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

I am Dr. Nichol Salvo, member and Director of Young Physicians' at the American Podiatric Medical Association (APMA). I am also a practicing VA physician, maintaining a Without Compensation (WOC) appointment status. I am before you today representing APMA and the podiatric medical profession, and specifically our members currently employed, and those seeking to be employed, by VA. While I do not represent VA in my capacity today, I do bring with me first-hand experience and knowledge of hiring practices within VA, as well as knowledge of the widespread disparity between podiatric physicians and other VA physicians.

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

Mr. Chairman, when the Veterans Health Administration (VHA) qualification standards for podiatry were written and adopted in 1976, I was not yet born. Podiatric education, training and practices in 1976 starkly contrasted with that of other physician providers of the time, and with podiatric medicine as it is today. Unlike thirty-nine years ago, the current podiatric medical school curriculum is vastly expanded in medicine, surgery and patient experiences and encounters, including whole body history and physical examinations. In 1976, residency training was not required by state scope of practice laws. Today, every state in the nation, with the exception of four, requires post-graduate residency training for podiatric

physicians and surgeons. In 1976, podiatric residency programs were available for less than 40 percent of graduates. Today there are 597 standardized, comprehensive, three-year medicine and surgery residency positions to satisfy the number of our graduates, with 77 positions (or 13 percent) housed within the VA. In contrast to 1976, today's residency programs mandate completion of a broad curriculum with a variety of experiences and offer a direct pathway to board certification with both the American Board of Podiatric Medicine (ABPM) and the American Board of Foot and Ankle Surgery (ABFAS). These certifying bodies are the only certifying organizations to be recognized by the Council on Podiatric Medical Education (CPME) and VA. These bodies not only issue time-limited certificates, but they participate in the Centers for Medicare and Medicaid Services (CMS) Maintenance of Certification (MOC) reimbursement incentive program. Unlike the residency curricula in 1976 (which were not standardized, nor comprehensive), today's residency curriculum is equitable to MD and DO residency training and includes general medicine, medical specialties such as rheumatology, dermatology and infectious disease, general surgery and surgical specialties such as orthopedic surgery, vascular surgery and plastic surgery. CPME-approved fellowship programs did not exist in 1976, but since their creation in 2000, they offer our graduates opportunities for additional training and sub-specialization. Today, podiatric physicians are appointed as medical staff at the vast majority of hospitals in the United States, and many serve in leadership roles within those institutions, including but not limited to chief of staff, chief of surgery, and state medical boards. Many of my colleagues have full admitting privileges and are responsible for emergency room call as trauma and emergency medicine are now also incorporated into post-graduate training. The competency, skill and scope of today's podiatric physicians are vastly expanded and truly differ from the podiatrist that practiced before I was born. Because of this, CMS recognizes today's podiatrists as physicians, and Tricare recognizes us as licensed, independent practitioners.

The total number of VA enrollees has increased from 6.8 million in2002 to 8.9 million in 2013 (1). While we are slowly losing our Vietnam veteran population, we are gaining a solid base of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) patients, returning from war with their unique lower extremity issues. The projected patient population of Gulf War Era veterans is expected to increase from 30 percent in 2013 to approximately 55 percent in 2043 (1). The number of service-connected disabled veterans has increased from approximately 2.2 million in 1986 to 3.7 million in 2013 (1). Over 90 percent of disabled veterans were enrolled in VHA in 2012 (1). The likelihood of service-connected disabled veterans seeking VA health care generally increases with the veteran's disability rating (1). The majority of male veterans who are currently seeking care from VA served during the Vietnam era (1).

As a matter of fact, veteran patients are ailing and have more comorbid disease processes than do age-matched Americans (2, 3, 4, 5, 6). This includes major amputation, where age-specific rates are greater in the VHA compared to the US rates of major amputation (7). Elderly enrolled veterans have substantial disease burden with disproportionately poor health status compared to the same age enrolled in Medicare (8). The prevalence of diabetes is substantially greater among veteran patients compared to the general population, and unfortunately, the prevalence is trending up (6). While diabetes affects 8 percent of the US population, 20 percent of veteran patients carry this diagnosis (9).The aging veteran population combined with these increased rates of diabetes has increased the burden of diabetic foot

ulcers and amputations (10). Veteran patients with one or more chronic diseases account for 96.5 percent of total VHA health care (9). In addition to diabetes, some of the most common chronic conditions documented in our veteran patients manifest in the lower extremity such as hyperlipidemia, coronary artery disease, chronic obstructive pulmonary disease, and heart failure.(9).

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

This is my patient population, Mr. Chairman. I serve patients who are statistically comorbid with psychosocial and socioeconomic issues, all of which play a role in my delivery of care and final outcome. I know first-hand, with private practice experience and VA experience, that the veteran population is far more complex to treat than patients in the private sector, as a whole. Greater than 90% of the veteran podiatric patient population is 44 years and older, with the majority of our patients of the Vietnam era, who are plagued by the long-term effects of Agent Orange. Because of this and because of the increasing number of OEF, OIF, and Operation New Dawn (OND) veterans with lower extremity conditions, one of our major missions as providers of lower extremity care is amputation prevention and limb salvage. The value of podiatric care is recognized in at-risk patient populations. Podiatric medical care as part of the interdisciplinary team approach reduces the disease and economic burdens of diabetes. In a study of 316,527 patients with commercial insurance (64 years of age and younger) and 157,529 patients with Medicare and an employer sponsored secondary insurance, there was noted a savings of $19,686 per patient with commercial insurance and a savings of $4,271 per Medicare-insured patient, when the patients had at least one visit to a podiatric physician in the year preceding their ulceration (11). Nearly 45,000 veterans with major limb loss use VA services each year. Another 1.8 million veterans within the VA Healthcare Network are at-risk of amputation. These at-risk veterans include 1.5 million with diabetes, 400,000 with sensory neuropathy, and 70,000 with non-healing foot ulcers (12). Despite having a large at-risk patient population from the Vietnam era, VA podiatric physicians are seeing increasing numbers of OEF, OIF and OND patients who are at-risk for amputation. From FY 2001 to 2014, the number of foot ulcers increased in the OEF, OIF, and OND populations from 17 documented cases to 612 (12). Despite our statistics of at-risk patients, lower extremity amputation rates among all veteran patients decreased from approximately 11,600 to 4,300 between fiscal year 2000 and 2014 (12). Given the magnitude of amputation reductions, podiatric physicians not only provide a cost-savings to VA, but we also play an integral role in the veteran quality of life (12).

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

The mission of VA health providers is to maintain patient independence and keep the patient mobile by managing disease processes and reducing amputation rates. Podiatric physicians employed by VA

assume essentially the same clinical, surgical, and administrative responsibilities as any other unsupervised medical and surgical specialty. Podiatrists independently manage patients medically and surgically within our respective state scope of practice, including examination, diagnosis, treatment plan and follow-up. In addition to their VA practice, many VA podiatrists assume uncompensated leadership positions such as residency director, committee positions, clinical manager, etc. Examples include:

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

Despite this equality in work responsibility and expectations, there exists a marked disparity in recognition and pay of podiatrists as physicians in the VA. These discrepancies have directly resulted in a severe recruitment issue of experienced podiatrists into the VA, and unfortunately have also been the direct cause of retention issues. The majority of new podiatrists hired within the VA have stories just like mine. They have less than ten years of experience and they are not board certified. As a result of the disparity the VA is attracting less experienced podiatric physicians. After hiring, the majority of these new podiatrists that hire into the VA separate within the first 5 years. I am speaking from personal experience, Mr. Chairman. As stated earlier, I am one of the majority. I entered the VA with less than five years of experience and was not board certified at the time. I gained my experience, earned my board certification, and separated from the VA to take a leadership position with my parent organization. I will forever remain loyal to VA, which is why I still voluntarily treat patients at my local facility, without compensation. Having worked inside and outside the VA, I can truly attest to the disparity that exists.

Compounding the recruitment and retention issues, there exists lengthy employment vacancies when a podiatrist leaves a station. The gap between a staff departure to the time of filling the position is in excess of one year. I am personally aware that my position was assumed by a podiatric physician 14 months after my separation. Because of employment gaps as a consequence of the inherent and chronic recruitment and retention challenges, wait times within the VA for lower extremity care are unacceptably long. Since October 2014, 22,601 of the 191,501 (11.8 percent) established patients suffered a wait time of greater than 15 days, with some greater than 120 days. During this same time period, 23,543 of the 25,245 (93 percent) new patients suffered a wait time of the same magnitude. The prolonged vacancy exists partly because the VA is not capable of attracting experienced candidates, but also because the credentialing process is ineffectively burdensome. My credentialing process for my recent two without compensation (WOC) appointments was 11 months and 5 months, respectively.

Those are 16 months of missed opportunity to treat patients, but instead, I was needlessly waiting, as were the patients

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

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

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

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