



National Service & Legislative Headquarters
807 Maine Avenue, S.W.
Washington, D.C. 20024-2410
Phone (202) 554-3501
Fax (202) 554-3581
www.dav.org

***STATEMENT OF
ADRIAN ATIZADO
DAV DEPUTY NATIONAL LEGISLATIVE DIRECTOR
FOR THE RECORD OF THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 22, 2017***

Mr. Chairman and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify on the recruitment and retention of high quality clinical and administrative Department of Veterans Affairs (VA) employees. As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

Virtually all of our members rely on the VA health care system for some or all of their health care, particularly for specialized treatment related to injuries and illnesses they incurred in service to the nation. To overcome the size and scope of barriers to effective recruiting and retention of VA health care personnel, Congress and VA must work in concert. In reviewing this issue, we highlight those areas where VA lacks control, requiring Congressional action. VA must be empowered to hire the right people, have them in the right places, and empower these dedicated employees to care for our nation's ill and injured veterans.

As the largest integrated health care system in the country, VA is the proverbial "canary in the coal mine" for identifying physician shortages in America's health care workforce. While the exact need has yet to be determined, the Association of American Medical Colleges estimates that the United States is facing a shortage of between 61,700-94,700 physicians by 2025, with specialty shortages particularly acute. The most vulnerable patient populations are in underserved areas, many of which have large veteran populations. With more than 60 percent of United States trained physicians receiving VA training prior to employment, the VA health care system plays an important role in training the next generation of physicians and filling such shortages.

NEEDED CHANGES IN EXISTING AUTHORITIES

VA's effective recruitment and retention strategies must include the coordination of other resources such as physical space issues. All too often we hear of the VA facilities built recently in areas struggling with long waits because planning and building these facilities take so long that they are often immediately over capacity when the doors are opened. Changes in the local health care market occur constantly, but significant changes likely occur during long building timeframes. Certainly, such changes can be addressed in part with last minute but costly changes

in the initial design, but VA must identify strategies to truncate this process or better estimate future demand. In addition, Congress should assist VA to be more nimble with its physical footprint by enacting legislation to allow VA to lease facilities.

Leasing Authority

Under current law, Congress must enact legislation authorizing VA to lease medical facilities with average annual rental payments in excess of \$1 million. Since 2012 however, Congress has not approved VA leases for its health care employees to work in, hampering the ability of the Department to provide much-needed health care and services to veterans around the country.

The Congressional Budget Office (CBO) changed the way it scores these leases in 2012. Previously, VA major medical facility leases were designated as operating leases and recorded the obligations on an annual basis in an amount equal to the lease payments due in that year, which was the amount used to score the legislation for such leases. In 2012, CBO determined that budget authority for these leases must be recorded up front when the leases are initiated and the acquisition occurs—not when the debt is being repaid. This change significantly increased the scoring of leasing legislation even though actual spending would not increase and the leases are ultimately subject to annual appropriations.

Starting with this Subcommittee, Congress must allow leases to go forward while working on a more permanent resolution on the scoring challenges facing these leases. Without Congressional action, VA will remain unable to effectively manage its physical footprint and its health care workforce to meet the changing health care demands of veterans across the nation.

Telemedicine Authority

Physical capacity constraints can be mitigated, however. Telehealth is one of the VA's major transformational initiatives, and the number of veterans utilizing telehealth services continues to climb. More than 12 percent of VA patients receive elements of their care through telehealth services. Nearly 90 percent of veterans who utilized the VA's effective telehealth services were satisfied with the care they received and telehealth services save on average \$2,000 per year in health care related costs, including travel to a VA medical facility.

Yet under current law, the VA may only waive the state license requirement for telehealth services if both the patient and physician are located in a federally owned facility. In addition, the VA may only perform in-home telehealth care when the patient and physician are located in the same state.

Legislation is required to address these barriers, which prevent ill and injured veterans from being seen by a VA physician in another state. Rural veterans are particularly affected by this lack of authority and in some cases force them to travel great lengths to a federal facility before receiving telehealth services.

Graduate Medical Education

VA's participation in graduate medical education (GME) programs assists the Department in the recruitment and retention of high quality clinical staff. GME residency programs occur after medical school graduation, which require three to seven years of additional training and allow physicians to gain specialty knowledge and judgment. Medical residents directly contribute to the clinical care of veterans in their role as supervised trainees who are granted clinical responsibility.

Congress took an important first step towards addressing these shortages and expanding VA's training mission by increasing VA GME slots up to 1,500 residency positions authorized under section 302(b) of Public Law 113-146, the Veterans Access, Choice and Accountability Act of 2014 (VACAA). We applaud VA for including in its effort to successfully utilize this new authority additional funds for such things as the salary of VA staff who are instructors for or supervise residents and trainees; overhead/administrative costs associated with maintaining a GME program, and; minor construction projects, or augment major construction projects, that will allow for necessary expansions of space.

Notably, VA's expanded support for residencies to help address physician workforce shortages must be leveraged using the synergy between a VA hospital and its affiliated academic medical center. Academic partnerships facilitate the joint recruitment of faculty to provide care at both VA and academic medical facilities. VA GME programs also educate new physicians on cultural competencies for treating veteran patients (inside and outside the VA), and help recruit residents physicians to the VA after they complete their residency training. According to results from the VA's Learners' Perception Survey, residents that rotate through the VA are nearly twice as likely to consider employment at VA institutions.

However, VA residency programs are sponsored by an affiliated medical school or teaching hospital. While programs and specialties at VA medical centers vary considerably, on average medical residents rotating through VA spend approximately three months of a residency year at VA. To successfully expand VA GME, VA estimates that affiliated teaching hospitals need two to three positions for every VA position to meet all program requirements.

In addition, VA is limiting additional appointments of residents when fulfilling the requirements of section 302(b) of VACAA. Existing law established in 1997, under title 42, United States Code, imposes a ceiling on hospital residency positions for cost-reporting purposes in the federal graduate medical education program (which reimburses residency costs from federal funds). Congress must address this primary barrier to increasing residency training at medical schools and teaching hospitals.

VA'S PATIENT POPULATION

To improve and strengthen VA's ability to recruit and retain employees, we assume the providers hired by the Department have the requisite training and expertise. VA's patient population resides in rural and highly rural settings to a greater degree than the general

population as a whole. The median age of veterans is nearly 60 years old and over half of veterans using VA outpatient care are older than 65.

Nearly half of veterans enrolled in VA are age 65 and older, nearly a third are over 75, and over a million veterans are over 85. A September 2011 study of the VHA funded by Commonwealth Fund found that VA patients (primarily older men) had much higher rates of many chronic health problems—such as high blood pressure, diabetes, and depression—than the U.S. patient population as a whole. That is, we can expect the average age of enrolled veterans to continue to rise and use VA services at an increasing rate as they age. It should be alarming to this Subcommittee that most VA providers are not Geriatricians.

VA needs physicians trained to meet the special health issues of older veterans. As veterans age, it becomes more common to have a number of health issues and to take several medications at the same time to deal with those problems. Moreover, diseases and medications can have a different effect on older veterans. Geriatricians are trained in the specialty of medicine that focuses the diseases and disabilities of advanced age supported by extensive and decisive literature demonstrating that care of elder patients by non-specialists substantially deviates from established medical recommendations.

Mr. Chairman, if children are best seen by Pediatricians, complex aging patients should be seen by Geriatricians who know how to manage all their health issues and design care plans to deal with the whole person.

The supply of providers best able to meet the type of demand is lacking with interest in practicing this type of medicine in severe decline. Just as it is with Primary Care, practitioners of geriatric medicine are reimbursed at a lower level than other physicians. Who would want to incur additional debt to specialize in a field of medicine and be paid less? Practitioners specializing in the care of elderly patients may need to move from practicing to teaching future providers to increase the supply of clinicians with this advanced knowledge. We urge VA to address this critical need if it is to deliver effective high quality care to our nation's ill and injured veterans.

There are a number of available options to influence the workforce that can be initiated at any time: Congress can target geriatricians using the VA/Medicare GME program; VA can grow the number of providers with advanced training in caring for this challenging population; VA can increase geriatric competencies across the entire workforce, including physicians, nurses, social workers, mental health providers, pharmacists, and; VA can increased provider-to-provider consultation might serve as a partial strategy while building the necessary workforce.

RURAL AREAS

The DAV believes VA is working in good faith to address its shortcomings in rural areas but still faces major challenges. Shortages, recruitment and retention of health care personnel are key challenges to rural veterans' access to VA care and to the quality of that care. *The Future of*

Rural Health report recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health care professionals working in rural areas.¹

Through VA's existing partnerships with 165 medical schools, over 43,000 medical residents and 24,000 medical students receive some of their training in VA facilities every year. In addition, nearly 54,000 associated health sciences students from over 1,000 schools—including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants, and nurse practitioners—receive training in VA facilities.

VA is in the unique position of employing individuals within the same profession under two differing hiring authorities, title 5 and title 38 of the United States Code. VA also has been given the authority to classify employees in a “hybrid” employee status, which removes employees from a Title 5 competitive service system and empowers VA to offer competitive salaries as well as create and interpret rules for hiring and promoting certain health care employees exclusively under its own unique authority.

Whether in health, benefits or other services, VA invests a significant amount of effort and resources into training its workforce to meet the specific needs of veterans. Maintaining the wealth of experience, skills and knowledge needed by VA employees is essential to carry out the VA mission. To retain quality employees, VA needs to provide employee incentives and programs that include child care benefits, flexible scheduling, and adequate continuing education allowances to expand skills and underwrite board certification.

COMPETITION IN RECRUITING

The bureaucratic and lengthy process VA requires for candidates to receive employment commitments and onboarding continues to hinder the VA ability to recruit and officially appoint physicians, nurses, and most commonly, new graduates, who are often in debt from student loans. VA must reduce the amount of time it consumes to bring these new employees on board, and provide its human resources (HR) management staff adequate support through updated, streamlined hiring systems, new procedures, and better training, to maintain the VA ability as a provider of health care, benefits, and other services to veterans.

DAV is aware that more seasoned recruiters are able to streamline and compress VA's lengthy process using current authority in aggressive and novel ways. VA should encourage these local innovators to self-identify, test the feasibility of their practice, and disseminate this information through dedicated times for education and training.

While VA has statutory authority to directly hire physicians, it is not authorized to offer them employment until after they complete their residency program. Since private health care systems often offer residents employment a year or two before completing their residency programs, VA is at a disadvantage when hiring health care professional who complete their residency at VA medical facilities. This statutory limitation hinders VA's ability to hire and

¹ *Quality Through Collaboration: The Future of Rural Health*, Committee on the Future of Rural Health Care, Board on Health Care Services, Institute of Medicine of the National Academies, the National Academies Press, Washington, D.C., 2005.

retain physicians who complete their residency program at VA and would like to continue to work at VA.

Also, VA leadership must ensure recruitment strategies and goals are shared by local HR staff across the system as they carry out their duties. VA administrations produce annual Workforce and Succession Strategic Plans that establish VA-wide HR recruitment and retention goals. VA must create and adopt performance measures and standards that systematically identify when these recruitment goals are achieved, and when they are not.

To this end, we are appreciative of the report by the Government Accountability Office on its findings of high attrition among VA's HR staff and an increasing workload to fulfill HR functions have made it difficult to implement its Workforce and Succession Strategic Plans. VA must fully address challenges with its workforce identified by GAO before HR staff can be held accountable to performance measures and goals for recruitment and retention. The failure to fill critical vacancies across VA in a timely manner directly impacts the Department's ability to provide services to veterans.

BURNOUTS

VA's Center for the Study of Healthcare Innovation, Implementation and Policy (formerly the VA HSR&D Center of Excellence for the Study of Healthcare Provider Behavior) has been studying VA provider burnout—a syndrome characterized by specifically work-related emotional exhaustion, otherwise known as cynicism, depersonalization and a reduced sense of personal accomplishment.

As this Subcommittee is aware, VA launched the patient-aligned care team (PACT) initiative in 2010 to implement a medical home model in more than 900 primary care clinics nationwide. Two years later in 2012, a survey showed that about 39 percent of primary care employees participating in PACT transformation screened positive for burnout and includes 45 percent of all providers that were surveyed.

A more recent study published in the Journal of Internal Medicine looking at burnout among VA Primary Care team members, the overall prevalence of burnout was 41 percent for fully staffed teams with team turnover and overcapacity patient panel. There was a lower but significant burnout prevalence of 30 percent for fully staffed teams with no turnover and caring for a patient panel within capacity. DAV believes the burnout rate in VA health care teams needs to be addressed by VA and deserves strong oversight by the Subcommittee.

In closing, we thank you for this opportunity to provide testimony for the record. We ask the Committee to consider these situations as it deals with its legislative plans for this year. This concludes my testimony, and I will be happy to address any questions from the Chairman or other Members of the Subcommittee.