineers and led by an occupational therapist, produces customized 3D-printed solutions that have increased veterans' quality of life and independence. The office's emphasis on producing versus purchasing devices for veterans encompasses the outlook that would best serve amputee veterans in need of prosthetics.

Despite leading the way in ground-breaking solutions for severely disabled veterans, ROAM's manufacturing lab is underutilized, and most veterans don't know of its existence. WWP's Government & Community Relations (GCR) team highlighted ROAM in our Spring 2024 newsletter for veterans, but it is not clear how to connect veterans to these types of innovative solutions. Moreover, WWP was disappointed to learn that ROAM is facing budget cuts in FY25. Rather than cutting innovative solutions for veterans, VA should be investing in – and more importantly educating veterans about – the resources available to them.

Amputee veterans would greatly benefit from the ability to learn more about state-of-the-art prosthetic technology, equipment, and device options likely to be most appropriate to meeting their needs. This is another area in which WWP recommends that VA use DoD as a model. DoD regularly conducts outreach to amputee veterans to engage with them about new technologies and encourage them to learn about new devices. WWP recommends that VA

¹² CRS Report. "Department of Veterans Affairs Amputee System of Care: An Overview." July 18, 2024.

¹³ Department of Veterans Affairs. Office of Advanced Manufacturing. <https://www.innovation.va.gov/oam/>

similarly connect with amputee veterans regarding new equipment to have them test it and provide feedback. This will help ensure that VA is providing the highest level of veteran-centric prosthetic care.

Also of concern is VA policy, established by recent regulations, which only allows the provision of one prosthetic item to veterans without a clinical determination of need for a spare.¹⁴ It is critical that veteran amputees have a functional replacement at all times, especially considering the long wait times that veterans experience with VA replacement prosthetics and repairs. WWP recommends that VA establish a policy to enable every veteran who receives a primary assistive prosthetic device, required for mobility or to perform activities of daily living, to be furnished with an identical secondary prosthesis. In-house fabrication capabilities would enhance VA's ability to provide spares so that amputee veterans are not immobilized or forced to live in chronic pain while waiting for a replacement.

Unify Management of Amputee Prosthetics Services at VA

VA faces several additional issues affecting the quality of care for amputee veterans, many of which center around care coordination. Veterans often experience inconsistent case management, characterized by a lack of consistent points of contact (POCs), leading to fragmented care. Veterans frequently find themselves alternating between different providers, causing miscommunication and delays. Some veterans feel victimized or unfairly treated by their VA healthcare providers, exacerbating trust issues. As a result, veterans often trust outside healthcare providers more than those within the VA system, undermining confidence in VA services.

Amputees often need to advocate for their own needs per VA regulations (38 CFR § 17.3250), but many are unsure of the specific questions to ask for proper care. Additionally, amputees do not receive an adequate number of needed supplies for their prosthetics, as mandated by regulations (38 CFR § 17.3200), and VA does not consistently adhere to recent regulations¹⁵, which impact the quality of care provided to veterans.

There are also unique challenges in managing lower limb versus upper limb amputations. VA is not well-equipped to handle the variety of limb technologies available and lacks DoD's innovation in prosthetics advances. VA clinicians responsible for prescribing assistive devices reflect wide variability in their knowledge of, and experience with, new prosthetic technologies, and are often unable to provide veterans informed recommendations. In my own experience, I was told by my local VA, where I sought assistance for my myoelectric prosthetic, that I was the only veteran with this type of prosthetic device and would be able to receive better care from DoD.

Since the beginning of Global War on Terrorism (GWOT) conflict, DoD has treated 1,743 amputee veterans, like myself, including 1,440 veterans with lower extremity conflict-related amputations (82.6%); 203 veterans with lower extremity amputations (11.6%); and 100

¹⁴ Federal Register. "Prosthetic and Rehabilitative Items and Services." December 28, 2020, <https://www.federalregister.gov/documents/2020/12/28/2020-27014/prosthetic-and-rehabilitative-items-and-services>

¹⁵ Ibid.

veterans with both upper and lower extremity amputations (5.7%). DoD has also provided 92 patients (119 limbs) with osseointegration (OI) surgeries.¹⁶

Despite VA having 145 rehabilitative centers compared to DoD's three, many veterans – who are often dual-eligible for both DoD and VA – prefer DoD facilities for their prosthetic needs. Approximately 43% of veterans use only DoD for their prosthetic services, 30% use both DoD and VA, and 26% use only VA. Rapid access to prosthetics, a full interdisciplinary healthcare team, connection with peers, and other factors motivate patients to remain at or return to a DoD facility for their prosthetic needs. WWP believes that VA should be the first and only place veterans want to go for prosthetics care. We recommend that VA take complete responsibility for handling amputee prosthetics for veterans, focusing solely on patient care and reducing the need to refer veterans to DoD as well as the need for community providers.

Managing the needs of amputee veterans' requires a comprehensive and coordinated delivery of services throughout the continuum of care to help restore function and improve quality of life. Implementing the aforementioned recommendations – to establish a dedicated Prosthetics Center for Excellence, hire more prosthetists, and fabricate prosthetic devices in-house – will allow VA to unify management of amputee prosthetic services and provide specialized care for amputee veterans.

CUSTOMIZED CARE PLANS

Prosthetics are not just functional devices; they are integral to a veteran's mobility and quality of life. The journey of an amputee veteran is deeply personal and unique, shaped by the specifics of the injury as well as his or her physical health, mental well-being, and individual goals. A personalized care approach addresses all of these facets to minimize burdens and empower veterans to focus on living fulfilling lives.

38 USC requires VHA “to provide for the specialized treatment and rehabilitative needs of disabled veterans,” including veterans with amputations, “in a manner that affords those veterans reasonable access to care and services for those specialized needs.”¹⁷ It is important that this personalized approach include customized prosthetic solutions designed to fit the unique anatomy of each amputee, considering factors such as residual limb length, skin condition, and activity level. Providing adaptive equipment tailored to individual needs and training veterans on how to use these tools effectively is crucial as well; this might include specialized wheelchairs, mobility aids, or home modifications to enhance independence. Beyond prosthetics, customized care plans may include physical therapy, occupational therapy, and mental health support. In addition, the needs of amputees can change over time. Regular follow-ups are necessary to continually reassess function and satisfaction as well as lifestyle and interest changes and make adjustments accordingly. These follow-ups help ensure that the support provided evolves with the veterans' needs, helping them to maintain and improve their quality of life.

¹⁶ Data provided by Tony Joyner, Chief, Strategic Outreach, Communications and Public Affairs Division, Military Health System/Defense Health Agency, regarding Extremity Trauma and Amputation Center of Excellence, July 23, 2024.

¹⁷ 38 USC § 1706(b)(1)

Customized care is also necessary as veterans with amputations are at greater risk for developing not only amputation-specific conditions, such as infection, skin irritation, muscle atrophy, and osteoporosis,¹⁸ but also comorbid diseases and conditions. A VA Office of the Inspector General (OIG) report found that, after separation from active duty, over 80 percent of amputees had diagnoses in each of the following categories: mental health disorders, diseases of the musculoskeletal system and connective tissue diseases of the nervous system and sense organs.¹⁹ A 2017 National Center for Biotechnology Information (NCBI) study, specifically focused on psychiatric comorbidity after traumatic limb amputation, found that the most common psychiatric comorbidities were major depressive disorder (71.2%), suicidality (30.5%), and posttraumatic stress disorder (PTSD) (20.3%).²⁰ Thus, veterans need customized care plans to manage the needs of both their amputations and comorbidities.

These specialized treatment plans must be effectively developed and implemented. VA's current policy²¹ includes the development of treatment plans that begin with a comprehensive assessment of each veteran. An interdisciplinary Amputation Specialty Clinic Team assesses the amputee veteran's clinical needs and develops a treatment plan that includes prescribing and evaluating prosthetic devices over the lifetime of the veteran through annual follow-up appointments. However, there are inconsistencies in how VA follows its own standards and processes for carrying out this treatment plan; these continuity of care issues create challenges for veterans and can significantly impact their well-being and recovery. It is important that VA take accountability and adhere to established standards to help healthcare providers understand the specific needs of amputee veterans and develop appropriate care plans.

Several problems have also been identified that undermine VA's ability to implement these specialized treatment plans. As mentioned, many veterans experience inconsistent case management, find themselves alternating between different providers, and feel victimized or unfairly treated by their VA healthcare providers. Often, they find themselves acting as mediators between providers, having to advocate on behalf of their own needs. These issues arise because there is often no dedicated individual overseeing the case throughout the duration of a veteran's rehabilitation. Effective case management is key to providing a more supportive and streamlined care system.

One group which has historically experienced challenges receiving specialized prosthetic care is women veterans. VHA's national policy directive states that ASoC provides "patient-centered, gender-sensitive, lifelong, holistic care and care coordination for the Veteran or Servicemember who have undergone amputation."²² However, the directive does not specify what gender-sensitive prosthetic care means. Most prosthetics are not purposefully designed for

¹⁸ Department of Veterans Affairs. Fact Sheet: Long-Term Care Following Traumatic Amputation, https://www.prosthetics.va.gov/factsheet/ASoC_Traumatic_Amputation_Fact_Sheet_Short_Version_Sec_508_9_20_12.pdf

¹⁹ Department of Veterans Affairs. Office of Inspector General. Healthcare Inspection: Prosthetic Limb Care in VA Facilities, <https://www.vaog.gov/sites/default/files/reports/2012-03/VAOIG-11-02138-116.pdf>

²⁰ Sahu et al. "A study of psychiatric comorbidity after traumatic limb amputation: A neglected entity." NIH. National Library of Medicine, <https://pubmed.ncbi.nlm.nih.gov/articles/PMC6058428/>

²¹ VHA DIRECTIVE 1172.03, https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=11629

²² VHA DIRECTIVE 1172.03, https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=11629

women; rather, they are designed for men and then scaled down. This results in several issues; for example, many women veteran with lower limb amputations face difficulty finding shoes that fit both a woman's foot and a much wider prosthetic device.²³

The *Deborah Sampson Act*, passed as part of the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020* (P.L. 116-315), required VHA to provide a report on women veterans' ability to access specialized prosthetic devices. Findings of this December 2021 report further emphasized that women veteran amputees often felt that prosthetic devices were designed for men and didn't take their needs into account. Women veteran amputees reported experiencing problems with the fit and weight of the prosthetic devices, which led to mobility issues, wounds and infections, decreased usage of the device, and overall dissatisfaction. In addition, women veteran amputees reported a lack of social support resources, such as female amputee support groups.²⁴

To address these challenges, WWP recommends that VA improve continuity of care, establish dedicated POCs to oversee care delivery, and prioritize gender-specific prosthetic care. These adjustments will more effectively address the specific health needs of amputee veterans, both male and female.

HOLISTIC HEALTH MAINTENANCE

Adaptive prostheses and terminal devices empower veterans with limb loss to participate in a variety of sports and other recreational activities, such as running, biking, and swimming. Adaptive prostheses can be designed to fit the user's specific needs, including their activity level, strength, and flexibility, and terminal devices can be designed for specific activities, such as contact sports and other recreational activities. VA's definition of "medical services" (38 U.S.C. § 1701) includes wheelchairs, artificial limbs, trusses, and similar appliances, and accordingly, VA provides these devices to veterans. However, adaptive prostheses or terminal devices for sports and other recreational activities are not currently part of VA's definition of "medical services."

Although VA clinicians work with veterans to identify recreation activities and needed adaptive recreation equipment to support a veteran's rehabilitation goals, VA will not provide adaptive recreation equipment, including adaptive prostheses or terminal devices, if the purpose of the equipment is to support the veteran's participation in an activity for personal enjoyment.²⁵ Specifically, VA regulations only provide adaptive prosthetics and terminal devices for sports and other recreational activities for veterans if the device: 1) is needed to promote, preserve or restore the health of the veteran; 2) serves as a direct and active component of the veteran's medical treatment and rehabilitation; and 3) does not solely support the comfort or convenience of the veteran. (38 C.F.R. § 17.3230(a)(1)). Therefore, if a veteran wishes to use adaptive

²³ GAO Report. "Agency Efforts to Provide and Study Prosthetics for Small but Growing Female Veteran Population." November 2020, [GAO-21-60, VETERANS HEALTH CARE: Agency Efforts to Provide and Study Prosthetics for Small but Growing Female Veteran Population](#)

²⁴ CRS Report. "Department of Veterans Affairs Amputee System of Care: An Overview." July 18, 2024.

²⁵ Federal Register. "Prosthetic and Rehabilitative Items and Services." December 28, 2020, <https://www.federalregister.gov/documents/2020/12/28/2020-27014/prosthetic-and-rehabilitative-items-and-services>

recreation equipment, he or she must use it to support rehabilitation goals and, accordingly, must be enrolled in a VA rehabilitation program.

The necessity to participate in such rehabilitation programs can be a deterrent for some veterans who may not be able to travel or devote the time required. These programs are also repetitive as they require that veterans be retrained to use replacement adaptive equipment for which veterans completed rehabilitation training in the past. For these reasons, some veterans may choose not to obtain or replace adaptive recreation equipment, hindering a veteran's ability to maintain an active and healthy lifestyle. WWP supports the *Veterans Supporting Prosthetics Opportunities and Recreational Therapy (SPORT) Act* (H.R. 9478), which would amend 38 U.S.C. § 1701 to add adaptive prostheses and terminal devices for sports and other recreational activities to VA's definition of "medical services."

Improving a veteran's quality of life holistically should be the highest priority for amputees requiring prosthetics. The ability to play sports and participate in other recreational activities is integral to a veteran's mobility and mental wellbeing. WWP has seen firsthand the positive and life-changing effects of adaptive equipment on a veteran's quality of life and mental health. Through WWP's Adaptive Sports and Soldier Ride programs, warriors learn to use adaptive sports equipment and develop athletic skills. WWP's Soldier Ride program allows veterans across the country the opportunity to engage in multi-day riding events using adaptive equipment that helps warriors build their confidence and strength through shared physical activities in a supportive environment.

Under VA's current regulations, veterans who wish to participate in such activities for personal enjoyment would not qualify for adaptive recreation equipment or prosthetic devices. These regulations focus on the clinical need for adaptive prosthetics rather than their potential to improve veterans' quality of life. In 2018, WWP submitted a public comment expressing concern with the proposed rulemaking regarding these regulations. WWP specifically expressed concern about the shift from "promote, preserve, and restore" – which takes into account quality of life – to medical necessity and the redefinition of adaptive recreation equipment. WWP expressed caution that these changes would have significant negative long-term impacts on veterans' quality of life and thus, negative long-term impact on the veterans' medical goals and overall health.

The current population of post-9/11 veterans is young, mobile, and active. WWP believes that VA should be building an ecosystem of care that is encouraging of such an active lifestyle versus a sedentary one. Adaptive equipment promotes and supports an active and healthy lifestyles for amputees. We recommend that VA authorize adaptive equipment for amputees without requiring that they be enrolled in a VA rehabilitative program for the profound physical and mental health benefits provided by sports and other recreational activities.

PILOT PROGRAMS

One significant way in which VA is addressing lag times and delays in prosthetics care for veterans is through the creation of the Mobile Prosthetics and Orthotics (MoPOC) team pilot program. This innovative initiative is designed to cater to veterans based on drive times and

population density, ensuring that those in rural and underserved areas receive the support they need. Currently, there are 15 operational MoPOC sites, with plans to open five more in the coming year. A cornerstone of this program is the Mobile OMP Shop, which travels three days a week for up to 1.5 hours to reach veterans who lack access to VA facilities. This mobile unit not only fabricates and repairs prosthetics but also conducts home visits one day a week to provide personalized care directly to veterans' doorsteps.

An evaluation team oversees the program, focusing on metrics, such as satisfaction rates, travel time, and prosthetic needs. Their efforts have yielded impressive results, with the program achieving over a 90 percent success rate. Additionally, a 2023 survey administered by the evaluations team highlighted the critical role that MoPOC plays, revealing that 20 percent of veterans using these services would have gone without them, if not for the program. This underscores the essential nature of MoPOC in providing necessary prosthetic services to veterans.

Despite its success, several issues hinder the program's efficiency. As with VA prosthetic care in general, logistics and procurement challenges arise as all prosthetics are grouped under PSAS. Additionally, VA's internal capacity building is hindered by congressional funding holds. Clinical care is nested under procurement and logistics, creating an internal dilemma as to whether VA should build or buy services for prosthetics. Moreover, VA has funds to purchase advanced prosthetic devices but lacks the internal capacity to hire the necessary personnel. The lack of money for clinical care, insufficient prosthetists, and inadequate support staff within VA further complicate matters.

To address these challenges, WWP emphasizes several recommendations already proposed for PSAS, including categorizing amputees separately from other prosthetic users, establishing a dedicated amputee prosthetics Center for Excellence at VA, and increasing the hiring of prosthetists within VA. Additionally, WWP recommends providing increased funding to support and expand the MoPOC program and extending the reach of the MoPOC services to urban areas to benefit a larger population of veterans.

Despite current challenges, MoPOC provides essential quality of life services while remaining cost-effective. Veterans greatly benefit from the convenience aspect, and providers offer a holistic approach, assisting veterans with needs that extend beyond prosthetics. Growing and refining the MoPOC program is essential for continuing to provide vital prosthetic services to veterans across the country. WWP applauds VA's use of MoPOC to reach veterans in rural and other underserved areas and hopes to see it further expanded.

CONCLUSION

Wounded Warrior Project thanks the House Committees on Veterans' Affairs Subcommittee on Health, its distinguished members, and all who have contributed to a robust discussion of prosthetics for those who suffered amputation during or after their military service. WWP stands by as your partner in meeting the needs of all who served – and all who support them. We are thankful for the invitation to submit this statement for record and stand ready to assist on these issues and any others that may arise.

Prepared Statement of Matt Brown

Thank you Chairman Miller-Meeks and Ranking Member Brownley for inviting me to testify on my prolonged and frustrating experience with VA Prosthetics Services and specifically the Fayetteville, North Carolina VA Medical Center. I am a U.S. Army veteran who enlisted in 2009 and sustained two Traumatic Brain Injuries and spinal fractures due to airborne training operations at Fort Bragg, North Carolina. I left active service in 2011 and transitioned to the Maryland National Guard. I was honorably discharged from military service in 2015. I have always been very active physically, running, doing martial arts, and scuba diving. I was diagnosed with bone cancer in May 2021 and my life was forever changed in ways I do not wish on anyone. I was still a young man with a family and a thriving business and much of my self-worth was derived from my physical abilities. Due to the extent of the cancer and my concerns about having the surgery done at a VA hospital, I was cleared for a Community Care referral to Duke Medical System in Raleigh, North Carolina in summer of 2021. My left leg was amputated above the knee on August 1, 2021 at Duke. After the surgery, I used a wheelchair for 7 months. During those 7 months I was unable to communicate with the prosthetics department because the phones were not functioning properly at my local VA center in Wilmington. I had to load my wheelchair in my truck and drive to the VA, where I would wait in the lobby to see the prosthetics person and ask them the status of my prosthetic. In the interim, I was cleared for follow on VA care on November 10, 2021. My first VA treatment appointment was on November 18, 2021. The VA will tell you I was given a martial arts protective socket within 28 days and a state-of-the-art prosthetic leg system within 53 days of that appointment, but neither of these systems worked for me because they would not stay on my residual leg. I have since been told that getting out of a wheelchair and beginning to use a properly fitting and safe prosthetic within weeks, not months, of an amputation is optimal and can be essential to a positive overall physical and mental recovery. At that time in early 2022, I had no idea it would take VA another 2 years to get me that proper prosthetic and that I would have to advocate vigorously for myself at every turn, eventually seeking help from Representative Rouzer, Senator Tillis, and The Independence Fund to advocate for my health and well-being to the VA.

My experiences with the VA over those 2 years were nothing short of bewildering and demoralizing. It seemed the staff at the local VA hospital consistently failed to communicate well about my care, follow through on my care coordination, and expedite requests for prosthetics. During that period, I worked with three different VA network private prosthetists in my local area of Wilmington, North Carolina. Although I was initially told I could select any provider, the one I selected for their reputation was not in the VA network so the VA selected another vendor for me at the onset.

All of these vendors over time responded to VA requests to produce a proper fitting leg socket. On more than one occasion they told me the acquisition approval process at VA was often slow and sometimes they would not be paid promptly by VA for their services. I complained to VA about the poor communication from VA to these local vendors multiple times. While all of this was going on, VA denied my travel claims for the trips I took to Duke in 2021 for my cancer treatment and the surgery. I am still working with Congressman Rouzer to resolve this. Meanwhile, I have been contacted by bill collection agencies. This only added to the stress of not being able to resume my normal activities outside of a wheelchair.

In October 2022, I heard from a fellow veteran amputee about a special socket the VA had provided him, called the Quattro variable volume socket. Given my level of physical activity and the changes in blood flow within my residual limb, I thought this system could be the answer to my ongoing search for a proper prosthetic. I indicated this to VA and requested they obtain one for me. I found out some time later that VA placed a requisition order for that socket, but never followed through to acquire it. The requisition sat idle while I repeatedly asked for this socket. The purchase order eventually expired and I had to start all over advocating again for the proper socket.

I continued to work with a local vendor to obtain a properly fitting socket and during this period of months I was using a prosthetic ankle. I visited the vendor for routine maintenance in September 2022 and the vendor told me they had to repossess this item because VA hadn't replied to their requests for payment. I left the vendor that day without that ankle and had to use an older ankle that was not as flexible.

For the next year, VA continued to pursue the same types of sockets and I continued to tell VA that I needed a different type of socket, basically the Quattro. This "ground hog day" process was extremely frustrating for me and my family. During

this period, I was stuck in a wheel chair for 6 months. I missed out on so many personal activities.

In October 2023, I was preparing to travel overseas and was still waiting for a socket to be delivered that fit properly. I let VA know I had a time limit on how long I could wait before my travel and VA directed a local vendor to provide me with a socket, but the vendor was concerned it wouldn't fit well and when it wouldn't I had to travel using my old, poorly fitting socket. That socket failed during my trip and it was very painful to walk and I came home with an infection. Upon my return, I was so frustrated that I let my contact at Congressman Rouzer's staff know about this. They assisted me further with VA, but progress was slow. After almost 2 months of congressional inquiry, I reached out to The Independence Fund's Casework Team in Charlotte. Their team and Congressman Rouzer's staff partnered to press VA for answers on the continued delays in my care and obtaining a properly fitting prosthetic. In December 2023, after calls and emails between Representative Rouzer's staff and the team at The Independence Fund with VA staff at Fayetteville and Washington DC, VA finally agreed to shift my prosthetic care from Fayetteville, North Carolina to Richmond, Virginia. My prosthetic doctor in Wilmington had left her practice at VA in 2022, so I was consequently assigned to a prosthetic doctor in Richmond as a result of the outreach to VA. That new doctor looked into my medical conditions and spent significant time assessing my needs for a different type of socket so I could get out of a wheelchair, travel more easily for my business, and finally participate in sporting activities with my wife and friends for personal and family well-being.

The Richmond VA doctor worked with me and a third local vendor to get me an interim socket that fit well and allowed me to travel for business in January 2024. It would not be until May 2024 when VA finally purchased and delivered the Quattro socket I use today. Since then I have lost thirty five pounds due to my increased activities and feel like a new person today. This only happened because of continued pressure on VA from Representative Rouzer, Senator Tillis, and The Independence Fund.

Looking forward, it's clear to me that VA needs a major rework or reform of how they address and process everyday amputee's needs for prosthetics, especially ones like mine, and deliver them timely. The entire experience can be overly bureaucratic, sluggish, and often impersonal, sometimes uncaring. I know VA has testified that the costs of these special recreational limbs is a concern, but very honestly these experts don't realize what it's like to be confined to a wheelchair for months, unable to swim or run, and they are ignoring the other unseen costs the long delays I experienced can cause, like the mental anguish I went through with my family and the related financial costs VA paid for with additional mental health visits I needed over those 2 years. There are also lifelong future cost savings for VA when veterans obtain the prosthetics they need to live active and fulfilling lives and don't have to rely on VA for more medical care. The VA has also testified that all these services are already being provided, yet I and other amputees are proof that commitment is not being uniformly honored or followed by local VA staffs and supported by a responsive acquisition system. We are not looking for special treatment, we just want to live our lives as independently and actively as possible.

Prepared Statement of Ashlie White



Mariannette J. Miller-Meeks, M.D.
Chairwoman
VA Subcommittee on Health

cc: Julia Brownley, Ranking Member, VA Subcommittee on Health

The Amputee Coalition expresses its gratitude to Chair Miller-Meeks, Ranking Member Brownley, and the distinguished members of the VA Health Subcommittee for the opportunity to testify in the hearing titled, *"Life After Limb Loss: Examining VA Amputee Prosthetics Care."*

Established in 1986, the Amputee Coalition is a 501c3 organization that provides support, education, and advocacy for the over 5.6 million individuals who have experienced amputations or were born with limb difference living in the US. The Amputee Coalition provides information, referral, healthcare navigation services, and peer support programming through its operation of the National Limb Loss Resource Center (NLLRC), which is funded through a Cooperative Agreement under the Administration for Community Living (ACL) in the Department of Health and Human Services.

At the heart of the Amputee Coalition's mission is our peer support programs. Our goal is to make sure that no one goes through this journey alone. We believe that support comes in many forms and can make an incredible difference in recovery and rehabilitation. The Coalition offers peer support in the form of support groups, hospital partnership programs, youth camp, and our Certified Peer Visitor program through our HHS grant.

Through an annual contract with the Department of Veteran Affairs, our organization provides technical support, print and digital resources, Certified Peer Visitor (CPV) training as well as train the trainer programs and help facilitate the Amputation Systems of Care (ASoC) Peer Support program.

No one is in a better position to understand the experience of living life with an amputation or supporting a person with limb loss than someone who has traveled that journey. A well-trained peer can offer encouragement and information an individual navigating the start of their own journey can better understand, absorb, process, and accept. A peer-reviewed study published in 2022 noted that peer support interventions "showed promise" in addressing suicide risk (Bowersox et al., 2021).

As noted in a recently published GAO report, over 93,000 veterans living with limb loss receive care through the VHA. Beyond combat-related injury from serving in the armed forces, limb loss could also be the result of the insidious effects of diabetes mellitus (DM). VA reports that most patients living with limb loss treated by ASoC suffer from DM or peripheral vascular disease. Veteran amputees with diabetes may experience further complications if they were exposed to Agent Orange and other related herbicides.

The GAO report also highlighted, as have others who have testified today have noted, that the Amputation Specialty Clinics through which many veterans living with limb loss receive care related to their limb loss, are staffed by an interdisciplinary team. This team includes a prescribing clinician (often a physical medicine and rehabilitation physician), a physical or occupational therapist (or both), a prosthetist, and a rehabilitation coordinator. An interdisciplinary model is the gold standard and one that we at the Amputee Coalition wished civilians could have access to throughout their continuum of care.

Recognizing that some veterans living with limb loss may experience mobility challenges, a virtual amputation clinic exists to access care from a VA Medical Center. This opportunity provides veterans living with limb loss the ability to connect with a provider from various locations, - including at home, a VA clinic, or a community prosthetic partner. The benefits of virtual clinics also include access to veterans with mobility challenges, elimination of transportation challenges, and reduction of work loss and the cost of travel. This is also not a standard of care available to most civilians, and the Amputee Coalition commends the efforts of the VA to make care more accessible for those living with limb loss.

In acknowledging the successes of the VA care model, it's also important to note some of the challenges and potential areas for improvement.

1. Healthcare access challenges faced by individuals experiencing limb loss in rural America continue to be a concern for the Amputee Coalition. The GAO report previously mentioned confirmed that 28% of Medicare Beneficiaries who received amputations lived in rural areas, but only 20% of all Medicare beneficiaries live in rural America. While the report did not provide this data for the veteran population, one cannot ignore that rurality plays a role in access to coordinated healthcare.
2. While the VA employs many certified prosthetists orthotists (CPOs) for its various clinics, much of the prosthetic care received by veterans is still provided by community O&P providers. The anecdotal reports we receive highlight differences in communication processes between clinicians within the VA and those in a community setting that vary from facility to facility. Creating more streamlined and coordinated channels of communication between community providers and VA clinical teams is vital to ensure that care remains coordinated when an individual is receiving prosthetic services outside of a VA setting.
3. Our partners in provider groups representing the orthotic and prosthetic field have expressed their concerns about the orthotics and prosthetics workforce pipeline, and it is my understanding that the National Commission on Orthotic and Prosthetic Education (NCOPE) is in the process of initiating a study to look specifically at those

workforce shortages. While the VA remains an attractive employer for CPOs, the Amputee Coalition is concerned with the recent reports of attrition that are from the Master of Orthotic and Prosthetic (MSOP) programs, especially since there are only 13 programs currently graduating MSOP students.

In closing, the Amputee Coalition expresses its gratitude for the opportunity to be a trusted partner in service to our Nation's veterans every single day. We value our partnership with the VA and are committed to supporting efforts to improve prosthetic care and the mental health and wellbeing of those veterans who have or are at risk of experiencing amputations.

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STATEMENTS FOR THE RECORD

Prepared Statement of the U.S. Government Accountability Office



United States Government Accountability Office

Statement for the Record to the
Subcommittee on Health, Committee on
Veterans' Affairs, House of
Representatives

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VETERANS HEALTH CARE

Information on Agency Efforts to Provide and Study Prosthetics for Female Veterans

Statement for the Record by Jessica Farb, Managing
Director, Health Care

GAO-25-107702

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee:

Thank you for the opportunity to submit this statement highlighting our work examining the Veterans Health Administration's (VHA) efforts to provide prosthetics to female veterans.

VHA provides veterans with prosthetic services to assist with their mobility, vision, and hearing needs. Veterans seeking prosthetics due to amputation have complex needs and are significant users of health care services. In 2008, VHA established an Amputation System of Care to provide specialized rehabilitation, prosthetic care, and other leading practices to veterans with amputations stemming from major limb loss. The Amputation System of Care is a tiered system with four levels of care into which each VHA medical facility is classified.

Women are the fastest growing veteran subpopulation, with the number of female veterans using VHA health care services increasing 29 percent from 2014 to 2019. Female veterans accounted for an estimated 10 percent of the total veteran population in fiscal year 2019. Women have unique needs when limb loss occurs. For example, one study found that 42.9 percent of women were successfully fitted with a lower limb prosthetic at discharge after amputation compared with 68.6 percent of men.¹ Women are also generally studied less than their male counterparts in prosthetic and amputee rehabilitation research.

My statement provides information from our November 2020 report entitled *Veterans Health Care: Agency Efforts to Provide and Study Prosthetics for Small but Growing Female Veteran Population* that examined, among other objectives, (1) characteristics of the female veteran population with limb loss and how VHA provides prosthetic services to these veterans; and (2) VHA's research efforts and the challenges that exist in studying prosthetics for female veterans with limb loss.²

¹R. Singh, J. Hunter, A. Philip, and S. Tyson, "Gender Differences in Amputation Outcome," *Disability and Rehabilitation*, vol. 30, no. 2 (July 7, 2009).

²See GAO, *Veterans Health Care: Agency Efforts to Provide and Study Prosthetics for Small but Growing Female Veteran Population*, GAO-21-60 (Washington, D.C.: Nov. 12, 2020).

For our November 2020 report, we analyzed VHA documents, as well as data from fiscal years 2015 to 2019 on prosthetics and veterans with amputations. We interviewed agency officials from VHA central office and officials and female veteran amputees at two VHA medical facilities selected for expertise in amputation care and prosthetics research activities. In addition, we interviewed VHA researchers conducting studies on prosthetics for female veterans. The report includes a full description of our scope and methodology.³

The work on which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VHA provides prosthetics to veterans who have experienced the loss or permanent impairment of a body part or function. Generally, for a veteran to obtain a prosthetic, a VHA provider first determines a veteran's need and prescribes a specific item. VHA also has prosthetist and orthotist staff who participate in the evaluations of prosthetic needs for veteran amputees and subsequently design, fabricate, fit, and adjust artificial limbs and custom orthotics.

VHA Promoted Individualized Prosthetics Care for Growing Population of Female Veterans with Limb Loss under Its Amputation System of Care

In our November 2020 report, we found that VHA provided prosthetic services to a small but growing female veteran amputee population (almost 3 percent of veteran amputees in fiscal year 2019), who were generally younger than male veteran amputees. The number and proportion of female veterans with major amputations grew from 902 (2.1 percent of all major amputations) to 1,171 (2.5 percent of all major amputations) from fiscal year 2015 to 2019.⁴

We also found that VHA established an individualized patient care approach in its Amputation System of Care that seeks to address the prosthetic needs of each veteran, including accounting for gender-specific

³See [GAO-21-60](#).

⁴A major amputation involves a leg at or above the ankle, or an arm at or above the wrist.

VHA Funded Eight Studies on Prosthetics for Female Veterans and Participant Recruitment Was an Ongoing Research Challenge

factors.⁵ VHA officials said that using a standardized, multidisciplinary approach across VHA medical facilities also helps them incorporate the concerns and preferences of female veterans. For example, veterans are provided care by a team that includes a physician, therapist, prosthetist, and other providers as needed. Female veteran amputees we spoke with at one VHA medical facility said they were satisfied with their VHA care. However, they also noted a lack of commercially available prosthetic options that VHA providers can use to meet women's needs.

In our November 2020 report, we found that VHA designated prosthetics for female veterans a national research priority in 2017. VHA had funded eight related studies as of May 2020: four pertained to lower limb amputation, three pertained to upper limb amputation, and one pertained to wheelchairs. VHA officials noted that while the research is a priority, they face an ongoing challenge of recruiting study participants due to the small female veteran population. For example, in a study on improving prosthetic footwear options, the study goal was to recruit three female veterans with lower limb amputations in the local area. However, the VHA researcher told us there were only two female veterans locally who fit the inclusion criteria.

To address recruitment challenges, the seven VHA researchers we spoke with said they employ various tactics, such as using multi-site studies and recruiting participants from the non-veteran population. However, these tactics may add complexity, time, and resources to completing the research and meeting study aims, according to VHA researchers and other officials. For example, it can be challenging to identify the necessary principal investigators and other research staff at each site of a multi-site study, which may in turn increase the time needed for data collection and the research cost. Extra steps may be required for recruiting non-veterans, such as demonstrating that recruiting enough veterans is not possible. Further, including non-veterans can raise issues as to whether researchers can then generalize the results to the veteran population.

⁵VHA's Amputation System of Care is comprised of (1) seven regional amputation centers, (2) 18 polytrauma amputation network sites, (3) more than 100 amputation specialty clinic teams, and (4) amputation points of contact responsible for consultation, assessment, and referral of veterans to a facility capable of providing the level of services required.

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee, this concludes my statement for the record.

**GAO Contact and
Staff
Acknowledgments**

If you or your staff members have any questions concerning this statement for the record, please contact Jessica Farb at (202) 512-7114 or farbj@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement.

GAO staff who made contributions to this testimony include Raymond Sendejas (Assistant Director), E. Jane Whipple (Analyst-in-Charge), Jacquelyn Hamilton, and Cathleen Hamann Whitmore.

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Prepared Statement of Scott Restivo

I joined the United States Army in March 2006 and was honorably discharged in January 2014. I deployed overseas with each unit I served. My combat service began in Iraq from 2007–2008 with 2d Battalion, 22d Infantry Regiment, 10th Mountain Division where I was attached to Special Forces and participated in air assaults and multiple fire fights. I deployed a second time to Iraq from Fort Lewis, Washington in 2010 with 2d Battalion, 23d Infantry, as an infantryman in a Stryker unit. My last deployment was from Fort Campbell to Afghanistan with 3d Battalion, 187th Infantry. During that deployment, a guard tower I was posted in was struck by enemy rocket propelled grenade fire. Early in my military service I injured my right leg in training and that injury was later aggravated on deployment, eventually requiring a rod placement. I also have a moderate traumatic brain injury (TBI), hearing loss, and ongoing complications such as seizures and PTSD in addition to other medical conditions. The rod that was placed in my leg by the Army at Fort Drum later dislodged into my knee tearing my meniscus and causing revision of my patella tendon. I was willing to remain in the Army, but due to administrative issues and what I saw as improper handling of my medical care in the Army, including a misrepresentation of the origin of my injury as occurring pre-service, my medical discharge process was denied and I was not medically retired by the Army. Consequently, I do not qualify for TRICARE and have since faced prolonged and significant challenges since my discharge receiving timely and appropriate treatment and care from the Department of Veterans Affairs (VA).

This is a condensed summary of my medical journey and my advocacy efforts relative to the VA:

- My primary health care doctor at the VA had us apply for the Caregiver Program in 2016 given our needs. We were subsequently denied admission to the program in 2016, despite my need for continuous care. The reason given was I did not need 6 months of continuous care. Due to my medical conditions, Lelia had to quit working because I was having seizures, incontinence, and non-cognitive episodes. I had a home health nurse for wound care, a PICC line my wife had to change every few hours, speech therapy, OT, PT, and a leg that was impeding my mobility. I endured multiple knee surgeries without improvement, had PICC line complications, and ER visits.

- On November 15, 2016, the VA performed right knee surgery to remove the dislodged rod and reconstructed my knee.

- Post-surgery, I frequently visited the ER with severe symptoms, including loss of consciousness, seizures, fever, and a discharging incision wound. The VA ER only provided fluids and a few times cleaned the wound and stabilized my condition. Multiple outside hospitals identified an infection, but could only stabilize the issue and kept referring me back to the VA since they did the initial surgery.

- My wife, Lelia, aggressively advocated for my care and condition. She reached out to my Primary Care Provider, Mental Health Specialist, Neurology, Orthopedics, social workers, and patient advocates since surgery complications began.

- In January 2017, my wife finally got a call from the head of the Nashville VA hospital's Orthopedics department and arranged a time for me to be seen. During that visit, 500+ liters of fluid were drained from the knee in my right leg and I was wheeled into immediate emergency surgery due to sepsis.

- I awoke days later burning up with a fever, I had gone into shock and nearly died from sepsis. My wife had called family members in as the staff didn't think I would make it. Four days later I had broken my fever only to awaken confused and remember being frustrated, in pain, and being wheelchair dependent with round the clock PICC line changes.

- Recently, we discovered several news articles that revealed the VA's sterilization equipment was down during the initial surgery, indicating non-sterile conditions.

- After 6 months of constant advocacy by my wife and pleading with the VA orthopedic surgeon an outside Orthopedic referral was finally approved in June 2017.

- During the first appointment Tennessee Ortho Association images revealed that the infection had spread into the bone and they could do nothing to stop the spread of infection. I was referred for care at Vanderbilt University Hospital.

- I had bone grafts, and several surgeries at Vanderbilt, but was still sick and losing more and more mobility. Essentially, I had a dead limb I was dragging around with me daily. The last surgery and attempt to save my leg was unsuccessful. I

broke down and decided I was done living ill and I wanted to live my life to the fullest even if that meant without a leg.

-On October 18, 2018, my right leg above the knee was amputated at Vanderbilt. Some days I wish the guard tower attack had taken me out or the rocket just had taken my leg off then. It had now been 6 years since the rod had initially dislodged into the knee, and I suffered the slow death of my leg into the bone, primarily due to negligence. This is not how anyone should lose a limb.

-The VA delayed providing me with a prosthetic for 6 months and offered inadequate Physical Therapy. The Nashville VA prosthetic clinic was ineffective, offering incorrect prosthetics, infrequent appointments, and poor communication. I experienced frequent prosthetic malfunctions, falls, and inconsistent care. Liners last approximately 3 months, but I went 18 months with two liners and this caused sores and wounds to my stump. I had a loaner leg for over 6 months due to a micro-processor malfunction and the need for it to be sent out to be fixed by the manufacturer. That was the third time I had a loaner leg for extended periods of time. Each time I am in a loaner leg, it affects my gait and ability to walk and function correctly. As of this testimony, I am still waiting for a proper prosthetic leg that allows me the normal mobility I am seeking.

Based on my experiences with VA, I offer the following observations:

-I essentially have received inconsistent care throughout the entire VA system, predominantly in Nashville and not just only with prosthetics care.

-A 2018 VA hearing sought repayment of separation pay, later found to be improperly coded, because DOD had granted me relief and the VA judge recommended relief, but the VA overruled their judge and recouped all pay from March to August 2020. This was during the pandemic and the sudden loss of that money caused me and Lelia undue stress and hardship.

-My VA primary care provider changed, leading to misdiagnosis and overlooked issues, such as infections and kidney stones. VA imaging showed one kidney stone and Vanderbilt's showed multiple.

-In February 2020, I experienced severe blood pressure issues, leading to ICU admission and a finding of a mitral valve issue, yet I was discharged without resolving my blood pressure cycling. I was admitted to Skyline hospital, they found I was allergic to the medication the VA put me on and I was on the stroke watch for 5 days. Advocacy efforts resulted in a new Primary Care Manager in 2021 and I was assigned to a palliative care team, but my major health issues remained unresolved.

-In 2022, a congressional inquiry revealed lost caregiver applications and vehicle grants dating back to 2018. By early 2023, vehicle repairs prompted reapplication for a vehicle allowance, revealing systemic VA issues. Continuous communication with the chief of staff's secretary at Nashville VA resulted in no tangible outcomes.

-In March 2023, my wife quit her job teaching to advocate for my medical issues full-time, leading to a confrontational prosthetics appointment and to an inner facility consult with transfer of prosthetic care from Nashville VA to Tampa VA.

-We made regular trips from Tennessee to Tampa for laser treatments and prosthetics fittings and while we experienced initial improvements in care, we faced logistical and financial challenges.

-By late 2023, the prosthetic issues persisted, requiring multiple repairs and causing frequent falls.

-Dental complications arose, with VA dental falsely diagnosing an emergency infection.

-Advocacy again led to some progress, such as an adaptive housing grant approval, but continuous care and prosthetic issues remained unresolved.

-Our second Caregiver Program denial was appealed, and I faced significant ongoing challenges with prosthetic fitting and functionality.

-Travel expenses are not fully covered to Tampa for necessary treatment and have imposed significant financial burdens. Communication with Tampa prosthetics is now crossing over into other care communications issues between other VA providers.

-In February, 2024, Tampa VA was supposed to have ordered or prescribed a new socket for the current daily use prosthetic because mine is broken and does not fit. This prosthetic knee was repaired over 4 times within a 6-month period, and I had

been in a loaner leg since November 2023. The repaired knee was to be used as a backup in place of a loaner leg situation. A new fitting socket and copy of the daily use microprocessor was also supposed to be ordered for the function of daily use in the event we lose power at our home, as has happened for days after storms. I received this new system on July 8, 2024. It was not functional for long term daily use; it is supposed to be waterproof so I may be able to use it as a shower leg and not need a shower leg made, though I have requested a water leg since the day of surgery because I want to be safe and feel normal and be able to stand in the shower. I did receive two liners and they arrived a year after I had last received liners, despite multiple communications stating the need for them since our November 2023 visit to Tampa. I left my appointment with Hanger Prosthetics in July with the still broken socket and malfunctioning knee, carrying the non-microprocessor system with videos of gait training so my wife can assist me in learning how to use the leg on my own.

In conclusion, I pray that my journey illustrates the severe challenges faced in obtaining adequate care through the VA. Despite some progress, due in significant part to The Independence Fund's unceasing effort to get our voice finally heard and this story told at the upper levels of the VA in Washington DC and by this Committee's staff, significant gaps in care and support persist, necessitating ongoing advocacy and intervention to improve my quality of life. I thought going to war would be the end of the battle, but the fight has been for my life in seeking medical care in the VA system. I ask Congress for a change of access to timely and efficient prosthetic care whenever requested, so that no Veteran suffers the loss and function of a limb or inadequate prosthetic limb care the way I have.

Prepared Statement of The American Legion

Chairwoman Miller-Meeks, Ranking Member Brownley and distinguished members of the House Veterans' Affairs Subcommittee on Health on behalf of National Commander James LaCoursiere and The American Legion, the country's largest service organization for veterans, comprised of more than 1.5 million dues-paying members, we thank you for the opportunity to offer this statement for the record regarding life after limb loss and the prosthetics care provided to veterans by the VA.

Amputees' Stories

This year our organization has conducted numerous interviews with amputees. This includes an interview with U.S. Army veteran Geoffrey Quevedo on November 6th, 2024¹ and a subsequent interview with U.S. Army veteran Earl Granville on November 14th, 2024². Additionally, U.S. Air Force veteran Adam Popp was interviewed on the Tango Alpha Lima Podcast on May 7th, 2024³.

On Nov. 30, 2012, while on patrol in Afghanistan, Geoffrey Quevedo and a fellow soldier from the 10th Mountain Division discovered an improvised explosive device (IED). As they attempted to disarm the device, it exploded—catastrophically wounding Geoffrey and his squad mate, leading them to be medically evacuated to Walter Reed Medical Center in Bethesda, Maryland. Geoffrey originally had his left foot and left arm above the elbow amputated. These injuries led to more than 40 surgeries with the eventual amputation of his left leg below the knee. Due to complications, he now deals with chronic pain, vision loss and migraine headaches.

When asked about his experiences in receiving treatment, Mr. Quevedo mentioned difficulties in reordering extra sleeves and prosthetic supplies from VA. These reorders are due to the wear and tear of Geoffrey pushing himself to run 5-kilometer and 10-kilometer marathons. He said, "Sometimes it feels like I'm being punished for trying to be active." It is clear that VA should recognize these kinds of supplies, adaptive sports and recreation prosthetics as clinically necessary for amputees.

We should be eliminating barriers to exercise, not creating them, as it is an essential part of living a healthy life and addressing upstream health complications. Geoff-

¹Petrie, Andrew, Joshua Hastings, and Geoffrey Quevedo. The American Legion Health Policy Amputee Interviews. Personal, November 6, 2024.

²Hastings, Joshua, Sri Benson, and Earl Granville. The American Legion Health Policy Amputee Interview. Personal, November 14, 2024.

³Marr, Adam, Stacy Pearsall, and Adam Popp. A Record-Setting Veteran Amputee. Other, n.d. <https://www.legion.org/information-center/news/tango-alpha-lima/2024/may/a-record-setting-veteran-amputee>.

frey also talked about his decision to move closer to his community care provider and his frustration with VA's delayed payments to his provider after receiving care.

When asked to describe his strongest support system, Geoffrey noted how instrumental peer support from the amputee community was in his recovery. He said it is an honor to be an example to younger veterans walking down a similar road: "Pain becomes a part of life—there is really nothing you can do to take it all away. You go from being top dog, to someone always asking for help." He realized the most painful thing about his recovery was dealing with the loss of his independence. "This is why I always tell them to stay active."

Earl Granville agreed with Geoffrey, noting that working with other amputees has been critical to his own recovery. Earl was deployed to Afghanistan when—on June 3, 2008—an IED exploded, ejecting Granville out of the vehicle and killing two fellow soldiers, Major Scott Hagerty and Specialist Derek Holland.

Mr. Granville talked about the training he received from the Amputee Coalition, where they worked on learning to listen. There, he would often break the ice with younger amputees, saying "Hey, you've got that new shiny thing. How is that going?" Granville now tours around the country promoting his philosophy of the three Ps: purpose, passion and being part of something bigger than oneself.

When asked about his experience receiving care, Mr. Granville gave the Walter Reed Medical Center a glowing recommendation. He is generally pleased with the care he is receiving from VA. One drawback he mentioned, however, is the inconvenience of having to go in person to a VA facility when a certain process could be conducted digitally. "We need to make it easier on these guys."

In addition to interviewing Mr. Quevedo and Mr. Granville, The American Legion Tango Alpha Lima podcast interviewed Air Force veteran Adam Popp on May 7, 2024. Mr. Popp became an amputee during his deployment to the province of Paktia in Afghanistan, where he was wounded by a secondary IED, resulting in the amputation of his right leg above the knee. Since then, he has become an outstanding athlete, setting seven new marks in the Guinness Book of World Records.

In his interview, Popp mentions that he understands his achievements reflect not only his physical fitness, but his strong mental state. He admits that in the aftermath of his injury, he did not seek out such challenges. "It's about seeking out selective struggles, some type of challenge, and then coming out stronger on the other side, whether that is through physical activity, education or personal struggles that happen in anyone's daily life." He ended with a question: "Is that going to beat us down or lead us to a more fruitful and productive life?"

Post-traumatic Growth

The theory of post-traumatic growth (PTG) suggests that people can rebuild their foundation by believing they are not defined by what has happened to them, i.e., positive psychological change can occur after experiencing a traumatic event. PTG therapies often pursue new experiences to take advantage of the increased neuroplasticity (the brain's ability to form and reorganize synaptic connections) of traumatized patients. This increased neuroplasticity follows both physical and psychological trauma. Due to the untraditional nature of PTG therapies, it has been difficult for the VA to implement system-wide programs. The Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program should continue to seek community partners who deliver PTG programs for veterans. The image of the broken hero needs to be replaced with one of strength and mental resilience.

Opioid Use Disorder

Many veterans become amputees due to explosions or blast-related events; these lead not only to injuries such as amputations but often cause spinal cord injuries (SCIs) and traumatic brain injuries (TBIs). These types of injuries can lead to chronic pain, loss of movement, and other serious medical problems throughout the body.

About one-third of veterans with SCIs will experience persistent neuropathic pain after injury, and opioids are considered among the most effective treatments for neuropathic pain. This puts veterans suffering from polytrauma at a substantial risk for opioid use disorder.

According to the National Library of Medicine, U.S. military veterans have been heavily impacted by the opioid crisis, with drug overdose mortality rates increasing

by 53 percent from 2010 to 2019.⁴ The need to improve overdose prevention efforts remains clear and more should be done to provide effective alternatives to opioids for chronic pain management.

Gaming Therapy

In January 2024, The American Legion conducted a System Worth Saving (SWS) site visit to the James A. Haley Veterans' Hospital (JAHVH) in Tampa, Florida. During a tour of the facility, the SWS team was given the opportunity to meet Jamie Kaplan, a recreation therapist who informed us about JAHVH Gaming, a gaming community of about 350 servicemembers and veterans who meet five nights a week. The array of adaptive gaming controllers and other gaming prosthetics was most impressive, using combinations of hands, feet and even lung power.

These innovative approaches are a critical part of addressing the isolation felt by many veterans with limb loss and can provide both support and entertainment. When The American Legion's Health Policy team highlighted these innovations with Mr. Quevedo in our interview, his face brightened—envisioning playing video games with his daughters. More should be done to make such dreams a commonplace reality.

During the Tampa visit, the late Autrey James, previous Chairman of The American Legion's Veterans Affairs & Rehabilitation Commission, became extremely interested in the gaming program and spoke about the Legion's efforts in California to create supportive veteran gaming communities. He informed Mr. Kaplan that the Legion's Department of California had established a Gaming Committee in 2023 to help promote camaraderie, improve mental health and aid recruiting efforts.

Age/Gender-Appropriate Resources

The young age of traumatic and non-traumatic amputees highlights the need for age-appropriate resources. Many of the post-9/11 veterans are still within working age, as indicated by a study that showed 37 percent of veterans with limb loss are employed. Post-9/11 veterans have different prosthetic needs compared to older veterans.

According to recent research, approximately 85 percent of veterans with a limb amputation are under the age of 35. Older veterans with co-morbidities related to their limb loss are often physically challenged and have difficulty exercising; this is in contrast to younger veterans who are more physically able but face other challenges such as mental health difficulties due to trauma and PTSD.⁵

Last, with the increase number of women veterans serving during the post-9/11 era, we have also noticed an increase in gender-specific prosthetic needs. In past years, amputations among veterans were a male-dominated concern. Many women who served in recent wars have also suffered from limb loss and they have different needs when it comes to prosthetics. For example, thinner and lighter devices are required to provide the function and agility women need to be as independent as possible.

Conclusion

The lack of age/gender-appropriate resources for young veterans must be addressed. Alternatives to opioids must be made readily available to veterans who suffer from spinal cord injuries and chronic pain. Access to alternative treatments for polytrauma—such as PTG virtual reality therapy, adaptive sports and recreation prosthetics – must be increased and additional research must be funded. VA and DoD need to work more closely in helping to ease the burden of transitioning servicemembers who require prosthetic maintenance, training and rehabilitation.

The American Legion strongly supports VA efforts to fund, develop, and provide gender-specific prosthetic appliances, orthotics, and services through multiple avenues—such as medical facilities, community outreach centers and mobile clinics. VA must continue to engage in research and innovation to ensure that veterans are provided with sufficient opportunities to mobilize independently.

⁴Woller, Sarah A., and Michelle A. Hook. 2013. "Opioid Administration Following Spinal Cord Injury: Implications for Pain and Locomotor Recovery." *Experimental Neurology* 247 (September): 328–41. <https://doi.org/10.1016/j.expneurol.2013.03.008>.

⁵Murray, Craig D., Heather Havlin, and Victoria Molyneaux. 2023. "Considering the Psychological Experience of Amputation and Rehabilitation for Military Veterans: A Systematic Review and Metasynthesis of Qualitative Research." *Disability and Rehabilitation*, March, 1–20. <https://doi.org/10.1080/09638288.2023.2182915>.

Research should encompass the latest technologies in prosthetics and orthopedic devices and should include comparative analyses on best practices and outcomes derived from the Medicare program and the commercial health insurance market relating to the coverage of assistive technologies.

Finally, the tragic effects of physical and mental disabilities overwhelm some veterans who end up taking their own lives. Without question, successful treatment plays a key role in suicide prevention. The restoration of mobility, positive psychological changes, safe pain management and a sense of community are powerful tools in reducing veteran suicides.

Two of the veterans who shared their stories with The American Legion have felt the tragedy of suicide. Mr. Quevedo's former squad mate, Quinton Picone, died from suicide 5 years after the IED incident in Afghanistan. Mr. Granville's twin brother Joe took his own life in 2010; the brothers had served together in the Army on multiple deployments.

Suicide prevention remains The American Legion's most important mission. In partnership with The Columbia Lighthouse Project and the QPR Institute, our national "Be The One" program has provided training in suicide prevention for more than 10,000 members of The American Legion family – our goal is to train more than 100,000 by the end of 2025.

Furthermore, The American Legion Buddy Check Program aims to reconnect veterans who may need assistance but do not know where to go or who to ask for help. In concert with this effort, the VA held its first Veteran Buddy Check Summit last month, an event that was extremely well received.

Chairwoman Miller-Meeks, Ranking Member Brownley and distinguished members of this Subcommittee, The American Legion thanks you sincerely for your leadership and for allowing us to explain the position of our membership on the issue of VA prosthetics care for amputees. For additional information regarding this testimony, please contact the director of our Legislative Division, Julia Mathis, at jmathis@legion.org.

