STATEMENT OF

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ON

"BREAKING DOWN BARRIERS: GETTING VETERANS ACCESS TO LIFESAVING CARE"

Good afternoon. Chairman Bost, Ranking Member Takano and distinguished members of the Subcommittee Thank you for having me here to testify this morning. I am honored and privileged to be here and serve the country. I am Dr. Shankar Yalamanchili, my friends and colleagues call me Dr. Chili. I'm a psychiatrist with over 20 years of experience in working to improve mental healthcare efficiency and accessibility. I'm testifying here today to discuss how we can improve patient care while increasing efficiencies in mental health services in Veteran's Affairs Hospitals by allowing the VA to contract with private physician groups, when appropriate.

After completing my residency and fellowship in psychiatry, I began working at the Veterans' Affairs (VA) hospitals in Montgomery and Tuskegee in 2005. While working there, I became frustrated with the inefficiencies that were interfering with my ability to treat patients, so I transitioned to Community Mental Health Centers. These centers allowed me the flexibility to improve operations, although financial mismanagement later destabilized the system. Through my experience in both systems, I recognize the national scale of these financial and efficiency issues and the effect on proper patient care. This led me to create sustainable solutions that would improve patient care while making the system more efficient.

Today, I lead River Region Psychiatry Associates (RRPA), a multi-state psychiatric practice designed to bring care directly to patients where they live, rather than having to travel long distances. At RRPA and our owned outpatient delivery system, Ally Psychiatry, we emphasize a holistic approach that focuses on treating patients' underlying issues and thoughtfully incorporating families, when necessary, to develop

manageable and successful treatment plans. In 2024, Ally Psychiatry now operates in 51 clinics across nine states, employs 68 physicians, over 150 nurse practitioners and physicians, which allows us to see over 115,000 patients.

RRPA's inpatient presence spans 55 inpatient facility locations across 7 states (specifically Alabama, Tennessee, Missouri, Georgia, Mississippi, South Carolina, and North Carolina), in hospitals, emergency departments, jails, community health centers and more. In 2024, RRPA managed more than 1,000 inpatient facility beds, served more than 48,000 patients (about twice the seating capacity of Madison Square Garden), and completed more than 400,000 patients (about half the population of Delaware) visits/encounters.

Our doctors also provide the highest qualities of care. We provide professional ethics and new innovation training, we have high standards for different levels of care (intake, crisis treatments, and then stable patient continuing care) and we believe in wholistic care that uses the newest technology and engages families, rather than simply prescribing unnecessary medications. We also rigorously comply with all of the state and federal regulations and standards. If we are not providing excellent patient care, we won't succeed.

Unfortunately, the one area where we are not able to expand our patient care and services is where it is needed the most – VA hospitals. It is critical for U.S. veterans to have stable and qualified healthcare providers. An estimated 41% of veterans are in need of mental health care programs every year, and the VA provided over 1.7 million Veterans mental health services in 2024. Mental health issues and suicide among veterans are prevalent and complicated problems to sufficiently address, but we need to be more proactive and provide consistent treatment. Roughly 17 veterans die by suicide each day, according to a 2022 report by the VA and fewer than 50% of returning veterans in need receive any mental health treatment.

Mental health services are just one area where patients are struggling to receive timely and consistent care. In general, VA hospital average wait times can be anywhere from a few days to a few months for needed care, and then appointments are often canceled at the last minute. Congress and the Administration recognized the need for more providers and they implemented the CHOICE Program, now VCCP, which provides opportunities for veterans to seek care from private, non-VA or Department of Defense doctors through "community care" providers. This allows veterans who need services not offered by the VA automatically or veterans who live in a state without a full-service VA facility, such as New Hampshire, Alaska, or Hawaii. However, the current system does not allow VA hospitals to contract directly with private physician practice organizations to address situations where veterans are underserved or forced into the lengthy waits by the VA due to staffing shortages and physician availability. Additionally,

while the Community Care Network's (CCN) intended benefit of faster care, more access, and patient choice, are often undermined by red tape, payment issues, and poor coordination. Veterans end up waiting longer, juggling providers, or getting denied care, while private doctors are frustrated and leave the network. As the Committee heard yesterday, there can also be issues with consistency in patient data between community care and the VA. By allowing VA hospitals to partner with physician staffing groups, they will be able to provide enhanced access to consistent, reliable, and continuing quality care for our veterans and consistency in patient data. This will, in turn, extend availability from big cities, and provide some relief to CCN networks, to bring these critical services to the smaller rural communities in a timelier manner.

Improving the health and well-being of our veterans who have served this nation requires a collaboration between public and non-profit mental health providers. It is imperative that we increase the availability of mental health services and professionals for all veterans, and I believe that practices like mine can help achieve this. This includes encouraging more community-based services AND allowing private physician groups to provide services to the VA.

In addition to the long wait times due in large part to shortage of key staff at the VA, which result in delays in care, there are also high overhead expenses. While the VA has met their own hiring initiatives designed to increase the number of inpatient and outpatient mental health providers, they continue to face challenges in hiring adequate mental health staff to meet the full demand for services (GAO, 2015). The GAO cites pay disparities with the private sector, competition between VA medical centers (VAMCs) to fill positions, lengthy hiring processes, a lack of space for new hires, a lack of sufficient support staff, and a nationwide shortage of mental health professionals as reasons why the vacancies are going unfilled. Practices like mine can help solve these issues.

When comparing the current state of the VA mental health workforce with private enterprise health groups, significant improvement in both patient care and efficiency is seen. For example, private health groups can staff a VA hospital so that twice as many patients can be seen, and that there are doctors available Monday-Friday, with weekend availability, and on-call 24 hours a day. Importantly, when hospitals contract the doctors out, there is a decreased per-patient cost of treatment while maintaining quality, value-based care and a decrease in the overall infrastructure costs while working with existing VA best practices and meeting VA quality metrics. In my practices, we use all the tools at our disposal. We evaluate patients using assessment tools in addition to talking to patients and their loved ones and previous providers because understanding past failures is essential to therapy going forward. We utilize community resources including religious institutions and groups such as AA, Alzheimer's foundation, and disease specific associations, and we empower patients to sustain lifelong stability with focus

being able to get back to work and relationships. No one's disability should define them. Finally, all of the doctors in our practices train and collaborate with each other.

We must improve where and how our veterans receive care and ensure that it is scalable, affordable, and patient centered. While veterans Community Care Programs may work well for very specific, targeted treatments over short durations of time, the gap remains for the sustainable and chronic care treatment model, which requires a higher level of continuity of care than can currently be offered through Community Care Networks, especially in the mental health space.

To decrease cost to taxpayers, and improve efficiency and access to care, we propose that the VA **ALSO** contract with local private enterprise providers who can see VA patients in their clinics. The existing Community Care Network model is designed to meet episodic (time-limited) problems and short-term needs. While important, this leaves a gap specific to chronic care, which requires a higher level of continuity of treatment than can currently be offered through Community Care Networks. That is why we also propose a permanent public/private partnership that utilizes the resources of the VA with defined support from private enterprise (e.g., private practices). Support models can be tailored to meet the needs of individual VA facilities and communities.

This is not without precedence. There are currently two pilot projects underway in three states that could serve as models for a program. First, there is a VA-Private Telehealth Partnership Pilot in rural Montana and Alaska where VA facilities are sparse. Under this project, funded through the VA Office of Rural Health (ORH) grants and CARES Act telehealth expansion funds, the VA contracted with private telepsychiatry groups to deliver care via VA-provided telehealth platforms. The result has been that Veterans were seen faster and often in non-clinical community settings (like local libraries or community centers) with VA-trained facilitators. Wait times went from 60+ days to under 14 days for mental health appointments and there was high satisfaction among veterans, especially those hesitant to visit VA clinics due to stigma.

In Texas, under a state grant, several private psychiatric groups were brought into VA's Community Care Network, but the difference was they received dedicated liaisons and fast-track credentialing from the VA. A shared portal was created for scheduling and communication, avoiding usual CCN bottlenecks. This resulted in 80% faster referral-to-appointment time compared to standard CCN clinics and providers stayed in the network longer due to faster reimbursement and reduced paperwork.

I can also envision a model where the VA continues to manage robust inpatient services, while then transitioning veteran's outpatient care to an identified partner who has established a care network in that market/region. To ensure a seamless care transition, the partner practice would utilize the VA's EMR while managing the patient's

care. This will allow for seamless patient health information management including collaborating with VA care management teams.

It would also be possible to have the private enterprise partner provide facility enterprise coverage for the VA community. This potential solution would make access to care easier and improves the quality of care for the veteran community while driving down the cost of that care as funded by the taxpayer and increasing its all-around value. VA contracting with local, private providers who can safely, securely, provide quality service based on VA quality measures in areas where there are provider shortages could be game changing for vulnerable Veterans. We will see our valued veterans in our clinics closest to their homes along with the rest of the community. Utilizing our existing efficient practices in place we can see a thousand more encounters per provider per year. This could be a $50,000 reduction, on average, in cost per provider per year, in my opinion.

The public/private partnership model is mutually beneficial to both physicians and patients. These models I presented could reduce costs by 20%-30% while expanding patient capacity by the same margin and outperforming traditional VA and community mental health systems. At RRPA, we have found that when hospitals contract with us, there is also a 20% reduction in emergency department visits, a 25% decrease in inpatient length of stay, and a 15% reduction in readmittance. As a private company, we're not successful if the patient care and efficiencies don't make a meaningful difference.

We strongly support the VA's mission to best serve veterans who have borne the battle with honor, and it would be our privilege to help improve their mental health care.