HARNESSING BIOMEDICAL INNOVATION: MODERNIZING VA HEALTHCARE FOR THE FUTURE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

TUESDAY, APRIL 1, 2025

Serial No. 119–15

Printed for the use of the Committee on Veterans' Affairs

Available via http://govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

60–687 WASHINGTON : 2025

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C O N T E N T S

TUESDAY, APRIL 1, 2025

HARNESSING BIOMEDICAL INNOVATION: MODERNIZING VA HEALTHCARE FOR THE FUTURE

TUESDAY, APRIL 1, 2025

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

The committee met, pursuant to notice, at 10:15 a.m., in room 360, Cannon House Office Building, Hon. Mike Bost (chairman of the committee) presiding.

Present: Representatives Bost, Radewagen, Bergman, Miller-Meeks, Murphy, Ciscomani, Hamadeh, Barrett, Takano, Brownley, Cherfilus-McCormick, McGarvey, Ramirez, Budzinski, Kennedy, Dexter, and Conaway.

OPENING STATEMENT OF MIKE BOST, CHAIRMAN

The CHAIRMAN. The Committee will come to order. Good morning. I want to thank you—I want to say thank you to all of our witnesses for being here. When, you know, when I got home from the Marine Corps, U.S. Department of Veterans Affairs (VA) was a different place. It was a long time ago, too, by the way. It was slow, it was frustrating, less modern. Now, we have made progress, a lot of it, because of the work this committee, not only in this session but over the years, has done to make sure that it is moving into the modern world. I am not interested at all in patting ourselves on the back. There is still too much work to do.

Today's hearing will be about making sure veterans have access to the best healthcare technology available, no matter where they live, what they have been through, or when they serve. We are here to ask a few basic questions. What innovations are working? What is holding them back? How can we move faster? Government delays and red tape should never be the reason a veteran cannot get life-saving care. I support efforts to cut waste, eliminate duplication, streamline the way VA buys new tools and services. From my seat as Chairman, I am focusing on pushing VA into a modern agency. I know it can be done.

Acquisition reform is not flashy, but it matters. When it comes to bringing new technology into VA, the stakes are too high to let process get in the way. VA has said they want to partner with industry and academic leaders, and that is good. We need to know what that really looks like, who is getting through the door, and how long it is taking. Let us get past buzzwords. Veterans do not

need more talking points. They need results. That is what House Republicans and the Trump administration are focused on.

Over 30 million American lives with—over 30 million Americans live with diabetes. The VA, one out of every four patients have it. Heart disease is the number one cause of hospitalization at the VA, and it kills two thirds of our veterans who have diabetes. Post-traumatic stress disorder (PTSD) makes those things worse. It increases the risk of heart disease. It causes sleep issues. Veterans with chronic pain suffer more and longer than the average American. These are real challenges, but there are real solutions out there. Many of them are sitting in this room today.

Still, innovation takes too long. A recent study showed that hospitals struggle to bring new products and tools. Budgets are tight. Training takes time. I want the VA to be the exception. Veterans cannot afford to wait. That is especially true for rural veterans. Too many lives—too many live hours away from care. They deserve access to the same devices and services as someone in the big city. That is what this hearing is all about.

The people here today are not just developing impressive technology. They are building tools that have veterans—and give veterans more options, more access, more chances to live healthier lives. Our job is to make sure the system helps, not hinders, that work. We owe that to today's veterans and to the veterans of tomorrow. One day I suspect more of my grandchildren will be veterans, and I want them to walk into a VA that is not just functional but forward-thinking, fast, innovative, at the front edge of modern medicine. Let us keep moving toward that goal.

With that I want to welcome our witnesses and look forward to your testimony. I now recognize Ranking Member Takano for his opening comment.

OPENING STATEMENT OF MARK TAKANO, RANKING MEMBER

Mr. TAKANO. Thank you, Chairman Bost. I want to be very clear. Veterans deserve to receive gold standard health care. Veterans deserve access to the most cutting-edge medical innovations. Veterans deserve a VA that is fully staffed to deliver the world-class care and benefits they have earned. These are core beliefs that I hold.

Achieving these goals depends on Congress meeting the true funding needs of VA. Under Trump and Secretary Collins, VA leaders are being forced to make impossible choices. Cut after cut after cut to personnel, contracts, and veterans care all in the name of so-called efficiency. These cuts are not making VA more efficient. They are forcing VA to decide between keeping staff on the floor and investing in expensive equipment that may sit idle without enough personnel to operate it.

Let me say that again. The gentlemen that are before us today to talk about the innovations and the medical equipment that they want to sell to VA that there may not be the personnel that is trained and ready to operate that equipment. If the draconian cuts at VA were improving care, VA would be—would be here telling us about it. What we are actually hearing are reports of the exact opposite.

On poster number one, this is a prosthetics customer service center shut—has its doors shut in Greenville, North Carolina, the VA

clinic. Prosthetics are, you know, the—the artificial limbs that veterans need. That is a VA facility that has been closed in a member's district who sits on this committee. Poster number two, Department of Government Efficiency (DOGE) has canceled a contract for a mobile MRA unit at the Danville VA Medical Center. Then finally her is a contract for supply chain management support canceled by DOGE.

As we sit here today instead of sending officials to testify before us, VA leaders two miles away at central office are planning how they are going to cut, how they are going to fire over 80,000 additional employees.

Unfortunately, due to the financial reality VA currently faces and the uncertainty about the future of VA's workforce, medical center and Veterans Integrated Service Network (VISN) directors have to make either/or decisions routinely. Either/or. Either new cutting technologies or fully staffing VA. In many cases, staffing VA enables to facilitate the operation of these new innovations.

Just a few months ago, we heard from a VA medical center director who told us that he had to put off purchasing new telemetry—a new telemetry unit and hiring additional staff to operate it because his budget had been eaten away by skyrocketing community care costs. We know for a fact that there is expensive medical equipment sitting idle in VA facilities across the country because it does not have the staff to operate or maintain it. We are talking about medical equipment that already exists at VA.

We are missing a whole side of this conversation today and that is no accident. The majority deliberately chose not to invite VA to testify, shielding the department from the responsibility and real oversight this committee is supposed to provide. When the minority invited VA to send witnesses, VA declined. I will say that again. VA declined the minority's invitation to be here today. The majority decided that we do not need to hear about VA's actual need for these devices, that we do not need to hear how VA will pay for these investments, and they did not care if we heard whether VA has sufficient workforce to supply—to provide the manpower and follow-up maintenance that is necessary with machines and devices like the ones our witnesses sell.

Without VA here to provide—excuse me—without VA here to provide the other side of the story about the on-the-ground reality of veteran's needs, all you are going to hear today is a sales pitch, and indeed an expensive one at that.

VA leaders also deserve to speak about the department's proud history of research and innovation. VA has long been at the forefront of biomedical breakthroughs that have saved millions of lives. Breakthroughs that corporations like Philips and Boston Scientific have profited from. For instance, Dr. William Oldendorf, a VA neurologist at the West LA VA Medical Center, developed the first prototype and held the first patent for a Computed Tomography (CT) scanner in 1963. Philips now sells CT scanners to VA.

Likewise, Boston Scientific would not have been able to develop and sell its pacemakers had it not been for the groundbreaking research of Dr. William Chadrick and Mr. Wilson Greatbatch of the Buffalo VA Medical Center in 1960. If VA is to remain a leader in medical renovation, we need to invest in its research infrastruc-

ture, not outsource that expertise to private companies whose bottom line takes priority.

Now, VA should be here. That is exactly why I find the timing and participants of this hearing so strange. At a time when Secretary Collins is cutting research, slashing staff, eliminating worker protections, and canceling critical contracts, my colleagues across the aisle are suddenly eager to talk about innovation and the brand new equipment VA needs to buy. How tone deaf is that? I do not believe the Trump administration is setting up VA—is setting VA up for success in providing basic care for our veterans right now, let alone creating an environment that will lead to groundbreaking innovations. I have to say, if things continue at this rate, the time of VA as an innovative force will be behind us. I am not willing to see that outcome come to pass.

My colleagues across the aisle talk a lot about making hard choices to get our country's finances back in line. Let us be clear, those hard choices should not mean choosing between veterans' care and corporate profits. Right now, VA facilities are being forced to decide whether to keep the staff they need to provide veterans quality care or spend billions on expensive high-tech equipment sold by for-profit companies whose promises are not to our veterans but to their shareholders' bottom lines. I am worried that we are not even getting that. We are not even getting to be able to fulfill the fundamentals of care and benefits for veterans if Trump and Collins keep arbitrarily cutting staff and resources.

I want the veterans VA services to have it all. World-class care, cutting-edge innovations, and a fully staffed VA that is prepared to meet their needs today and in the future. That future is at risk if we continue down this path of arbitrary cuts and misplaced priorities. We cannot allow VA's mission to be undermined by short-term cost cutting or long-term privatization.

With that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Ranking Member Takano. It is great to see that jet lag has not affected your ability to deliver messages.

Mr. TAKANO. Oh, thank you. Glad to see you here this morning.

The CHAIRMAN. We both got in from Japan yesterday. It was wonderful with where we went and what we did. We will now turn to the witnesses testimony.

Now testifying before us today, we have Mr. Will Gray, Vice President for Marketing, Commercial Operations, and Government at Boston Scientific. Boston Scientific has made advances in the medical device field using stents, among other technologies.

We also have Dr. John Bloom. He is the Chief Executive of Podimetrics. Podimetrics has partnered with the VA on programs calling the initiative to end diabetic limb loss at VA.

We also have Mr. Jeff DiLullo, Executive Vice President and Chief Regional Leader of Philips North America. Philips North America offers a range of products that, among other functions, utilize imaging to create visual representations of the body's interior.

We also have Dr. Parthasarathy, Director of the Center for Sleep and Neuroscience Research at the University of Arizona Health Science. The University has invested in sleep apnea research, among other areas.

[Witnesses sworn.]

The CHAIRMAN. Will each of the witnesses please stand and raise their right hand? Do you solemnly swear that the testimony you are about to provide is the truth, the whole truth, and nothing but the truth?

Thank you. You may be seated. Let the record reflect the witnesses all answered in the affirmative.

Mr. Gray, you are now recognized to deliver your testimony for 5 minutes. I will explain the light system here. Green, you are going. Yellow, it is coming to a close. Red, you better get her stopped. And I do not want to play rodeo and throw you out in 8 seconds. There we go.

STATEMENT OF WILL GRAY

Mr. GRAY. Great. Thank you. Chairman Bost, Ranking member Takano, and distinguished members of the committee, thank you for the opportunity to testify today.

My name is Will Gray. I am a proud Marine and have spent the past 25 years at Boston Scientific. For the past 13 of those years, I focus on the commercial strategy in the VA and the U.S. Department of Defense (DOD), ensuring that veterans and military personnel have access to life-saving medical technologies.

I also lead our marketing and commercial operations strategy for Boston Scientific for our largest civilian health care systems. This role gives me a unique perspective on how advanced civilian hospitals provide care in the Quadruple Aim and that is efficiency, quality, cost, and patient satisfaction. At the same time, I remain personally dedicated to the veteran community, mentoring and advocating for those that have selflessly served our country.

Boston Scientific is a leading U.S. global medical technology company headquartered in the Boston area. We have a strong U.S. presence in manufacturing and research with thousands of employees in states like Massachusetts, Minnesota, Indiana, Texas, and Georgia. We focus on technologies that address major health needs in the veteran population. Pain, heart disease, stroke risk, and neurologic and gastrointestinal disorders.

Over 65 percent of veterans suffer with pain. To help reduce opioid use and improve quality of life, we offer non-opioid solutions like spinal cord stimulators, which deliver personalized pain relief.

For veterans with atrial fibrillation, our Watchman device offers a safe alternative to blood thinners, reducing stroke risk through a minimally invasive procedure, and those patients are five times more at risk than those without atrial fibrillation.

We have also developed FARAPULSE, a pulsed field ablation technology that is truly transforming how atrial fibrillation (AFib) is treated. In less than a year, that therapy has become the dominant type of treatment for AFib for Electrophysiology (EP) ablation, taking over for Radiofrequency (RF) and cryoablation.

For those patients and veterans with peripheral artery disease, our technologies help keep arteries open and prevent repeat procedures and potential limb loss. For the heart, we have an agent drug-coated balloon which was just U.S. Food and Drug Administration (FDA) approved that delivers medication directly to the artery, reducing the chance of blockage for stents. These innovations

have already improved care in civilian hospitals and all veterans deserve the same access.

The VA has made meaningful progress in integrating clinician voices into its procurement system. In 2017, we worked with other companies in this committee alongside representatives Scott Peters and General Jack Bergman to help improve the Med Surge Prime Vendor Program. This effort brought clinical expertise into purchasing decisions and created a rolling process for adding new products. I would say the Medical/Surgical Prime Vendor (MSPV) today is a model for how clinician-led sourcing can work.

Today we are working with this committee to apply those same principles on the Prosthetics and Sensory Aid Services, or PSAS, Program. Again, ensuring that clinicians are part of the procurement process helps ensure product decisions reflect the needs of veterans, and this is what we do on the civilian side as well. Having physicians and clinicians involved in that process is critical.

Despite these successes, challenges remain. Technology adoption is often delayed due to staffing shortages, budget unpredictability and inefficient procurement workflows. One example is that pulsed field ablation technology I talked about that is become the dominant therapy for EP ablation. In the U.S., we project 61 percent of EP ablations will occur with pulsed field ablation this year. Right? 61 percent. Less than 10 percent of VA hospitals have access to that therapy. Less than 10 percent.

To address this, we recommend the following. A transparent, predictable budget process at the hospital level. That is number one, number two, hiring and training more procurement staff. Number three, adding two site product cycles when you can add products on all National contracts. You have it on the MSPV. We recommend you put it on the PSAS as well. Then consider an innovation fast track for high-impact technologies.

Again, the VA has made commendable progress in modernizing procurement, especially through clinician engagement. More must be done to ensure veterans receive timely access to the technologies available in commercial hospitals. Boston Scientific is proud to support the VA, this committee, and all those working to improve care for those who served.

To this committee, I thank you for your service to our veterans, and I thank you for your time.

[THE PREPARED STATEMENT OF WILL GRAY APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Gray.

Dr. Bloom, you are recognized for 5 minutes for your opening statement.

STATEMENT OF JON BLOOM

Dr. BLOOM. Chairman Bost, Ranking Member Takano and distinguished members of the committee, thank you for the opportunity to testify today.

I am Dr. Jonathan Bloom, a physician and the proud son of a decorative Vietnam veteran who is sitting behind me today. I cofounded Podimetrics over 13 years ago after spending way too many whole days in the operating room doing nothing but amputa-

tions for diabetes, essentially Civil War medicine. Limbs we could have saved with early intervention.

A staggering one in four veterans have diabetes. Double the rate of nonveterans in our Nation. Compromised blood flow into the limb and diminished sensation in the feet, both the result of unchecked diabetes, can result in a diabetic foot ulcer, a typically silent wound to the bottom of the foot. Veterans and caregivers are often unaware until the wound is open, infected, life-threatening, and requires emergent intervention, a life-altering amputation.

In fact, 85 percent of lower limb amputations are a result of a diabetic foot ulcer. Most crazy enough, the 5-year mortality after a foot ulcer is 70 percent, which makes it worse than almost all cancers that we have.

Then, of course, each year the VA estimates that they spend approximately $3.2 billion in direct expenditures just caring for diabetic foot ulcers. More recently, $3.5 billion.

I have been working with the VA for over a decade to develop a solution to prevent diabetic foot ulcers, starting with our very first clinical trial in the VA in 2013. 7 years later, in 2020, after years of research and study, we formalized our partnership to develop and deploy a remote temperature monitoring program with the Podimetrics SmartMat called the VA's Initiative to End Diabetic Limb Loss. Supported in part later on, thanks to all of you through the 2020 Coronavirus, Aid, Relief, and Economic Security (CARES) Act. Here it is real quick here.

Basically, from the comfort of a veteran's home, a veteran stands on the SmartMat for just 20 seconds a day while they are brushing their teeth or combing their hair. The mat then scans for temperature changes in the feet, which may indicate a developing foot ulcer. The data is then securely transmitted for analysis without the need of Wi-Fi or mobile device, allowing a clinician to intervene hopefully in time to prevent the complication before it occurs. The impact of this collaboration has been remarkable.

VA-led research suggested that clinicians could detect 97 percent of diabetic foot ulcers on the bottom of the foot over 5 weeks before they would have otherwise recognized them. VA research presented last year suggested participation in the program resulted in a 37 percent reduction in 1-year mortality. That equates to one veteran life saved for every 23 veteran participants who came into the program in just the first year alone.

In March of last year, fewer than 6 percent of eligible veterans enrolled for 12 months. With that population, the VA reported that it had saved an estimated $100 million over that period. Almost $16,000 per veteran participant per year. If scaled to all 110,000 veterans at the highest risk of a new diabetic foot ulcer, this program could save approximately 1.8 billion annually to the VA, to U.S. taxpayers and save approximately 5,000 veteran lives in just that first year. Partnering with the VA, we have proven remote temperature monitoring. The program works, but scaling this technology to every eligible veteran remains a challenge.

I want to share four observations that I have seen over my 10-plus years working with the VA on foot ulcer prevention.

One is that rural and low-income veterans still struggle to gain access to the system relative to their counterparts. It is still a challenge.

Two, almost all enrollments come from Veterans Health Administration (VHA) podiatry. Yet only half of at-risk veterans get their podiatric care at the VA. We must ensure equal access regardless of their geography or circumstance. No veteran should be left behind.

Number three, budgeting silos do affect veteran care. The prosthetics budget pays for the system, but most of the savings goes to medical care. Budget must be protected to ensure that we do not save a little spend in one silo at the expense of dramatic savings in another. These budgets do not coordinate as they work together.

Then last, the workload credit to do an amputation is dramatically higher than the workload credit to prevent one. Until incentives are fixed for this complication, the VA will struggle to deliver preventive care. Stated hyperbolically, we have all the people we actually need. They are just too busy treating preventable complications.

To close, in most of your districts right now, Podimetrics and the VA Remote Temperature Monitoring Program are improving our veterans' healthcare. Almost 100,000 veterans still need access. Over one and a half billion in lost savings each year. No veteran should walk into a hospital 1 day and then leave in a wheelchair or worse, not at all. Especially when we have the technology to prevent it.

Thank you, and I look forward to your questions.

[THE PREPARED STATEMENT OF JON BLOOM APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Bloom.

Mr. DiLullo, you are recognized for 5 minutes.

STATEMENT OF JEFF DILULLO

Mr. DILULLO. Chairman Bost, Ranking Member Takano, and distinguished members of the committee, it is an honor to be before you today.

My name is Jeff DiLullo. I have the privilege of serving as the Chief Executive Officer (CEO) of Philips North America. Leading a dedicated team of 17,000 professionals, many of whom are veterans themselves.

Philips is a global health technology leader, delivering Artificial Intelligence (AI)-enabled solutions in diagnostic imaging such as Magnetic Resonance Imaging (MRIs) or CT scans, non-invasive cardiac procedures, and patient monitoring solutions spanning from hospital to home. Our mission is to improve the lives of two and a half billion people per year through meaningful innovation. Nowhere else are we more focused on this mission than in serving America's warriors.

At Philips, we get to serve heroes, and we know that. We do this by putting our innovation to work specifically for the VA. Some examples: a critically needed MRI in the aftermath of a battlefield trauma. Helping clinicians to monitor veterans remotely because we know veterans recover better at home, accelerating precision detection and treatment of cancers and bringing the highest quality

cardiac care to our veterans. Our mission is clear. To support the best possible care for those who have defended our freedom.

For me, the mission is also a personal one. I am a graduate of the United States Military Academy. I served as an Infantry Officer and an Army Ranger. More importantly, I am a proud father of a soldier. Every morning, my daughter Emma dons the uniform of a U.S. Army officer, having answered that same call to serve. At some point, she will rely on the VA for her health care. That is why my work is not work, it is personal.

Philips has been a proud innovator with the VA and a partner for more than 50 years, helping design and deliver innovative solutions to improve care for millions of veterans during that time. In fact, when a veteran walks into a VA medical center today, there is a better than 50 percent chance they will interact with a Philips piece of equipment. Innovation exists today commercially that will improve veteran patient experience, relieve workload on we know are stressed VA staff, and reduce the overall cost of delivering that care. In several areas of innovation, we are proud to say the VA has already demonstrated a clear leadership.

For example, in 2020, the VA implemented with Philips the Tele-Critical Care program, or TCC, which utilizes a secure digital infrastructure and network to connect all VA intensive care units. TCC digitally leverages critical care nurses and specialists from other VA locations across the network for real-time support and better monitoring in high-acuity settings. The VA has done an incredible job with the TCC program. It is a banner example to any health system, and I talk to every health system in the Nation. Better patient care, better staff utilization. It just works.

We believe also the VA should expand virtual nursing support by using existing technologies to develop more comprehensive virtual nursing programs for lower acuity settings, which is the vast majority of care, like medical surgery units, stroke units and emergency departments where timely interventions are critical and where staffing continues to be a challenge.

The opportunities for virtual care go far beyond nursing, however. The VA handles more than 25 million diagnostic imaging scans annually. That is a staggering number of scans. Today, the VA radiology departments often operate largely independently, relying on their own resources, their own capacity, and their own expertise. Radiology is a complex discipline. Creating a network that connects all VA radiology departments, distributing the remarkable expertise of VA radiologists, would allow facilities to share expertise and improve utilization of those radiology teams in the same way it currently does with TCC.

The Philips Radiology Operations Command Center, we call it ROC—not to be too cute as an infantryman—we call it ROCC, an innovative solution that allows technicians in a central command center format to connect with technologies operating imaging machines in real time across many locations in the network. Not just Philips locations, any location, any original manufacturer piece of equipment. We can do it across any. These technicians can remotely deploy protocols, conduct views, and fine-tune imaging exams. The approach standardizes image acquisition quality and reducing rescan rates or think of that as veterans revisiting for a

scan and ensures more accurate diagnosis with a smoother workflow for clinicians, saving time across millions of scans a year.

We also have AI-enabled solutions in the scanning process that itself can dramatically reduce scan times for veterans, enabling the same staff to schedule more veterans per day with significantly lower sedation rates.

These are just a few of the examples of the opportunities available today in commercial technology today, when they are more needed than ever. Better care for veterans, better experience for VA clinicians, lower cost for taxpayers.

Chairman Bost, Ranking Member Takano, thank you very much for holding this hearing today. Thank you for your unwavering dedication to those who have served our Nation and those that defend our freedom and their families. Thank you for asking us to show how we can deliver smarter technology to serve those who protect America.

I look forward to answering your questions. Thank you.

[THE PREPARED STATEMENT OF JEFF DILULLO APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you. Dr. Parthasarathy, you are recognized for 5 minutes.

STATEMENT OF SAI PARTHASARATHY

Dr. PARTHASARATHY. Thank you. Chairman Bost, Ranking Member Mr. Takano, and distinguished members of the committee, it is an honor and privilege to give my testimony in front of you today.

My name is Sairam Parthasarathy. I am a Professor of Medicine and Chief of the Division of Pulmonary Allergy Critical Care and Sleep Medicine at the University of Arizona in Tucson, Arizona. I previously served in two Veterans Affairs hospitals, both at Edward Hines Jr. VA Hospital in Hines, Illinois, as well as at the Southern Arizona VA Healthcare System in Tucson, for a total of 11 years, where I served as Section Chief for Pulmonary, Critical Care, and Sleep Medicine, and also subsequently as Chief of Research at the Southern Arizona VA Healthcare System. I speak to you today as Member or Board of Director for the VA Non-profit affiliate, also known as the Southern Arizona VA Healthcare System, Biomedical Research Education and Foundation of Southern Arizona, and board certified in Pulmonary, Critical Care, and Sleep Medicine.

I am here to talk about the area of my research expertise, which has a special focus on implementation science in the area of sleep medicine. The approach of implementation science entails harnessing new biomedical innovations and bringing it to the bedside and clinics to benefit patients and veterans everywhere. Hence, I believe that I can speak to the topic at hand, which is regarding "Harnessing Biomedical Innovation: Modernizing VA Healthcare for the Future."

Essentially, a wealth of scientific knowledge is being generated by biomedical research, especially in the area of sleep and circadian science which has cost-cutting benefits to veterans health in every organ system. In order for us to realize the full return on investment to such scientific knowledge and to improve the health of veterans and the Nation, especially with the extent to which chronic

disease afflicts our people, there is a dire need to disseminate and implement, or simply put, "harness," these research findings into day-to-day clinical practice.

It is frequently reported that there is a time lag of 17 years before 15 percent of research innovation that is developed by research and science that is being brought to day-to-day clinical practice in order to benefit both veterans and civilians. Such harnessing, if you want to call that, has evolved into the science of implementations and the veterans' healthcare system and affiliated university partnerships are uniquely and well poised to thoughtfully harness and implement these wonderful innovations into the real world and benefit veterans everywhere.

Implementation science takes into account the healthcare provider's work-related burden in a busy clinic or hospital system and the validity and applicability of the scientific findings to that context. The ability to get clinics to adopt these practices and maintain them over time is another crucial aspect that needs to be taken into thoughtful consideration. We need to carefully assess the metrics that will measure the process of implementation and return on investment for us to exercise proper financial stewardship. We need to identify barriers for implementing these medical innovations and identify facilitators to better assist with such implementation or harnessing efforts. Essentially, we need to perform a shifting of the task from the busy healthcare providers to machines that can work hand in hand with them.

One such example is in the area of sleep apnea, which is an area of my expertise, and sleep apnea is very common in veterans and is characterized by repetitive obstructions of the upper airway and throat and cessations of breathing and low oxygen count. Both sleep apnea and insomnia have been associated with heart attacks, strokes, high blood pressure, road traffic accidents, poor outcomes in individuals with traumatic brain injury, PTSD, depression, suicidality, and even death. However, one in four individuals remain undiagnosed with sleep apnea and many with insomnia, and the remaining individuals are left undiagnosed.

We and others have refined machine-based algorithms that are developed by various researchers, including at Massachusetts Institute of Technology (MIT), that embed into electronic medical records within the system of the University of Arizona Healthcare System, which can identify individuals with a high likelihood of sleep apnea and alert healthcare providers to the fact that they have it and enable them in a facile manner to play diagnostic tests and enable treatments to be brought to fore.

Moreover, treatment of sleep apnea with Continuous Positive Airway Pressure (CPAP) machines and other treatment devices that can help keep the throat open, can reduce motor vehicle accidents, reduce blood pressure, and reduce cardiac deaths. In about unfortunately, only two-thirds of people with sleep apnea are adherent to such treatments, and there are not enough providers and caregivers to support this. We need Artificial Intelligence/Machine Learning (AI/ML) based algorithms that need to be developed, which we have developed with funding from the Veterans Affairs Health Services Research and Development as well as from Patient-Centered Outcomes Research Institute (PCORI) to help vet-

erans and civilians to be adherent to treatment and to derive the full benefits from such treatment. There are similar machine-based approaches for behavioral therapies as well.

In summary, there are numerous approaches to successfully identify and treat individuals with these medical conditions in the sleep space with AI/ML approaches. There is now more than ever a need to harness these biomedical innovations to improve the health of veterans using such technology. Thank you.

[THE PREPARED STATEMENT OF SAI PARTHASARATHY APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you all. Now, time for questioning.

I recognize myself for 5 minutes.

Mr. DiLullo, could you tell us about your experience with the acquisition process at the National level and at the facility level as well?

Mr. DILULLO. Mr. Chairman, thank you for the question. Our general experience is we have a limited number of National level acquisitions that we do typically. In the nature of the business that we are in, those budgets typically are held at the VISN level or below level. We typically compete for localized contracts or consolidations at the local level. We see a distinct difference in how we would deliver capabilities around software and more advanced AI capabilities that should be more at the enterprise level, and I think the budgeting of that would be an area we would want to express or explore with the VA in more detail to show the total economic value creation of those solutions.

The CHAIRMAN. Thank you.

Dr. Gray—or Mr. Gray—Boston Scientific engages with VA through a number of different contracts. Is this variety of contracts appropriate or should we process be streamlined?

Mr. GRAY. Thank you, Chairman, for the question. I would say that our contract status at Boston Scientific is very—is very good. We have almost all of our products throughout all divisions of Boston Scientific on a National contract. As I mentioned before, the Med Surg prime vendor, I would say, is an excellent contract, one that allows clinician input. It also allows us to add products twice a year. It is pretty easy for us to get products on. The other one is the PSAS, the Prosthetics Contract, I also mentioned. I would say that one is more challenging and we are working with this committee on improving that so that again, clinician voice, two different periods per year where we can add products. That is one of the big challenges. When we have an implant or a piece of capital, it is very difficult to get it on that contract in a timely manner. that is why we are not able to get some of that technology quickly to the veterans where they deserve it.

The CHAIRMAN. Thank you.

Dr. Bloom, one out of every four veterans suffer from diabetes. How is your company's work helping prevent long-term complications and reduce hospitalization among this population?

Dr. BLOOM. Well, certainly one of the most dreaded complications of diabetes we talked about is the diabetic foot ulcer. What is not as well recognized is that when you have an open wound, you are twice as likely to be hospitalized for heart attack, stroke, Congestive Heart Failure (CHF) exacerbation, Chronic Obstructive Pul-

monary Disease (COPD) exacerbation. It tips the bodies over to have a number of very costly complications. If you are able to prevent that funnels from reoccurring, you typically can prevent this cascade of bad outcomes and cost.

That is what we have been able to do in partnership with the VA is to build a tech and a program around it to identify those veterans early, get them to care the moment we see an issue, and ultimately show the savings. Which, I believe, the VA last estimated about $16,000 savings per patient per year by being in the program.

The CHAIRMAN. Dr. Parthasarathy, veterans with post-traumatic stress and chronic pain often face serious sleep disorders. How is your work helping veterans treat these issues?

Dr. PARTHASARATHY. Sleep apnea can actually make PTSD worse, and it can actually cause traumatic brain injury to not heal as quickly as possible. Some of the technologies with colleagues here at the University of Arizona and elsewhere are using artificial intelligence and deep learning for developing virtual imagery-based diagnostic tests in order to be able to quickly, within 20 minutes, diagnose someone with PTSD. It can even be used in the war theater, where 4 hours of a neuropsychologist actually doing a cognitive exam is going to be difficult.

Some of these technologies are able to assist with diagnosing but also with regards to therapies, desensitizing people with PTSD, and help improve not just with medications but also by to be able to deliver cognitive therapy using machine-based approaches.

The CHAIRMAN. Thank you. I want to thank all the panelists because that is what today's hearing is about; the technology that we are moving forward with, each with unique situations where before we would only be able to start dealing with the problem and the problem—and do not do anything to prevent the problem. Much of this will save in the long run not only for the veteran health care that we spend but also for the veterans and improvement of their lives.

With that, I am going to yield my time back and recognize the Ranking Member, Mr. Takano.

Mr. TAKANO. Thank you, Mr. Chairman. Well, before we even consider investing in new, expensive equipment, we need to ask, can VA afford to operate and maintain this technology without sacrificing essential staff and services? In light of this administration's ongoing efforts to slash VA's workforce, VA medical facility leaders are facing hard choices. Every dollar spent on these devices is a dollar that VA cannot spend on retaining nurses, doctors, and technicians who are essential to delivering care.

I want to avoid a situation where President Trump and Secretary Collins are imposing on VA leaders the necessity of having to choose so that veterans do not lose out on whether—on either the innovation or the staffing side. To do that, we need all the information so that we can make sure we can make the case for more funding at VA.

Mr. DiLullo and Mr. Gray, last week my staff contacted your companies to request certain information about the products you sell to VA. Your companies both declined to provide this information, claiming it is proprietary. If these innovations are truly cost-

effective, why will not your companies provide the committee with full pricing information? This committee needs to know more not only about what resources Congress needs to make available to purchase those products but also about your company's respective fiduciary interests in doing business with VA.

I would like to also give you an opportunity to provide this information to the committee within the next week. I want to ask, will you provide A, a list of all the products you sell to VA? B, the unit price of each product. C the overall quantity of each of these products you have sold to VA. D, the overall number of VA facilities that have purchased your products.

Was—yes, Mr. Gray and Mr. DiLullo will you—will you do that in the next week?

Mr. GRAY. I—I would—I would answer your question. Ranking member, first of all, thank you for the question, and thank you, I know that—that we have worked with you. I was—I was in your office in the past year speaking to you.

Mr. TAKANO. Mr. DiLullo, I do not have a lot of time. I just need to know whether you will provide that information to us kindly.

Mr. GRAY. What I will do is provide the information that we have and how it got into your National contract. As I mentioned before, we have the vast majority of our products that went through the process of getting it on the contract.

Mr. TAKANO. Very respectfully, Mr. Gray, can we just get an answer to whether A, B, C, D, you will provide that information to us?

Mr. GRAY. That is proprietary information. I will get with—with my team.

Mr. TAKANO. It is proprietary information. Thank you. Mr. DiLullo?

Mr. DILULLO. Mr. Ranking Member, thank you. I would suggest that pricing is very dependent on specific contracts that we work across the VA. We can provide all of the information in material that we have sold to the VA. Those are contracts that we – we have in place and we would be happy to do that.

Mr. TAKANO. Thank you. Thank you. Mr. Gray, yours is a no. Yours is yes.

Mr. GRAY. We can provide our contracts and our contract pricing, absolutely.

Mr. TAKANO. I am going to tell you, Congress and the American people are entitled to this information. These are contracts. DOGE is canceling contracts left and right without even looking into—I mean, I just showed you on the board they canceled contracts for supply chain management support. If we are going to get a handle on how much things cost, we need to know. American people should have a right to know what they are buying. Thank you.

You know, VA was once the engine of biomedical innovation in this country. I am concerned that we are now outsourcing that role to for-profit companies whose primary goal is maximizing shareholder profits. If we are serious about modernizing VA healthcare, we should be investing in VA's own research and innovation capacity, not handing over billions to private corporations. The new administration is slashing VA's research left and right.

Already VA has indiscriminately fired researchers whose term-limited appointments have expired. They have delayed or outright canceled important clinical trials that veterans are relying on as their best last chance for care. They are driving away some of the country's best and brightest, many of whom would be thrilled to contribute to veteran research but have decided it is simply not worth the long-term uncertainty.

If this continues, I am very concerned that the VA, that this VA that laid the groundwork for pacemakers and CT scanners, which your companies are making money on, will be no more. As a Nation, we cannot afford to lose out on the advancements that VA research has a proven track record of providing.

I am disappointed that VA is not here to answer the questions I have about VA's workforce. However, to make sure that Congress can fulfill its oversight obligations, my colleagues and I will be sending a letter to VA demanding answers to many of these questions later today, and I hope VA officials choose to answer this letter.

Thank you, and I yield back.

The CHAIRMAN. The gentleman yields back.

Dr. Murphy, you are recognized for 5 minutes.

Mr. MURPHY. Thank you, Mr. Chairman. One of the things that drives me absolutely insane is inaccuracies and untruths that are being spoken sometimes. I am a surgeon, so I do not tolerate that crap very well.

The last administration Secretary came in here and by his own admission stated that they had over hired during the VA and that they did not quite know what to do about it. I am glad that we now have an administration that actually has accountability as their number one goal. You guys could not run companies if you did not have accountability. You cannot do that and there is no reason that the United States taxpayer should not demand the same thing from its government.

You know, the VA in Greenville, which happens to be in my district and I have actually been in that, a few years ago during the Arizona scandal where we did not get patients seen, bought I think 80-to $100 million worth of equipment. You know what that equipment turned out to be? Coat hangers. Guess what? The VA did not have the anesthesia set up or could not have the anesthesia set up to do. Just pouring money into problems, as you guys in any company would know, does not fix the problem.

The other thing I would like to for the record correct the ranking member's statement about my VA. The prosthetics department at the VA in Greenville remains open during normal business hours Monday through Friday, 8 a.m. to 4:30 p.m. to support the needs of veterans in the entire Durham VA Healthcare. Attachment, letter for the record.

The CHAIRMAN. Without objection.

Mr. MURPHY. Thank you all for coming. I use a lot of your products and continue to use them. I will say that I always had a penchant for Boston Scientific over Cook, but they are not here to defend themselves. That was a—it is a great thing.

I am going to ask some hard questions, though, because I think that is important. I look at all the great innovations that you have

had, especially on the left atrial appendage thing. I think that was absolutely brilliant whoever did that thing to help with clotting disorders. The real question comes down, and I believe this is a fair question, because I served on our hospital's administration for 3 years, is cost containment. How do we do that?

Guys, you know, we have seen literally the last 15 years an absolute explosion in the number of remedies, interventions that can be done now. Boy, it used to be cardiac surgery was always, when I was coming through, a heart wide open. Now there is so much that is being done, innovative-wise, to keep the patient out, send them out the next day.

I would like to know what each of you are trying to do for cost containment. This is critical for our Nation. It is wonderful to be able to develop these things, but how the hell do we pay for them? Throwing money at problems does not solve the problems.

Mr. Gray, if you guys will give me a 15-second answer, that would be great.

Mr. GRAY. Sir, we definitely focus on cost. I think the one thing that I have to give a lot of credit to the VA is the contracting establishment with the med-surg prime vendor and the PSAS, it is a very rigorous process. It is much more rigorous than civilian hospitals. Clinical data comparison, pricing, obviously features and benefits, that kind of stuff, any other kind of similar type of customer pricing, we have to provide that, too. From a cost perspective, the VA really drives it and that is the process.

Mr. MURPHY. Great. Dr. Bloom.

Dr. BLOOM. Yes. A few moments in prevention or having a patient walk less for 2 weeks has the potential to save an amputation, which can cost as much as $100,000. I think it is critical. We would be happy to talk pricing. We are trying to give at least a 4X return on invested capital to the systems we do.

Mr. MURPHY. Mr. DiLullo.

Mr. DILULLO. Congressman, I will go back to my radiology operations command center. We can deploy radiology exams into communities closer to where veterans live at a much lower cost than you would in a high-care, acute cost center. That immediately takes cost out of the exam.

Mr. MURPHY. I think AI with what you are doing with your pathology stuff is going to be—it is groundbreaking because that is just pattern recognition. That same thing, a lot with radiology, has moved forward.

Sleep apnea, how do you guys save money?

Dr. PARTHASARATHY. Just diagnosis and treatment of sleep apnea is one of the most cost-effective approaches to changing the paradigm of reducing heart disease and major cardiovascular events and hospitalizations and deaths.

Mr. MURPHY. This actually, if people will understand this, when you save money and you deliver more efficient care, it is better for everybody. Throwing money at problems does not solve them. Being smart about them and efficient about them is how we solve problems.

Look, I believe in competition and it is good that Cook is around because you guys would not be as good as you were had they not been around. I think this is very critical, that I am glad that ac-

countability has now come to Washington, DC. No one would run a business, as I said before, without it. This is the way we need to run our government.

Thank you all for coming. Mr. Chairman, I will yield back.

The CHAIRMAN. Thank you.

Representative Brownley, 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chair, and thank you to the panel for being here today.

While I appreciate all of your testimoneys on how VA can and should be the world-class healthcare delivery system, and I appreciate all of your contributions to that end, but it is important that we point out the actions VA has been taking with the planned reduction in force of about 80,000 employees, that is a fact. The ongoing hiring freeze, that is a fact. The haphazard contract cancellations, that, too, is a fact. How the Trump administration is hurting VA's ability to fulfill its promise of delivering high-quality care to our Nation's veterans.

It is ironic that we are here today talking about biomedical technological advances when we are hearing of VA employees who are responsible for ensuring surgical suites, exam rooms, and inpatient rooms at VA medical centers are stocked with the basic medical supplies are being fired. We have already seen how getting rid of supply technicians and inventory management specialists has led VA clinics to delay or cancel procedures due to delays in getting critical supplies. We cannot let illogical policies of the Trump administration get in the way of VA delivering the care our veterans deserve. We must ensure VA has access to state-of-the-art equipment and medical supplies so that VA clinician teams can actually provide the care our veterans need.

Mr. Gray, thank you for being here. I just wanted to mention that I have witnessed your spinal cord treatment for pain. Your Boston Scientific was in my district at one point, I think maybe 10 years ago or so. I went there, visited with the team and saw it and saw what was going on and it was really—the results are really extraordinary. I also appreciate how your testimony acknowledges the challenges VA faces when it comes to procurement and in which you provided recommendations for VA on creating an environment of stability and procurement through budget predictability, investing in procurement professionals to combat staff shortages, and modernization.

With the current slash-and-burn environment the Trump administration has created through this hiring freeze and a plan to cut 80,000 more VA employees, can you elaborate on how you see these executive actions impacting stability within the VA and its ability to continue working with companies like Boston Scientific?

Mr. GRAY. Thank you, Congresswoman. I honestly cannot answer that question because I do not know what positions are going to be eliminated. What I do know is exactly what you just said. You echoed my testimony, which is we have to have staff in there to order the product, to pay for the product. We have to have a process to be able to bring new products on, and we need physicians engaged in that process. That is really, really important.

I have been thinking about an analogy. It is almost like every VA has an academic medical center affiliated with it. Right? A lot of

times those physicians go between both. If you have the great technology and the academic medical center and you do not in the VA, it is almost like if you have a snowstorm in two different houses, use a shovel in one and a snowblower in the other one, you still get the job done, but that clinician is going to want to go to the academic medical center where it is more efficient and fast. That is my concern.

Ms. BROWNLEY. Well, it sounds like you have had a good experience with the procurement process within the VA. Do you think it is a perfect one?

Mr. GRAY. I have had a really good one with the med-surg prime vendor, and we have been challenged with the prosthetics one. I will say the leadership in the VA has been wonderful to work with. In the last 5 years, there is been a real paradigm shift, in my opinion, in their willingness to reach out to suppliers like Boston Scientific and be partners and collaborate on solutions to bring products in. I have been really impressed with the leadership.

Ms. BROWNLEY. Thank you. For anybody on the panel, my next question is, as a business with VA contracts, with knowledge that your contract could be cut at any moment, change how willing you are to continue to work with the VA? Any one of you can answer.

Mr. DILULLO. Congresswoman, I will answer. That is a good question. We are here because we are devoted to veterans. think it is not a matter of whether we want to work with the VA or not or whether it is a more profitable business for us to operate. We do this out of passion. We have been with the VA for 50 years, and we need to find creative ways. We are here to help work with you and the VA to find ways to creatively deliver these innovations to improve the productivity of the staff and drive better patient outcomes, better veteran outcomes into the communities where they live.

Ms. BROWNLEY. My time is up. I yield back.

The Chairman. Thank you.

Representative Barrett, you are recognized for 5 minutes.

Mr. BARRETT. Thank you, Mr. Chairman. Thank you, the panelists. Appreciate you being here. Mr. DiLullo, go Army. Thank you. I started my career in the Army as a grunt attached to an infantry unit as a forward observer and then ended up going to flight school as a warrant officer. I never did the academy or anything like that. I am not quite as smart as you are, but appreciate you being here nonetheless and always appreciate a good Army infantryman, so thank you. You wore your Army blue tie or infantry blue tie today. I could tell. Appreciate the rest of you for joining us as well.

Had a question for Dr. Bloom. With the issue of diabetes and the chronic nature of handling that disease, and especially the prominence it has within the veteran community, I do not think any American can turn their head today without these Glucagon-like Peptide-1 (GLP–1) advertisements smacking us in the face every time you turn on the TV, open your phone, use anything. Is that a promising preventative from some of the disease progression with diabetes? Can you give us any insight as to where that might lead going forward?

Dr. BLOOM. Well, I think the data coming out is actually quite dramatic. The potential for these medications, it could be consider-

able. I think we still, though, have some challenges. Like if you look at the other major blockbusters, Angiotensin-Converting Enzyme (ACE) inhibitors, Angiotensin II Receptor Blockers (ARBs), statin therapy, we are still not seeing these medications, and these are pennies, being utilized by the patients who really need it most.

Now we come back to the GLP–1s, which are often injectables. I think we are going to have to still figure out ways to make sure that the patients who need it most can get them. Often it is now it is not necessarily a—it is a challenge of access. Can they get those medications and use them? I think their promise could be considerable.

Mr. BARRETT. Then it sounds like from each of you describing the ounce of prevention versus the pound of cure and the potency in reality of which that provides us better patient outcomes, preventing disease progression, finding things, you know, more easily and quickly, and allowing us to treat those conditions that lead to a cost savings as well as a better patient outcome for the people that we are treating.

I have the privilege, I will say, Mr. Chairman, not the curse of chairing the subcommittee dealing with this electronic health record update, but the privilege of chairing that subcommittee, and we have taken testimony about some of the challenges related to that. One of the hopes I have is that we can cut down on the inconsistent nature of maybe duplicating expensive screenings, expensive testing that is done, and use of equipment. Appreciate the work that Philips does in a lot of this technology that is out there. These are expensive tests that can be done.

Do you have any insight into bringing that together to achieve a better cost savings for us around the duplicative—cutting out the duplicative nature of some of the testing, whether veterans are getting their treatment entirely within the VA or in combination with an outside, you know, civilian medical treatment, for example?

Mr. DILULLO. Maybe I can start. Congressman, thank you. It is a complicated question, but I think if you look at some of the specific technology around. Electronic Health Record (EHR), by definition, we work at the software level and at the product level. We work interoperably with any EHR that is out there. By definition, we should never have a vendor——

Mr. BARRETT. Okay.

Mr. DILULLO [continuing]. with the VA that is not interoperable across networks. Now, the challenge specifically with EHR is that is it connected to community care networks as well, because today a lot of times that is a flat file and it is not really a fully enriched product for the country.

Mr. BARRETT. You, meaning like editable or the data is——

Mr. DILULLO. The data is just flat.

Mr. BARRETT [continuing]. usable. It is almost like a faxed packet that is put into a PDF file.

Mr. DILULLO. Today, for radiology exams, or what we call Picture Archiving and Communication System (PAC) systems or archival and communication systems, for images for veterans within the VA, Philips has about 50 percent of that overall business within the VA with the different Veterans Health Information Systems

and Technology Architecture (VistA) applications, but they are highly——

Mr. BARRETT. Unique?

Mr. DILULLO [continuing]. unique or customized. In moving to a standardized central or enterprise level EHR, we have the opportunity to integrate all of those different instances into one. We are already in the VA, and I think it is an opportunity to say, hey, we can save a lot of money by trying—instead of doing something new, we just integrate the interoperable nature of our archival retrieval systems already holding millions of veteran records.

Mr. BARRETT. Okay. Thank you. My time is running out, so certainly appreciate each of you. If you have insight into how this is going, would appreciate the opportunity to hear feedback from you on that, you know, either privately or otherwise. Thank you, again.

Mr. Chairman, I yield back. Thank you.

The CHAIRMAN. Thank you.

Representative Cherfilus-McCormick, you are recognized for 5 minutes.

Ms. CHERFILUS-MCCORMICK. Thank you so much, Chairman Bost, and thank you so much to our witnesses for being here. I am very disappointed that we do not have anybody here from the VA. The reason being is, before I came to Congress, I was the CEO of a home healthcare company for 15 years and I am very well aware of your products and how great your innovation has been, especially when it comes to reducing readmission rates, when it comes to identifying real-time health issues and providing it to the providers, but also prevention. I do not believe that you cannot do prevention and treat critical care at the same time. It does take the right structure, it takes the right policy, and it also takes the right personnel in place to make sure that all of your technologies are successful.

None of your technologies are self-sufficient, meaning that they do not work by themselves. They have to go to a healthcare professional, a clinical care professional. Understanding that, it is important that we have the VA here to actually talk about the systems they have in place, to talk about the policy and the procedures they have in place. Without them being here, there is no substantial certainty that your products can actually help our veterans in its sole entirety.

My question is going to have to be to you guys, which I appreciate you taking these questions. Do you believe in this current environment and the cuts that we see that are going on, that the VA has been able to take the proper steps to set up the proper structure, process, and personnel to ensure our veterans get the same care or similar care as our private insurance patients? That could be for any one of you.

Mr. DILULLO. Congresswoman, it is again a wonderful and complicated question. I will take a stab at it from our perspective.

The first thing to think about, I believe I have been doing not just technology deployments at Philips, but for my entire career since the military. It is incredibly complicated. Change management and personal change is the biggest and hardest driver to really overcome to get the full adoption of that capability. At Philips, for example, when we come to the VA, if we have a new software

or application, because we are much more into the workflow of how the VA clinicians operate, not just the box itself or the piece of technology, it is about the workflow. When we do that, we bring our clinical specialists in during deployment, after deployment, to try to get the maximum use of the capabilities that we deploy.

We also have over 1,300 education platforms, either on demand, seminar, or onsite or physical trainings that we can deliver during the lifecycle of that project. We work that into our contracts with the VA because we also understand there is human turnover.

In every aspect, we understand it is hard. We cannot necessarily cover the people that are coming into the VA, but we can make sure that we have all the adoption, training, and capability delivery to them during the entire life cycle of the product within the VA.

Ms. CHERFILUS-MCCORMICK. I guess my question, just to make it short, would be a yes or a no. Do you believe or are you substantially confident that the VA actually has the process in place to ensure our veterans will get the best outcomes? Without the VA being here, they cannot answer, so I would pose that to you guys. I know it is a difficult question.

Mr. DILULLO. I could not answer for the VA. Maybe one of you want to, but I would suggest that we work very hard as part of the process in deployment to work that out with the VA on those specific applications.

Ms. CHERFILUS-MCCORMICK. Now, last session, I was the ranking member for technology modernization, and after several hearings, it became very clear that the VA did not have the structure in place nor the process or the personnel to ensure that their implementation was successful. That is why I had to come to you, because what we are looking at right now is a standard of care that our veterans are actually being denied. They are being denied because the VA is not living up to it.

I just want to, you know, reiterate that we can actually treat our veterans who are in critical situations while simultaneously preventing other disease and preventing and seeing our veterans do better. Most importantly, we have even seen that when you have these remote monitoring devices in their homes and you have personnel, that the entire family has done better, so not just the veterans, the caregiver, the spouses, and the children. It is important that we hold the VA to task and that the VA be invited and is present to make sure that we are all living up to our promise to our veterans.

My last question would be, do you believe that you actually have the resources? Once again, I know it is hard for everyone to answer this, but now let us look at the resources for prevention. Do you believe that you have the resources or do you believe that there can be investments into ensuring that we are dealing with prevention?

Dr. BLOOM. I do think many sites, thank you for the question, by the way, many sites do still struggle. Do they have enough staffing to be able to do preventative care? I think a lot of it just comes back to even the incentive structure making sure that they can incentivize preventative care, because many of them find that it is just—it is not as viable. They are going to need to stay on doing the adequate workload that it is going to take to keep them in good standing. I think there is a lot to that, making sure they have the

staffing. One key piece is just making sure that they are able to protect their time during toward the services that they need to do the most.

Ms. CHERFILUS-MCCORMICK. Thank you. I yield back.

The CHAIRMAN. Representative Hamadeh.

Mr. HAMADEH. Thank you, Chairman Bost, for convening this important hearing today.

As many are aware, Arizona is emerging as a prominent technology hub, especially as states like California implement regulations that hinder American innovation. I have an interest in biomedical innovation and its broader implications and I appreciate the opportunity to engage in this critical discussion.

Now, currently, the procurement process within the VA system places the agency at a significant disadvantage, often delaying access to the latest technological advancements by 2 years. This means that by the time the VA acquires a life-saving innovation, private hospitals across the Nation have already utilized it for an extended period of time. Furthermore, by the time the VA implements technology that was initiated for purchase 2 years ago, it is often outdated. Now, in my opinion, the dedicated men and women who served our country deserve better access to cutting-edge solutions and the medical staff at VA deserve better, more modern tools to deliver that care.

Now, my first question is to you, Mr. DiLullo, and thank you for your service and thank you for your daughter's continuing that legacy in her service as well. You must be very proud.

Now, I noted in your written testimony the section regarding RATE, or the Rapid Analysis of Threat Exposure. Now, this technology piqued my interest, particularly given my role in the House Armed Services Committee and your mention of Philips collaborating with the Department of Defense on RATE. Could you elaborate for my colleagues on what RATE is, how it operates, and its practical applications?

Mr. DILULLO. Thank you, Congressman, for the question. I would love to talk about this because it is a force protection measure for me. It is about friends that I have that are serving on the front lines in other places in the world that they are using this today.

RATE, Rapid Analysis of Threat Exposure, basically, years ago, we started with the Defense Innovation Unit. It takes commercially available devices like this ring that I have on and this watch that I have on that can record and other devices as well. They are commercially available that you can extract about 165 biomarkers, whether it is heart rate, stress level, sleep level, oxygen level, temperature. We have been building algorithms with the DOD for years as a force protection measure to determine when an individual might have a degraded state.

Where this becomes particularly applicable, over years of building thousands of servicemen and—women's data, we have been able to apply algorithms that allow us to determine whether someone will come down with an infection within—inside of 48 hours or outside of 48 hours from actually showing symptoms. Imagine you are on an aircraft carrier and you have an infection that you have not shown symptoms yet for a day or two. I can actually intervene

and quarantine you and keep the force safe and keep the mission going.

We would love to see that kind of speed and innovation working with the VA as well, because we see applications with healthcare providers within the VA, a critical resource and a constrained staff to make sure that if they are about to contract an illness, that they are not, a, passing that on potentially to another veteran that comes into a VA center or that we see a degradation that makes them vulnerable in an ill population, that we can avoid that and keep them safe and working another day.

Mr. HAMADEH. Very good. That is a pilot program, you said?

Mr. DILULLO. We ran a pilot. It is 11,000 participants, men and women in the armed forces that are doing this Pilot, even some Navy Academy midshipmen, I believe, much to my dismay. Still we find the algorithms are trainable and learnable to new solutions and new infections constantly as we are building this pilot.

Mr. HAMADEH. Will it be expanded?

Mr. DILULLO. We are working, we would love to continue the discussions with the VA to expand this into the VHA system as well. Yes.

Mr. HAMADEH. Very good. The privacy considerations on that is being taken into consideration as well. Correct?

Mr. DILULLO. It is complete. It is commercially available applications, but we secure that, obviously, and democratize or sterilize the data. It is really looking at human condition. It is not looking at any individual or personal applicable data, personal health information.

Mr. HAMADEH. Very good. Now, Dr. Parthasarathy, welcome from Arizona and my alma mater for law school. How has the University of Arizona used artificial intelligence to enhance patient care?

Dr. PARTHASARATHY. Yes, we have been able to embed that into the electronic medical record system. That, for example, for sleep apnea, we run algorithms that have been developed by researchers at MIT to able to identify and alert the clinician, the provider, the nurse, or the nurse practitioner at the very busy clinic that their patient may, for example, have sleep apnea. That way they are able to be alerted to the fact that this is essentially a disease that can be diagnosed, treated, and, therefore, keep patients out of the hospital, reduce the risk for heart attacks, strokes, and so on and so forth.

Second, we are developing algorithms to help them be more adherent to the treatment. Just because there is a medication, does not mean they are going to—or a device therapy, doesn't mean that they are going to use it. This is meant to actually be patient-facing technology that actually gives them psychological cues and advice and tips and tricks for them to be able to use the CPAP device, for example, for sleep apnea in a more adherent fashion. We are actually collaborating with researchers at Harvard to actually develop an algorithm for us to be able to use that to help augment the ability for people to be able to use the therapies and improve.

Similarly, there is actually an FDA-approved technology using algorithms embedded in an app that is helping deliver cognitive behavioral therapy for insomnia that can actually help bend the

curve on insomnia or address jet lag for active-duty military, for them to be able to adjust their sleep time before they travel across time zones. There are various technological approaches and we are being able to embrace some of them and some of them are in development.

One particular one that I would mentioned earlier was this Virtual Reality Military Operational Neuropsychological (VRMONA) technique that has been developed at the University of Arizona with funding from the Department of Defense that is looking at virtual imagery. It is almost mimicking a video game of shoot/no shoot situations to be able to test the neuropsychological decision-making of the individual. It is being tested in 1,000 individuals who have been at the war theater in order for us to be able to address whether a 20-minute video game can replace 4 hours of a neural cognitive battery.

Mr. HAMADEH. Very good.

My time is up. I yield back.

The CHAIRMAN. Representative Budzinski, you are recognized for 5 minutes.

Ms. BUDZINSKI. Thank you, Mr. Chairman. Thank you, Ranking Member Takano, for convening this hearing. Thank you to our witnesses for being here today.

I appreciate the pursuit of innovative technologies that help deliver world-class healthcare to our veterans, a goal I think everyone in this room does share. However, I, too, am deeply concerned that the Trump administration and Secretary Collins are rapidly dismantling the VA workforce, threatening VA's healthcare operations.

I have been listening to veterans back home. I hosted an event with Senator Duckworth and our local Veterans of Foreign Wars of the United States (VFW) and American Legion chapters in my district just this last Sunday. We also met with the Tri-State Women Warriors Network just yesterday. I listened to veterans sharing stories of friends who have committed suicide, veterans who rely on the VA every day, and asking me about who has been laid off and why. There are questions like those that I cannot answer because those are questions this administration itself cannot answer.

When the VA itself is headed to a crisis, why are we having a discussion about biotech? Without VA present at this hearing is a missed opportunity to look at VA's capacity at the staffing and resources needed to deliver care, to improve VA's procurement systems, to modernize VA's physical and software infrastructure. Without the VA witness here, we cannot get answers to the administration's recent actions on crucial VA research. Instead of building on the VA's tradition of innovative research, this administration has set us back by firing researchers and targeting research with, quote, unquote, "trigger words," such as "female," "women," and "gender."

As Ranking Member Takano noted in his remarks, VA research findings have contributed to not only—that have not only saved lives, but also greater profits for companies like Philips and Boston Scientific. Innovation is not limited to the Veterans Health Administration. As ranking member of the Technology and Modernization Subcommittee, I am also deeply concerned that the cuts to the VA

Office of Information and Technology's staffing and budget will disrupt VA's Information Technology (IT) modernization efforts.

The VA is still operating with outdated technology to manage its medical equipment inventory. For example, the Automated Engineering Management System, Medical Equipment Reporting System, a system built back in the 1980's, is not able to support today's interconnected software-based technology.

It seems tone deaf to engage in conversations about innovative biomedical equipment when the foundations of the VA are crumbling; when the VA is threatening to cut 80,000 of the mission-driven staff who serve veterans each day; when veterans crisis line operators say DOGE has made their job stressful to the point of tears, being forced to do more with less, while remaining steadfast in their mission of serving veterans in crisis; when VA clinical trials have been delayed or canceled because the staff who managed them were let go; when VA has canceled hundreds of contracts, including IT and management contracts, among others, that will impact cancer care and VA's ability to access toxic exposure and disability ratings; when President Trump's latest executive order attempts to intimidate Federal workers out of their unions and attack collective bargaining rights, including for over 425,000 veterans across the government.

To our witnesses here today, I do truly appreciate your work, the work you are doing to improve the care for our veterans. I wish the VA could have joined you today to be a part of this important discussion.

My question is for Mr. DiLullo. Do you know how many nonclinical staff members are required to install, inspect, maintain, and repair your products?

Mr. DILULLO. Congresswoman, I appreciate the question and I actually do not know that. I would be happy to follow-up and have a discussion separately.

Ms. BUDZINSKI. That would be great.

Mr. DILULLO. Both our side and the VA. As I mentioned earlier in a statement, one of the things that we do is we dedicate resources to the VA specifically for adoption and maintenance. We look at that in a geographic context. We have people that show up at vulnerability VA centers and help with that continuing education, but we also help maintain the equipment.

Ms. BUDZINSKI. That would be really wonderful because one of the things I understand the administration has been saying is that these layoffs are not going to—or only are going to be held off, you know, for folks that are doctors or nurses. The nonclinical staff are also very critical to making sure that the mission of the VA is complete and conducted for our veterans. I would very much appreciate that.

Thank you. I think I am about out of time, so I yield back.

The CHAIRMAN. Thank you.

Representative Radewagen, you are recognized for 5 minutes.

Ms. RADEWAGEN. Thank you, Chairman Bost and Ranking Member Takano, for holding this hearing today. "Talofa" and thank you to the witnesses for your testimony.

Dr. Parthasarathy, thank you for that extensive answer earlier on sleep apnea. What are some of the consequences of sleep apnea if left untreated and what is sleep apnea therapy nonadherence?

Dr. PARTHASARATHY. Thank you. Sleep apnea is when individuals have repetitive obstruction of the upper airway and it causes low oxygen count and, as a result, that reduces the amount of oxygen that goes to the heart and the brain and leads to increased risk of strokes, heart attacks, heart failure, motor vehicle accidents. Also reduces the rate of healing of traumatic brain injury and can also lead to depression and anxiety. These are all the consequences of untreated sleep apnea. It can also lead to increased amount of hospitalizations and also there is an increase in all-cause mortality, death due to any costs, if left undiagnosed and untreated.

The problem with adherence is that the therapies usually involve a CPAP mask that is applied on the nose with pressurized air and people find it difficult for them to wear and get used to. As a result, variably about two-thirds of people only are adherent or, in some communities, it is only half of the individuals are adherent to the CPAP therapy. We have shown, other researchers have shown that nonadherence to the treatment can actually lead to increased risk for all of the consequences that I enumerated previously.

It is very important to have these treatment approaches. Now the new GLP–1 drugs which are used for diabetes management has also been shown to be effective in treating sleep apnea and not just devices. Again, people are not necessarily adherent to medications or devices and, as a result, we need to do more to use these medications and devices.

As Everett C. Koop, the Surgeon General said, you know, pills do not work if people do not take them. Devices do not work if people do not use them. I think that is a very profound, but very simple statement. There, that is where we did our research, where veterans were actually helping veterans through a peer-to-peer intervention to help promote their importance of using it and to make them realize by talking veteran-to-veteran about the importance of using these treatments in order to get the full benefit from the therapy that has been delivered.

Ms. RADEWAGEN. Is VA equipped to monitor patients' adherence to sleep apnea therapy?

Dr. PARTHASARATHY. Yes, they are. Many of these devices have a centralized secure safe harbor system that has PHI, protected health information, in it. It is also held in a secure manner where these devices in people's homes transponds and sends it through the cell phone tower information about the usage and nonusage.

Ms. RADEWAGEN. Thank you, Doctor.

Let us see. There were a couple of questions earlier about diabetes. Dr. Bloom, what are some of the causes of diabetic foot ulcers and what are the consequences of diabetic foot ulcers if left untreated?

Dr. BLOOM. Thank you, Congresswoman, for the question. By the way, we should acknowledge some of the unique challenges I think you see and for the constituency you have. My understanding is that podiatric care comes from the Honolulu VA Medical Center and that this podiatrist has to come out only once a month to see patients. The opportunity is to catch problems in between those

visits. Systems that can offer, you know, expand monitoring passively hold, I think, a lot of promise there.

The causes of diabetic foot ulcer, there is a number of them. One is you have diminished blood flow into the limbs, so you cannot really bring all the healthy mediators in healing cells to a wound. You do not have enough oxygen to that tissue, so it is already acting dysfunctional. The nerves get destroyed, so now you cannot feel any pain, the gift of pain, you could get injured. Now you do not know that that wound is there, because of the high glucose you can get really bad bugs when they get infections like mucor, pseudomonas, some of the bad staph infections. It is basically a perfect storm to get now an ischemic wound, low blood flow, infected that would now need to see me in the operating room.

Ms. RADEWAGEN. Is it faster for VA to monitor a veteran's health by using a Podimetrics mat at home or by scheduling appointments at the office?

Dr. PARTHASARATHY. The hope is they do not need to come into the office. Yes. Give them a mat in the home, they can step on it for 20 seconds a day while they are brushing their teeth. Now our hope is to avoid the need to ever come into the facility in the first place.

Ms. RADEWAGEN. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Representative McGarvey.

Mr. MCGARVEY. Thank you, Mr. Chairman. Look, I am excited about today's hearing. I think this is an amazing, amazing opportunity. Truly an amazing opportunity to ensure that the VA is the leader in innovation so that we are giving the best care to our veterans.

I think about what the Department of Defense looks like. They had the Defense Advanced Research Projects Agency that I think everybody knows stands for DARPA. They incentivized Innovation. Because of that, we have things like Global Positioning System (GPS), we have the Internet. Not only are they helping our soldiers on the battlefield and giving us a technological edge, they are then technologies that all of us can use.

What if we did the same thing in the VA? What if we actually incentivized innovation? Think about what the VA is: 9 million patients, the largest patient population by a multiple; 75 percent of physicians do some of their training at the VA. We have the largest longitudinal data set of any healthcare system in the country. We get you when you are 18. Sometimes we keep you till the day you die. What are we doing with this? What today's hearing shows me is not enough, but that is what is exciting, because we can do this.

We have seen models of this that work. Think about what DARPA did. Now think about it in the VA context. If we find a cure for traumatic brain injuries, for PTSD, for spinal cord injuries for our veterans, we do it for everybody. Those are service-connected injuries. What happens if the veteran who comes in with diabetes or Parkinson's or heart disease or cancer, and we find a cure for that?

I think this is a both/and proposition, that the balance for this is through partnership, where the VA and industry develop solutions collaboratively that ultimately save money, generate revenue,

and provide better health care for our veterans. I would love to see this.

Dr. Bloom, I think your story is a perfect example of the kind of innovation possible at the Veterans Health Administration. In your case, CARES Act funding made it possible as a highly effective pilot project for monitoring diabetic foot ulcers. The VA's traditional acquisition structure does not really allow for this kind of innovation, does it?

Dr. BLOOM. No, sir. Thank you for the question. You know, what I have to acknowledge is that every—when you are starting your company off and you have a mission, a vision you want to accomplish, you need to go to the venture capitalists (VC) to fund this company. It is a big part of getting it up to speed. The blatant fact is that every VC I went to when I said I was going to go to the VA, often they would even roll their eyes. I was dead in water.

Now, the reason why they did that is they actually cited a number of companies that they had funded that commercialized through the VA, and they were all dead. Right? This was no longer a winning proposition for them.

If you actually could have something like an advanced market commitment that actually say, look, here is a critical problem the VA is saying that they have and they are eager to buy this type of solution, going to a venture capitalist with that type of some sort of commitment by the VA, that is company changing, that is healthcare changing. Right? It is the startups that take this enormous risk. We can put hundreds of millions into a system. Government is not set up to take that kind of risk and even larger companies cannot take that, but we can. Without that funding, we are dead in water.

Mr. MCGARVEY. Yes, and I am glad you brought that up, because last year, at the very end of last Congress, I introduced a bill called the Innovate Act, hoping to empower the VA with the authorities it needs to conceive of and scale up these type of innovative solutions you are talking about. I plan on reintroducing a newer version of that bill this time. The bill is not going to—it will support, not replace the outstanding research and innovations already underway inside the VA. Of course, it is going to do things that, like you talked about, it will provide VA with two specific authorities that would make these partnerships and pilots possible, the other transaction authority and the advanced market commitment that you talked about.

Just to break that down, you know that other transaction authority is a special authority that lets government agencies team up with outside organizations more quickly and flexibly. That is a big help that you just mentioned. The advanced market commitment, it is like a promise from an agency to buy a product in the future, even if it has not been created yet. This encourages companies to invest in developing solutions they might not otherwise pursue. Of course, you know this, this approach led to the creation of the pneumococcal vaccine, which has saved over 700,000 lives in developing countries.

I think we have to do more. I think we have to do more of this type of work where we are collaborating to help our veterans. I will say there is government spending, there is government investment,

and we are investing in these preventative medicines. We are investing in these cures and these innovations. We are not just helping our veterans, we are helping everyone. I think doing the mission of this committee.

Dr. Bloom, I appreciate your testimony. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you.

Dr. Miller-Meeks, you are recognized for 5 minutes.

Ms. MILLER-MEEKS. Thank you very much, Chairman Bost, for this hearing. I thank our witnesses for being here.

Two years ago, I was asked to chair a task force for my colleagues on modernization of health care, looking at what we could prepare for legislation. I actually focused that on three things, and that was access, prevention, and affordability through artificial intelligence, technology, wearable devices. I think what you have underscored today is exactly that.

Is it possible? I will ask you all this just very quickly if you can answer. Is technology disruptive? Sometimes, as we advance, whether it is from an agrarian society to the industrial age to the information age, are there people who lose jobs and positions? Mr. Gray.

Mr. GRAY. Just like during the agrarian time, there is, but they will flex and new jobs will be created.

Ms. MILLER-MEEKS. Dr. Bloom.

Dr. BLOOM. Your hope is you are going to be able to avoid the need for a number of clinicians, but those can be put to other uses.

Ms. MILLER-MEEKS. Mr. DiLullo.

Mr. DILULLO. I believe technology available today allows clinicians to work at the top of their licensure, which will help us——

Ms. MILLER-MEEKS. Dr. Parthasarathy.

Dr. PARTHASARATHY. I think this is where implementation science needs to be followed, where it needs to be faced, and rather than be disruptive.

Ms. MILLER-MEEKS. Not unusual that as technology advances, we will, one, have more access; two, be able to use prevention; three, make it more affordable. We may need less people to do certain things, such as 80,000 VA employees that were hired during the last 4 years at $126 billion increase in revenue to the VA with level national people applying for and receiving care. I think that that is a normal process as we develop and grow and innovate.

Dr. Bloom, I think Representative Radewagen asked you about the causes of diabetic ulcers. As a doc, I know them, but if you could, and I think you mentioned this, consequences of diabetic foot ulcers left untreated or poorly treated, and you mentioned amputations and the cost of amputations. Could you just reiterate that again?

Dr. BLOOM. Well, first, per VA national data, we know that the 5-year mortality of just getting the foot ulcer is 70 percent. That is worse than almost all cancers except for maybe glioblastoma, pancreatic cancer, a couple of the really big scary ones. That already is very alarming.

Of course, if they get infected, they might have to see one of us in the operating room. Now we are going to lose the limb. That is now a life-altering event where they now cannot take care of them-

selves the same way. We see dramatic increases in depression, suicide ideation, the actual suicide event. It is a devastating change in their life.

For example, we had one patient where they just stopped using it. Now, per protocol, we are going to reach out to that patient and try to find out what is happening, remind them to get on the mat. We had to just leave a voicemail. They called back the next day. Thankfully they did. He acknowledged that the pain was too much in his limb. He now wants to take his life. Thanked us for the care that he had, and just wanted to let us know that that was going to be the case. Thankfully, we were able to get him the services.

Ms. MILLER-MEEKS. It is because of those things that products like yours have recognized significant cost-savings as well as quality of life improvement.

Dr. BLOOM. Significant savings and now for that veteran, he is still with us just thanks for that extra touch to the patient.

Ms. MILLER-MEEKS. How was your experience engaging with the Office of Health Innovation and Learning at the VA?

Dr. BLOOM. Well, I think that the innovation group offers like this are a critical part to the industry. When we were just coming along, we did not know what we were doing. There is no manual to the VA. Try to come in, in any way you can. When we started to work with the, it had a different name prior, but Office of Healthcare Innovation and Learning (OHIL), essentially, they were able to figure out, okay, what is the right model for a company to adapt to the VA. It is arrogance to presume the VA is going to adapt and bend to us. We had to build it together. When we did, now it was perfect-built for our veteran, perfect-built for those VA infrastructures. That is why we are seeing the savings we are.

Ms. MILLER-MEEKS. Thank you. I am running out of time. Mr. DiLullo, what complimentary steps do remote services offer to connect VA practitioners with rural veterans and may save visits to the hospital or to practitioners?

Mr. DILULLO. Congresswoman Miller-Meeks, it is great to finally meet you. I would actually, I will use one example that is significant in our ability to reach into rural communities, specifically. We have something called a Lumify which if you can imagine an ultrasound today, an ultrasound can be done on an iPad. It can have a transducer plugged in. I can video in, on broadband, a technician, or a sonographer, or a radiologist, remotely anywhere. For example, I was in the Kalispell Clinic in Montana this summer. They have no imaging equipment there, but yet it is a large enough facility where you could put an iPad in there and beam in somebody from Fort Harrison from 3 hours away. I can get a gastro scan, I can get a prostate scan, I can get a liver scan with over-the-shoulder coaching and in real time results. I can do that anywhere in the country and we do that in private healthcare.

Ms. MILLER-MEEKS. Have you used artificial intelligence to enhance patient care?

Mr. DILULLO. Absolutely. I will just use that. We could talk for a long time on the ability to enhance imaging and speed the process. In that particular case we actually construct the image in AI on the system itself and render a very precise diagnostic. That is

our new opportunities, not just to reach patients, but give precise diagnostics quickly.

The CHAIRMAN. Thank you. Representative Ramirez, you are recognized for 5 minutes.

Ms. RAMIREZ. Thank you, Chairman from the great State of Illinois. I want to thank the Chairman and the Ranking Member for holding today's meeting, and I want to also thank all of the witnesses that are here today. Today's committee hearing is titled Harnessing Biomedical Innovation: Modernizing VA Healthcare for the Future. I want to start by putting on the record that I find it difficult to have this conversation, an important one, right, on innovation, without having the VA here. That is not your fault. You cannot represent the VA or ask them to be here.

In absence of them being here, it means that we are having this robust conversation about technologies and innovation, how to modernize the VA healthcare without the same agency, the very same agency that would be responsible for these implementations. It almost feels like a sales pitch instead of real conversation about how we modernize the VA in order to provide the highest quality of care for our veterans.

It feels like a calculated attempt. Not by you, but you know, in the way that this committee was set up in this hearing to accelerate privatizing the VA while padding the pockets of for-profit companies.

All it feels like to carry out a Musk-Trump agenda to dismantle the VA under the guise of modernization and efficiency. Look, the Musk bad-boss playbook is manufacture failure through hiring freezes, mass firings, and reduction in resources, scare and demean the workforce, disregard the clients, publicize every single problem. All so you can say, see it did not work all along. Then venture capital corporations can swoop in and claim their only solution left to try is theirs. We have all seen how that ends up.

Have we not learned from X formerly Twitter? Just last month Trump turned the White House lawn into a Tesla showroom after announcing that he planned to buy a Tesla himself. See, there is a pattern. Use Federal power to boost private industry and this time at the expense of our veterans.

Look, I do believe that veterans deserve the highest tech and devices possible. Our veterans need the state-of-the-art high-tech devices with fully funded, fully staffed VAs that can actually implement these devices and these technologies. Now, how do you do that if you do not have the staff to be able to operate them?

Mr. DiLullo, you lead a team of nearly about 17,000 employees, am I right?

Mr. DILULLO. That is correct.

Ms. RAMIREZ. Okay. If 15 percent of your workforce, if my math is right, that is about 2,550 employees were cut, could you operate effectively? Yes or no?

Mr. DILULLO. Congresswoman, that is not a yes or no question. I would tell you it would be harder. I would also try, treat it as a compelling event to find ways to deploy technology to make up or automate things that I do not want people doing anyway.

Ms. RAMIREZ. If you did not need those 2,550 employees then why would you hire them? See, given VA's planned reduction of

83,000 employees, how do you expect the VA to implement and sustain new technologies your company is providing?

Mr. DILULLO. Congresswoman, let me address it from my perspective only. I have no insight into VA or their perspective——

Ms. RAMIREZ. They are not here so they cannot answer.

Mr. DILULLO [continuing]. policy division. I would say from my perspective, everything that we are doing and we talk to the VA about as well as every other health system in the country, three things are true. Everyone is seeing an increase in needed care. People are getting older. More people are getting older, living longer, they need more care. Second thing is cost of care is going up. Seventeen percent of Gross Domestic Product (GDP) in north in the United States is spent essentially around health care which is an astronomical figure. It means cost for the average American to include veterans goes up. The third thing is that staffing is going down. People are not entering the medical field at the rate they are leaving. This is not a VA specific item. It is a national crisis in my opinion. Technology companies like Philips and like the other ones here are trying to find ways to create automation, AI enabled solutions to do much faster diagnostics and improve——

Ms. RAMIREZ. Thank you, Mr. DiLullo. I am low on time, so I really appreciate what you just said, and I absolutely agree with you. We need that innovation. We understand the challenges that we are living, but given the dramatic staffing reductions on the VA, it is hard for me to believe that the VA will have the capacity necessary to introduce Philips technology and ensure that there is proper maintenance, operation, and the effective use of these systems.

You know, I asked you the questions I did, recognizing you cannot speak on behalf of the VA, but unfortunately there is no one here that can. I am asking because they were not invited to appear before this committee. In your opinion, would not these be better questions for the VA leadership who could provide real insight into the workforce capacity, the budget constraints, and the operational readiness to be able to operate these devices?

Mr. DILULLO. Congresswoman, in my opinion, no single entity or healthcare provider can solve those things in a vacuum. I think it takes partnership and open discussion with partners that bring capability and——

Ms. RAMIREZ. Thank you, Mr. DiLullo. My time is up. I would like to have the VA here to answer these questions. With that, I yield back.

The CHAIRMAN. Thank you. Before I go to the next speaker, I want to respond to some things. Let us be clear, there is no final number of any potential reduction in workforce. None. What we do know is that unlike the previous administration, Secretary Collins and the VA have been transparent with Congress every step of the way. I expect to continue moving forward.

This idea that we should start ringing the alarm bell before the plan even exists, that is just more of the same fear tactics and political threats. If you want to have a serious conversation about oversight, I am here for it. Let us not sit here and pretend there is a five-alarm fire when we are still looking at the blueprint.

Veterans deserve the truth. I just want to stand—want to make sure that you understand that is the truth. Let us get back to the discussion here at hand. With that, I yield to General Bergman for 5 minutes.

Mr. BERGMAN. It is interesting to observe life. I was just sitting here reflecting on 20 years ago being at that witness table in uniform before a military personnel subcommittee hearing. There were seven Reserve and Guard chiefs and we were pretty underwhelmed by what happened and what was discussed up here. I would associate my comments with the chairman. Let us not waste time because veterans never wasted their time because of the fact that they fought to defend our country. We will get right to the meat of it right away.

Just, yes, I was in the Marines a few years. Probably most important for this discussion here was for three decades I was involved in the operating room equipment business. A lot of it in radiology, some in microsurgery and others. I will kind of put that hat on a little bit here. Let us get right to the questions.

Mr. Gray, your testimony states that approximately 61 percent of all AFib procedures in civilian hospitals will use post-field ablation technology. Yet only roughly 10 percent of VA hospitals have access to this technology. Could you—why?

Mr. GRAY. Yes, sir. Multi factorial. Really for the past year. This was launched by the FDA in March 2024 and there was a huge scramble for the technology. It was so transformational. I would say because of the budget uncertainty within the medical facilities in the VA, not across the VA, but each one, they were not sure if they were going to have the budget, when it was going to come, should they not make a purchase because they are not sure if they are going to have the infrastructure in place. It was almost this fog of war type of mentality. It was almost like stasis going on. That was a huge part of it.

The second one is what I talked about before with the prosthetics contract. There is not a, today, a process in place to add new products like there is in the Med/Surg Prime Vendor. You have to jump through so many steps. If you do not hit every single step and there is not money there, it is just a very, very challenging process.

While we are able to get some other new technology like that AGENT Drug-Coated Balloon into the Med/Surg program quickly, the prosthetics contract was just much more challenging. That is the biggest issue. Again, we have it in less than 10 hospitals and physicians are clamoring for it because, as you said, it is becoming the standard of care for atrial fibrillation in the United States and really, across the globe.

Mr. BERGMAN. Well, it is utilizing new technology that has been developed, tested, and getting it into the VA system as appropriately quickly as possible to provide better outcomes for the veterans.

Mr. GRAY. Yes sir.

Mr. BERGMAN. Okay.

Mr. GRAY. It is 40 percent faster and it is safer than the current technology. We have to get it in there.

Mr. BERGMAN. Well, just little data point. Several of the surgical instruments used today were invented in the 1700's, but that does not involve electricity——

Mr. GRAY. Right.

Mr. BERGMAN [continuing]. or computer programming. How important, to get back to the point here, how important is the clinical input? Speaking of instrumentation and medical equipment. How important is clinical input in the medical procurement process, that is the people who will actually be using that equipment in the Operating Room (OR), in the radiology lab, in wherever it is? How important is that clinical input?

Mr. GRAY. It is critical. It is necessary. Whether it is the VA or it is a commercial civilian hospital, physician voice has to be part of the process. When they are, the process runs smoother for the hospital, for the system and for the patients.

Mr. BERGMAN. Yes. The point is, include the people using it in the decision process.

Mr. GRAY. Absolutely.

Mr. BERGMAN. Since I serve on both Armed Services and Veterans affairs, how does VA compare to DOD when it comes to the procurement of medical technology, especially when it comes to timelines for implementation?

Mr. GRAY. It is a difficult question to answer because it is not an easy question to answer. I would say this. The DOD has a contract vehicle called the ECAT, Electronic Catalog. It is fantastic. Once you get a product, you submit the right information, it goes live pretty quickly. Almost identical to the Med/Surg Prime Vendor contract that you worked on in the VA. Very similar, but then you also have the prosthetics contract in the VA, which needs to catch up to the other two. It is a long answer to say the DOD and the ECAT is as good as the Med/Surg Prime Vendor in the VA, but the prosthetics contract is much lower and needs to get up to that level.

Mr. BERGMAN. To cap off, because I see I have 30 seconds left, it is okay and desirable, I would suggest to you, within just compare the DOD and VA to allow them to piggyback off and take each other's successes and build on it rather than reinvent the wheel in two different departments. Let us leverage what we have and let us move forward with good processes. With that, I yield back.

The CHAIRMAN. Representative Dexter, you are recognized for 5 minutes.

Ms. DEXTER. Thank you, Mr. Chair, and thank you all for being here. As I understand it, the purpose of today's hearing is to examine how our veterans can access the high-quality care that they deserve while ensuring the VA remains a responsible steward of taxpayer dollars. Absolutely an appropriate goal for this committee. Given that goal, I was shocked in preparing for this hearing, to learn that the majority had declined to invite anyone from the VA to testify.

As a pulmonary and critical care physician, I was involved in specialty relevant procurement processes. I know very well what a robust procurement process looks like. This is not it. I am, frankly, horrified that we are here having a discussion about important clinical decisions without any clinicians. No offense to my col-

leagues, but not a single one of us should be engaged in this. We have procurement processes. If it is not working optimally, let us focus on fixing it. That is absolutely the right thing, not go around it.

This right here today is how we increase risk for waste, fraud, and abuse. I am completely unclear on how having a series of industry adjacent representatives here today without the insight of a procurement discussion advances the goals of using taxpayer dollars wisely.

As someone who served as a VA provider for 7 years and as a U.S. Congresswoman, I care deeply about providing our veterans with the best possible care. That is not what this hearing is about. Instead, we have decided to use—my Republican colleagues have decided to use the incredibly valuable time and resources of this committee to give private industry an opportunity to pitch their products. At the same time, we are doing extraordinary harm to our systems of medical research and development that has historically been a priority for the VA.

I am just going to use one example, and I mean no disrespect. I just want to go through this for the purposes of illustration. Mr. Gray, I read your testimony regarding FARAPULSE and in your written testimony prepared for today's hearing, is it true that you cited the study entitled, quote, pulsed field or conventional thermal ablation for paroxysmal atrial fibrillation, to substantiate the value of this product?

Mr. GRAY. Yes, I believe so.

Ms. DEXTER. Thank you, Mr. Gray. Is it also true that the study draws its conclusions from a non-inferiority trial?

Mr. GRAY. I believe so.

Ms. DEXTER. Thank you. Finally, did I read correctly that the study was financed by Boston Scientific?

Mr. GRAY. I think so.

Ms. DEXTER. For those listening today, it is important to note that this study, financed by the company who manufactures the product, and which showed only that it is no worse than other treatments on the market, is the only evidence that was provided by our witness. Again, this is not the right place to do this. I am not trying to call you out specifically, it is just that it is not the right process.

We do not have access to the cost data to be able to compare it to current practice that is not inferior. The VA has a procurement process that we are not discussing here and we should be. If that process is not working, as we have heard it is not optimally, then it is our obligation to help it do better.

Although President Trump and the architects of Project 2025 claim to support a veteran-centric VA system, it is clear yet again that the rhetoric does not match reality. Instead, my Republican colleagues seem more interested in furthering corporate interest than truly serving the veterans who fought for our country.

Where is the VA today? Where are the clinicians who can talk about the impact of the hiring freeze, or the terminations on veteran care, or even whether or not they think these are good products to use? Why in the world are we politicians being involved in this procurement process? Maybe even just a sales pitch that

should be evaluated by a rigorous, reliable process, not a partisan body powered by special interest investments.

The absurdity of today's hearing is honestly quite stunning. I want to see a VA that fulfills its promise to our veterans and their families. One that is efficient and innovative, expands care to veterans most in need, and focuses on prevention, as many of you do. However, instead of focusing on that, we have listened to advertisements without hearing from the VA or the clinicians who will use these products, engaging in a forward-looking conversation about how to best use taxpayer dollars. That is what this committee should be focused on. That would be living up to our promise to our veterans. That would truly be veteran centric.

This hearing is a distraction from the harm being done to veterans across our country. We need to all be prioritizing their well-being, not corporate interests being discussed here today. I implore my colleagues to do better.

Thank you. I yield back, Mr. Chair.

The CHAIRMAN. Representative Ciscomani, you are recognized for 5 minutes.

Mr. CISCOMANI. Thank you, Mr. Chairman. You know my views on healthcare are pretty simple. No matter where a veteran seeks care, they should have the highest quality outcomes and the most efficient ones as well. I was proud to sponsor legislation that was signed into law to focus on support for at-home care services for our veterans and their caregivers. I want all options to be great options. This is what it truly means to have our veterans at the center of our mission in this committee.

I also want to, before I get into my questions, specifically thank and highlight a special guest from the University of Arizona, my alma mater. Doctor, I have the pronunciation here, so let me give it a shot and you correct me. Parthasarathy. Yes?

Dr. PARTHASARATHY. Yes, sir.

Mr. CISCOMANI. Okay, good. Well, I want to thank you for being here, and who leads the Center for Sleep Research and has treated veterans in my district at the VA. University is leading the world in this research which impacts all other healthcare outcomes. I am proud to support these partnerships that foster discovery, innovation, and results.

I have three questions, three separate questions that I would like to get to. If you would not mind, I will post the question, and if the three gentlemen can address it and I can go to the next one as well so we can cover all three areas.

Mr. Bloom, I will start with you, if possible. My district has a very high proportion of seniors with diabetes. In all of Arizona, out of the 1,727 eligible patients, only 63 veterans are being assisted by your company currently. Could you speak to the taxpayer savings that the remote temperature monitoring program in your company create? If this is saving money, what is keeping VHA from ensuring every vulnerable veteran has access?

Dr. BLOOM. Thank you, Representative Ciscomani, for that question. That is a big one. I will try to go efficient so you can get through them all. The savings per the VA presented to Senate last year is, it is about 15 and a half, $16,000 savings per patient or

per veteran participant per year. That typically comes from avoidance in hospitalizations and outpatient visits.

Mr. CISCOMANI. Fifteen and a half percent, is that?

Dr. BLOOM. Fifteen point five to $16,000——

Mr. CISCOMANI. Okay.

Dr. BLOOM [continuing]. per patient per year from avoided hospitalizations and outpatient visits. The savings is actually quite considerable. Yet many of our veterans are not getting access to it. There are a number of challenges.

Sir, some of the big ones are still just lack of access. We look at our rural veterans or veterans with limited financial resources. They are not able to get to the centers to get enrollment. Unfortunately, well, the vast majority of riders are VHA podiatrists, but over half of veterans do not have access to VHA podiatry. Right there, you are already losing a ton of access to the tech.

Then we talked about budgeted silos being a factor. Of course, I think the incentive structure needs to be addressed. Here is something that has proven savings, dramatic outcomes, improvements, including mortality. Yet the workload credit for delivering an amputation is dramatically higher than the workload to prevent it. That has to be fixed. We can do that. We can do a lot better.

Mr. CISCOMANI. Thank you. Thank you for that. I know it was very condensed. I will have a follow up if I have time here at the end. For now, Mr. DiLullo. Right? No? Mr. DiLullo. Congressman, you can say anything you want to.

Mr. CISCOMANI. No, no, no.

Mr. DILULLO. It is DiLullo. It is DiLullo.

Mr. CISCOMANI. DiLullo.

Mr. DILULLO. Yes.

Mr. CISCOMANI. Okay, great. DiLullo. I have also a high number of veterans in my district with lung disease——

Mr. DILULLO. Yes.

Mr. CISCOMANI [continuing]. and respiratory disorders, which remains one of the leading health risk factors for veterans, just overall. However, the VA has historically struggled with managing these caseloads, leading to long wait times, which could be very tragic. How can innovative technology help better serve our veterans and ease administrative burdens on physicians, specifically?

Mr. DILULLO. I am going to give as quick a thing as I can. This needs a dissertation. The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act (PACT) Act is an incredible piece of legislation. It also has unintended consequences of potentially increasing that problem with backlog of scans and diagnostic imaging or assessments of potential veterans that are at risk due to things that are not detectable in normal cancer or lung cancer CT scans like constricted bronchiolitis, Diffuse Restrictive Respiratory Disease (DRRD), and other symptoms that are common in 75 percent veterans with those exposures have a much higher lung cancer rate.

What we are doing is working with a partner called 4DMedical that is FDA approved that we can come in on a simple CT scan for hundreds of dollars at a rate of 20 times faster than you can do a lung biopsy, which is a, putting a needle in somebody's lung, taking it out, taking the biopsy into a pathology workflow that is

thousands of dollars, and I can do it 20 times faster at a 20th of the cost. Hundreds versus thousands. I can speed diagnostics, so I get the right veteran with the right care before it is too late. We know we have worse outcomes with lung cancer.

Mr. CISCOMANI. Thank you. Thank you for that, Dr. Parthasarathy, I am out of time on this one. If there is a second round, I will stick around to ask you a question. Thank you.

I yield back, Mr. Chairman.

The CHAIRMAN. Dr. Conaway.

Mr. CONAWAY. Thank you, Chairman Bost. As has been mentioned, we are here to discuss technology procurement in the VA. Of course, I should say that I am hopeful always for technology and technological advancement. We do know that we are in healthcare system, hospital system, in particular, we are dealing with shortages of nursing supply. Of course, we want to make sure that we are able, in spite of some of the deficiencies we are seeing there in personnel, that we can fill some of that gap with technology that will allow us to identify someone, as has been mentioned here, might be failing, who needs a higher level of care. We can get them transferred to an Intensive Care Unit (ICU) or to a step-down unit so they can be more carefully monitored by more expeditiously finding out if they are deteriorating in their health care status. It is very important that we do that.

I think I am not asking this as a question that many of these things are in the early stages in, because I have heard words like I hope it may, you know, save and reduce cost. I say that I hope it may, will become does, and will, in the very near term because it will be better for our patients and for the outcomes that we all seek. We want great outcomes obviously for our veterans in the VA system.

I must mention a concern at this point in my comments about the many things that we have heard in this committee room and outside of this committee room about deferred maintenance and other very important diagnostic capabilities and equipment within the VA itself. While this hearing focusing on technology is very important, it is certainly not without costs and there are other, and I think you would even agree, more critical devices, equipment, in our VA system that is not there now, and should be, to achieve the outcomes that we want for our veterans. I am certainly concerned that we do not have the VA here now to address some of the concerns we have heard throughout the hearing, since I have been sitting here anyway, about the procurement process.

I will take the Chairman's admonition that perhaps we do not know what cuts in the VA are. I hope that if he is suggesting that there will be less than the 80 to 83,000 we have been hearing repeatedly in the news is not correct and not knowable now. Okay. I hope that we will see that that number, whatever it turns out to be, is far less than the current number. I believe very strongly that hospitals and healthcare delivery, there is a system involved, and that system starts at the physical plant and goes right through security, and the people who deliver food and clean the facility, and make sure the equipment in there is maintained, right on up to the clinicians that are involved in providing the care, and indeed the people that manage the referral process and hears concerns and

complaints so that the hospital itself, as a system of providing care, can work as well as it should.

Mr. Gray, you mentioned in your testimony about the procurement process, and I hope that we will spend more time, I think this Congress, anything that happens in these departments, from contracting or to procurement, I think we have a right to know about it because our responsibility is to get that information, deliver it, and present it to the American people so they can assist us in bringing accountability for the services that receive through their government with their taxpayer dollars, I might add. I should not hesitate to add.

You mentioned that the procurement process at DOD or/and the VA in some respects are similar and work pretty well. Then you cited the prosthetics procurement process. Can you put some more clothes on that for me? What is going wrong there? Perhaps if you identify that to us, we can get together and figure out how to get either the resources or help the VA, either by bringing attention to it, that that process is improved because obviously there are a lot of veterans who come back who need a prosthesis to engage in as normal a life as they can in spite of the injuries they have suffered on behalf of our country.

Mr. GRAY. Yes, sir. The great news is we have been working with the ranking member as well as the chairman on this because we learned a lot of great lessons from the Med/Surg Prime Vendor. We think about Med/Surg Prime Vendor, that is more for non-implants. Like, not pacemakers or defibrillators or knee joints. It is more, not commodity. This contract is for permanent implants. Tips for permanent implants. Typically higher technology, higher cost technology. That is the one that needs help. In terms of what help? Clinician involvement in the process, more staff to ensure that they can order the product.

Mr. CONAWAY. There is a staffing issue?

Mr. GRAY. Staffing issue there.

Mr. CONAWAY. You mentioned inefficiencies. Is that also in——

Mr. GRAY. Yes, sir.

Mr. CONAWAY [continuing]. the staffing?

Mr. GRAY. Yes, sir. Inefficiencies. There is no time to add new products like there is in the Med/Surg Prime Vendor contract. In that contract you have two windows a year. There is zero in the prosthetics contract. That is one that we need to open up and add technology to. Things like FARAPULSE, when you are trying to bring that in, it is like, well, there is nothing open. There is no window. You cannot add it. We are asking questions and not getting answers. I think that is the one that really needs to get, you know, solved.

Mr. CONAWAY. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Representative Kennedy.

Mr. KENNEDY. Thank you, Chairman; thank you, Ranking Member Takano, for this important meeting. I would just want to join the chorus of my colleagues in my disappointment that the VA is not here being represented today. There are four of you, there are five seats. There is an empty chair right there waiting for the VA. They are not here to answer these questions. When we are talking about the gaps in the industry, work that is being addressed by

your technology—and first of all, thank you all for your work. Thank you for your commitment to the American people and our servicemen and women. When we are talking about the highlights in the gaps in industry, we do not have the VA here. That is a major problem. We cannot get to the bottom of the issues without the VA being represented here. When the, the Secretary comes out and says we are going to go back to 2019 levels of staff, that incurs a cut of 83,000-plus people to 399,000 workers, pre-PACT Act, pre-pandemic. We know that healthcare has changed in so many different ways.

When we are thinking about how the VA will maintain or operate your technologies with drastically fewer engineers and technicians and support staff, with 80,000 fewer employees, I find it absurd that they are not here to answer that question. The VA recently canceled 900 contracts affecting things like cancer care, supply chain management, prosthetics. Critical areas that directly impact veterans. How can we expect the VA to absorb the cost of new technologies when they are actively cutting these services? Again, I do not expect any of you to answer these questions based upon the fact that these are questions for the VA to deal with directly.

You can try and I appreciate the efforts, but you again, there is a very specific service that the VA provides to our military heroes that they have earned and deserve. You are there to complement that work. Without the staff to provide the resources, we are going backward. Also, as far as maintaining the technologies to have the cuts that are coming forth to our veterans services and not having those individuals in place to take care of the technologies, again, I appreciate the effort, but when we are already talking about a shortage of tens of thousands of workers, where in the community that I represent in Buffalo in western New York, the Buffalo VA had nurses out on the informational picket line because they were understaffed.

We have veterans that are going to the local VA because they love getting the services there, because they know that those workers that are there, underpaid and overworked, are doing their absolute best and pouring their heart and soul into their work because they care about our veterans. Again, I am appreciative of your efforts. I appreciate your testimony, each and every one of you. Again, I am disheartened and disappointed that the VA is not here. We will leave it at that.

I yield back. Thank you.

The CHAIRMAN. Representative Takano, you are recognized for your closing statements.

Mr. TAKANO. Yes, Mr. Chairman. Thank you. Before I begin my closing statement, I do want to clear up something. Here is a transcript of remarks that Dr. Murphy made earlier in the committee meeting in which I, in response to my claim, and I quote myself, this is a prosthetics customer service center that has closed its door in Greenville, North Carolina. That is a VA facility that has been closed in a members' district that sits on this committee.

Dr. Murphy, when it is questioning time, came to him, responded, quote, I would like to correct the ranking member statement about my VA. The prosthetics department at the VA in Greenville remains open during normal business hours Monday

through Friday 8 a.m. to 4:30 p.m. to support the needs of vets in the entire Durham VA Health Care catchment. He submitted, to support his contention that I had given out inaccurate information, he submitted for the record a VISN response. I want to point out that that very response that Dr. Murphy submitted for the record, I will quote from the middle paragraph the prosthetics customer service window at the Greenville VA Health Care Center, HCC, will remain closed until further notice. That document that Dr. Murphy submitted is dated March 18th.

I will point out that this photograph that I had on my poster which actually shows the Greenville facility being closed and it reads the Greenville VA HCC prosthetics customer service window is closed at this time. That is timestamped March 21st of this year. I would like to submit, resubmit Dr. Murphy's letter with unanimous consent as well as the transcript of our——

The CHAIRMAN. Without objections.

Mr. TAKANO [continuing]. and as well as the photograph.

The CHAIRMAN. Without objection.

Mr. TAKANO. Without question, what is accurate information is that the Greenville prosthetic center is closed. We can surmise and I think we can draw conclusions regarding the staffing cuts that have been undertaken at VA, that that might have something to do with this closure. I think this committee needs to needs to hold oversight hearings and get transparency from VA about this very thing.

Now, I want to point out also in that document that was provided to the committee whether Dr. Murphy submitted for the record is also an exchange between John Clark and Dr. Murphy's staff regarding concerns over this is a quote from John Clark, we have heard from a few constituents in the Jacksonville office front desk now is going unmanned at times due to termination of support. Assistant and clinicians are having to either pop out of appointments to help people that walk in or shift their schedule to cover the front desk.

Now, the chairman has said there is no five-alarm concern here. I would suggest differently. I, as many people know, taught English for a number of years, 24 to be exact. You know there is a famous quote in Hamlet where Queen Gertrude says the lady doth protest too much, implying that someone is overemphasizing or overacting their emotions or making their sincerity seem doubtful.

Now, the gentleman from North Carolina, I could say, is maybe doing both protesting too much against my inaccurate so-supposed inaccurate statements. I would also say protesting too little about the staffing shortages that are causing him concern and that there should be more protest about this particular concern by that gentleman.

Now, I want to also further say in my part of my closing that Secretary Collins has not met with a single Democratic member of the committee in the 2-months since he has been sworn in. Committee Democrats have sent 22 letters to the Secretary and he has only answered three. Just barely satisfactory responses to the three however, very, very superficial and scant responses.

The Secretary appeared on Fox and friends on March 10th where he confirmed VA planned plans to cut the workforce by 80,000.

That is a five-alarm fire about to occur. That is something the Secretary confirmed on Fox and friends.

Well, Mr. Chairman, my hope when I invited VA to be our witness at this hearing was that there that this would be this result in a conversation about how we can ensure veterans have access to life-saving technology at a fully staffed VA. Unfortunately, the majority chose to help VA continue to avoid any actual oversight of its staffing and procurement issues by not demanding their presence at the witness table. As we saw with regard to procurement, there was an actual contract cancellation with regard to procurement or supply chain management assistant.

It makes no sense to me why we would be having a hearing about VA's acquisition process without having VA here to talk about it. I can only assume that there is some hesitancy on VA's part to be able to answer questions from all the members of this committee. The many questions my colleagues and I have had about this topic today are left unanswered because we have had no one from VA to direct them to.

Sadly, this hearing has turned out exactly to be what I expected, a sales pitch with no bearing in reality. Trump, Musk, and Collins are bleeding VA dry and have so far offered very little information to Congress about where, when, and how they are making cuts. Our many letters and requests for information continue to go unanswered. Again, I want all veterans, I want veterans to have it all. Access to life saving technology presented here today is very much part of what I want veterans to have. A VA that is staffed to provide them the health care when they need it and is fully staffed to be able to make this technology accessible. This hearing today gets us no closer to these goals. Until VA starts showing up, these conversations are futile and unproductive.

Given Dr. Murphy's own concern about staffing his own district, Mr. Chairman, I ask you when we are going to have an oversight hearing on the 80,000 cuts that they are planning to do just two miles from here and they could not make it over to this hearing.

The CHAIRMAN. Well, I want to say thank you to the ranking member for bringing up many concerns. We have since received an email actually the clinic for the—there that has been in discussion is open. A service window was closed. That is it. A service window has a sign in it. The clinic is still open. That is important that we know that.

Mr. TAKANO. Mr. Chairman, that clinic is——

The CHAIRMAN. No, no.

Mr. TAKANO [continuing]. an hour and 40 minutes away from what you are talking about. That is the one they closed.

The CHAIRMAN. A service window is—I just got the answer from the VISN through a VA—through an email that that—there is the event—the VA did not close the facility. It closed a service window.

Mr. TAKANO. That is exactly what I said and actually exactly what Dr. Murphy, exactly what Dr. Murphy said I did not say.

The CHAIRMAN. He said the clinic is open. He said the clinic is open. That being said——

Mr. TAKANO. I offered you the actual quote.

The CHAIRMAN. With that being said, there are a few other things I would like to bring up. One, it was mentioned once again

as I said, we are seeing fear mongering from other side of the aisle. VA's decision to terminate 580 this was early on, non-mission critical duplicative contracts instead it is not a step backward. It is a long—but it is long overdue. These were not core services being cut. Many of these contracts were for duplicative work like paying a contractor just to produce material for other contractors to execute. That is not modernization, that is bureaucratic bloat. Let us be clear. The nearly $1 billion in recovered funds will now be redirected to what actually matters. Veterans' health care benefits and cutting edge technology.

This hearing was about the future. I sincerely hope the future, in days ahead, my colleagues across the aisle will not immediately turn to the hysteria every time a 24-hour news cycle flashes up. Trimming the fat is not a crisis. It is common sense.

Veterans deserve better than scare tactics. They deserve the results. That is what I will continue to lead this committee in.

One other issue when we talk about the concern about when is the secretary going to tell us. The Secretary is going to tell us like every other Secretary. There are a number of items raised, rightfully so. I will remind the colleagues that there will be plenty of opportunity to engage with the Secretary's questions when we hold our hearing on the details of the President's budget which always comes up. That is when we are going to have the opportunity to do it.

To criticize, let me tell you the majority staff did work to put the request in. VA chose not to show. That being said, let me tell you that as a member, two wrongs do not make a right. I still think I need to bring this up. When we had a situation with the previous administration where two of the lead people had made decisions to give bonuses to the upper echelon executives, when we asked for them to come, they chose not to send them. Instead, the Secretary came. It is not anything new for whenever we have this happen like this with the VA. I think both sides should work together to make sure the VA is accountable. There is no doubt.

Understand, remember when we are talking about the cuts, they keep saying the cuts. That was a memo. That was not a plan. That was just a proposal to get the people to the table.

Now, I have said in these hearings over and over again, if someone is cut and feel they were unduly cut, then they can contact our offices, they can contact your offices to answer to that question. We are glad to do that. Also remember one of the key things that is concerning that one of the key issues, if someone has been let go, they can appeal to their immediate supervisors. If your immediate supervisor does not think you are essential, I have been in jobs before and sometimes the immediate supervisors realize, okay, that one is not essential and it is not worth the fight.

I do want to thank our witnesses for coming here today. We are grateful to hear just a few of the many health care leaders and we have learned a lot, I think, through this hearing. We have identified challenges, healthcare innovators VAs in providing cutting edge quality, services, and products for veterans through the VA.

Together, I believe we can see a day when veterans receive the care they need to regain their strength, mobility and independence

without barriers of access costs. I look forward to working with my colleagues on both sides of the aisle to achieving this goal.

Now, again, I want to thank everybody for being here today. 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. The hearing is now adjourned.

[Whereupon, at 12:32 p.m., the committee was adjourned.]

A P P E N D I X

Prepared Statements of Witnesses

Prepared Statement of Will Gray

Testimony for the House Committee on Veterans' Affairs Hearing

Witness: Will Gray, Vice President, Marketing, Commercial Operations, and Government, Boston Scientific

Introduction

Chairman Bost, Ranking Member Takano, and distinguished members of the committee, thank you for the opportunity to testify today.

My name is Will Gray, and I have proudly been with Boston Scientific for more than 25 years. For the past 13 years, I have collaborated on the VA and DoD commercial strategy, ensuring that veterans and military personnel have access to the latest medical innovations. Prior to my corporate career, I was honored to serve as a United States Marine in the 1990s. Today, I remain dedicated to supporting the veteran community inside and outside Boston Scientific, volunteering as a mentor and advocate for veterans transitioning to civilian careers. That experience has shaped my deep respect for the VA's mission—and it's why Boston Scientific remains focused on supporting the VA and DoD through clinically proven technologies and procurement partnerships that serve those who served us.

In addition to my work with the VA and DoD, I lead our Marketing and Commercial Operations strategy for Corporate Accounts, which serves the largest and most strategic healthcare systems in the U.S. This role gives me a unique perspective on how the most advanced civilian hospitals acquire new technologies and improve patient care by focusing on the Quadruple Aim: improving efficiencies, quality outcomes, cost of care, and patient satisfaction.

Boston Scientific: A Leader in Medical Innovation

Boston Scientific, founded in 1979 and headquartered in the Boston area, is one of the world's leading medical technology companies. We employ approximately 53,000 people worldwide, with a strong U.S. presence—particularly in Massachusetts, California, Indiana, Texas, and Minnesota, where we conduct significant research and manufacturing. While we operate globally, the majority of our business is conducted in the United States, and our mission—"Advancing Science for Life"—drives us to develop minimally invasive medical solutions that improve patient outcomes, efficiency, and cost-effectiveness.

Boston Scientific has a strong connection to military service. One of our cofounders, Pete Nicholas, served in the U.S. Navy, and our other cofounder, John Abele, also has deep ties to the U.S. Navy. That legacy of service continues today, with many veterans among our workforce and an active Veterans Employee Resource Group that supports their transition and professional growth.

Our clinical teams work directly with VA providers across the country, integrating lifesaving and life-enhancing medical technologies such as cardiac stents, pacemakers, wearable cardiac

monitors, pain management implants, endoscopy and urology solutions. These devices improve veterans' quality of life, enabling them to be healthier and more active.

On a national level, Boston Scientific has also been a consistent partner with the VA. In 2017, we began working with industry partners and members of this committee to improve efficiency in the VA procurement process. These efforts led to collaboration with Rep. Jack Bergman and former committee member Rep. Scott Peters to bring clinical expertise and oversight into the Medical Surgical Prime Vendor (MSPV) Program. By placing clinicians at the forefront of contract decision-making, this initiative enabled a rolling process for new product additions. As a result, MSPV has made tremendous strides and serves as a successful model of clinically driven sourcing.

We thank the committee and VA leadership for their hard work in advancing this initiative, and we look forward to continuing efforts to expand timely access to life-saving technology for veterans.

Boston Scientific's Highlighted Technologies for Veterans

At Boston Scientific, we are committed to addressing the most pressing health challenges facing veterans with clinically proven, minimally invasive technologies. We focus on areas where innovation can significantly reduce complications, improve recovery, and lower the long-term burden of disease.

Atrial Fibrillation (AFib) and Stroke Prevention

Veterans experience a high burden of cardiovascular disease and atrial fibrillation (AFib), both of which increase the risk of stroke, heart failure, and diminished quality of life. Boston Scientific provides innovative solutions across key clinical areas.

Boston Scientific has pioneered two breakthrough solutions for AFib treatment and stroke prevention. FARAPULSE™ (Pulsed Field Ablation - PFA) is a revolutionary, non-thermal treatment for AFib that uses pulsed electrical fields to precisely disrupt faulty heart signals while protecting surrounding tissues. FARAPULSE™ significantly reduces the risk of damaging critical structures like the esophagus or phrenic nerve.[1]

For AFib patients at high risk of stroke who cannot tolerate blood thinners, Boston Scientific offers the Watchman Flex Pro™ (Left Atrial Appendage Closure - LAAC) device. This implant seals off the left atrial appendage (LAA), preventing blood clots from forming and reducing stroke risk. The minimally invasive procedure has a short recovery time and reduces reliance on lifelong blood thinners, lowering the risk of bleeding complications. By ensuring the VA can integrate these life-saving technologies more rapidly, we can provide veterans with the same advanced care available in commercial hospitals, reducing stroke-related disabilities and hospitalizations.

Cardiovascular Health and Peripheral Artery Disease

In addition to treating AFib, Boston Scientific's solutions help veterans manage other serious cardiovascular conditions. Cardiovascular disease remains one of the leading causes of morbidity and mortality among veterans. Boston Scientific has developed minimally invasive solutions that restore blood flow, prevent heart attacks, and reduce the risk of amputations. The AGENT™ Drug-Coated Coronary Balloon treats coronary artery disease by delivering a therapeutic drug directly to the artery, reducing blockages and preventing re-narrowing of the vessel after treatment.

For veterans suffering from peripheral artery disease (PAD), Boston Scientific offers advanced medical devices designed to keep arteries open longer than traditional treatments, reducing the need for repeat procedures and ultimately helping prevent limb loss and improve mobility.

Endoscopy, Urology and Gastrointestinal Solutions

Boston Scientific is also a leader in minimally invasive endoscopic, urological and gastrointestinal solutions, helping veterans receive faster, more accurate diagnoses and treatments. These cost-effective therapies allow physicians to better treat a myriad of gastrointestinal, stone management, urinary tract and numerous other conditions. We also manufacture single-use ureteroscopes, which are recommended by FDA, to prevent cross-contamination and reduce infections.

Pain Management Innovations

Many veterans suffer from chronic pain conditions, including lower back pain, neuropathic pain, and post-surgical pain. Expanding access to Boston Scientific's advanced, drug-free neuromodulation therapies within the VA can help veterans achieve better long-term pain relief, reduce opioid dependence, and enhance their ability to maintain an active lifestyle.

Why This Matters: The Case for FARAPULSE™

A prime example of how budget uncertainty and staffing challenges impact veterans' healthcare is the delayed adoption of FARAPULSE™, an innovative pulsed field ablation (PFA) technology that is transforming atrial fibrillation (AFib) treatment.

- AFib is a serious and progressive heart condition that increases the risk of stroke, heart failure, and blood clots.
- For veterans, stroke can be life-altering—leading to paralysis, loss of independence, and a diminished quality of life.
- FARAPULSE™ is a breakthrough solution that offers a safe and effective treatment option. Clinical data and real-world use found the system is not only as effective in treating atrial fibrillation as thermal options but also results in fewer unwanted side effects.[2]

Unfortunately, VA hospitals lag significantly behind civilian hospitals in access to this life-changing technology.

The Disparity Between Civilian Hospitals and the VA

In 2025, it is projected that 61% of all AFib procedures in commercial hospitals will use pulsed field ablation technology like FARAPULSE™.[3] However, in VA hospitals, only approximately 10% of the facilities that perform AFib procedures have access to this leading-edge technology.

This gap is not due to lack of clinical interest or demand but instead stems from budget unpredictability, staffing challenges, and procurement inefficiencies. We must modernize these processes to ensure veterans have access to the same life-saving advancements as civilians.

Key Issues and Proposed Solutions

1. Budget Predictability and New Technology Adoption

A structured, predictable budget and acquisition process is essential for timely adoption of life-saving medical technology. Unlike commercial hospitals with consistent annual budgeting cycles, the VA's capital allocation process is often fragmented and reliant on short-term budget solutions.

Additionally, staffing shortages in procurement roles exacerbate these challenges, leading to:

- Delays in purchasing decisions, slowing technology adoption.
- Added strain on clinical providers who depend on modern equipment.
- Reliance on outdated technologies due to prolonged purchasing cycles.

To address these challenges, we recommend:

- Implementing a structured, transparent annual budget cycle to enable better financial planning.
- Investing in procurement professionals to improve efficiency and eliminate bottlenecks.
- Mandating at least two product add periods annually for all national contracts, such as the Prosthetics and Sensory Aid Services (PSAS) IDIQ contract, to prevent widespread delays in integrating new technology.
- Creating a VA Innovation Fast Track solution for high-impact medical technologies requiring immediate integration into veteran treatment.

2. Modernizing Procurement

The VA's procurement process is highly complex, involving multiple layers of approval across procurement officers, clinical committees, and regional VISNs. While intended to ensure careful evaluation, this structure creates significant delays, that prevent veterans from receiving timely access to medical advancements.

Enhancing VA Procurement Through Clinician-Guided Strategies

The Department of Veterans Affairs (VA) operates in a uniquely mission-driven and clinically intensive environment. Many of the technologies used within the VA—particularly in cardiology, urology, endoscopy, and neuromodulation—require direct input from physicians and clinical leaders to ensure that the right products are selected for the specific needs of veteran patients. This clinician-driven approach has been instrumental in enhancing patient care by ensuring that procured products meet rigorous clinical standards and practices.

Importantly, many VA physicians also practice at affiliated academic medical centers and other commercial hospitals, where they routinely work with the most advanced technologies. To ensure consistency, safety, and continuity of care for veterans, it is essential that the VA maintain access to comparable innovations.

As procurement systems evolve, we respectfully encourage the Committee to consider how best to preserve the VA's ability to:

- Maintain clinician involvement in the evaluation and selection of medical technologies;
- Rapidly adopt innovative solutions that improve outcomes for veterans; and
- Retain the flexibility needed to meet specialized clinical needs that may not align with standardized government-wide contracts.

Programs like PSAS and MSPV have already demonstrated how clinician-led sourcing can be both thoughtful and efficient. These clinician-led programs ensure that procurement reflects real-world clinical needs and improves both care quality and resource utilization.

Progress in the Prosthetics and Sensory Aid Services (PSAS) Office

Building on that success, additional focus is needed to address persistent challenges within the PSAS program—particularly related to technology adoption timelines and administrative inefficiencies.

The Prosthetics and Sensory Aid Services (PSAS) Office plays a vital role in providing access to prosthetics and implants for veterans. Led by dedicated and reform-minded staff, the program has performed well. However, delays in adding new technologies—often ranging from 12 to 18 months—have created backlogs that slow access to the latest standards of care.

Post-procedure procurement is also inefficient, with some procedures requiring multiple purchase orders for a single supplier payment, leading to:

1. Redundant administrative work for VA staff.
2. Delays in supplier payments.
3. Inefficient allocation of resources.

To address these inefficiencies, we are working with staff to develop legislative solutions that will:

- Streamline the PSAS approval process for faster technology adoption.
- Ensure timely product updates to maintain the latest standard of care.
- Simplify supplier payment processes to improve efficiency.

By modernizing these processes, the VA can reduce delays, improve efficiency, and ensure veterans receive the best available medical innovations.

Conclusion

The VA has made tremendous strides in advancing clinically driven procurement, but further modernization is needed to ensure veterans receive timely access to cutting-edge medical solutions. By addressing budget predictability, procurement efficiency, and staffing shortages, we can eliminate delays, improve financial planning, and strengthen supply chain operations.

We share your commitment to ensuring that veterans receive the highest standard of care. With continued collaboration, we can modernize systems, eliminate delays, and deliver the medical innovations our veterans deserve.

Thank you, and I welcome any questions.

Best Regards,

Will Gray

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Prepared Statement of Jon Bloom

Testimony before the United States House of Representatives

Committee on Veterans' Affairs Hearing on Harnessing Biomedical Innovation: Modernizing VA Healthcare for the Future

April 1, 2025

Statement of Dr. Jon Bloom, Co-Founder and Chief Executive Officer, Podimetrics

Chairman Bost, Ranking Member Takano and distinguished Members of the Committee,

Thank you for offering me the opportunity to testify regarding the lifesaving work we do every day for our Veterans, their families, and caregivers at Podimetrics.

My name is Dr. Jon Bloom, co-founder and Chief Executive Officer of Podimetrics. As a physician and the son of a decorated Vietnam combat Veteran, I am proud to state we have built our company from the bottom up, in partnership with the Department of Veterans Affairs (VA), to improve Veterans' health from needless and costly amputations.

Executive Summary

Diabetic foot ulcers (DFU), a complication of type 2 diabetes, are costly and deadly. Given the diminished sensation and blood flow into the lower limbs of patients affected by type 2 diabetes, a DFU often presents silently, with the Veteran unaware of the severity until the wound is infected, life-threatening, and requires emergent surgical intervention, generally an amputation. For this particular complication, early detection and prevention is key.

DFUs cost VA $3.2 billion every year. The 5-year mortality rate for veterans with diabetic foot ulcers (DFU) exceeds 70%, a rate higher than most cancers To combat the tremendous costs of DFUs, the Veterans Health Administration (VHA) launched a promising practice that incorporates the use of remote temperature monitoring in the prevention of DFUs and amputations.

As part of this program, VHA partnered with Podimetrics to deploy the Podimetrics SmartMat Program to thousands of at-risk Veterans, resulting in major reductions in lower extremity diabetic amputations. By March 2024, VHA estimated the program saved U.S. taxpayers $99.9 million in unnecessary medical care even though fewer than 6% of clinically eligible Veterans had been enrolled in the program for at least one year.

If VHA expanded this program to reach all Veterans who are at greatest risk of amputation, the Department would see cost savings projected at $1.78 billion and would save approximately 5,000 Veteran lives, in the first year alone.

Despite strong clinical outcomes and significant healthcare savings demonstrated by VHA's own data, as well as broad support among both VHA providers and leadership, the Department has encountered persistent challenges in scaling this promising practice to enroll the approximately 110,000 highest-risk Veterans in remote temperature monitoring.

The Unsustainable Toll of Diabetic Foot Ulcers Among Veterans

Diabetic foot complications represent an enormous human and financial burden among our nation's Veterans. A staggering one-in-four Veterans suffer from diabetes, over twice the rate of this disease among non-Veterans in the United States.[1] It is estimated VHA treats approximately 110,000 Veterans at greatest risk of DFU each year and in 2022 this accounted for $3.2 billion in direct medical costs alone.[2] 85% of lower limb amputations are preceded by a DFU,[3] robbing Veterans of their independence and placing them at significant health risks downstream. A single amputation can cost as much as $100,000.[4]

The mortality rate is staggering. Seventy one percent of Veterans with a DFU will die within five years, making it deadlier than most cancers.[5]-

Prevention of DFUs Through Foot Temperature Monitoring

The use of temperature monitoring to identify DFUs prior to their development is not a new practice and was first cited in the 1970s. Between 2004 and 2007, three randomized controlled trials funded by the National Institute of Health were published demonstrating a 71% reduction in annual incidence by employing early offloading (reduced step count) at the first sign of increased, localized foot temperatures.[6-8] *Nearly 3 out of 4 ulcers were prevented!*

As a result, the use of temperature monitoring is now recommended as best practice by the American College of Foot & Ankle Surgeons, the Wound Healing Society, the International Working Group on the Diabetic Foot, and the U.S. Agency for Healthcare Research & Quality (7-10).[9-12] However, despite its recognition as best practice and inclusion in multiple clinical practice guidelines, adoption of temperature monitoring solutions was negligible due to poor patient ease-of-use and the absence of Medicare reimbursement.

Company Founding and Partnership with VHA

Podimetrics was founded in 2011 by a team from the Massachusetts Institute of Technology, Harvard University, and Stanford University, who worked to solve the challenges with existing temperature monitoring devices. As a physician, prior to co-founding the company, I spent far too many days in the operating room participating solely in lower limb amputations due to DFU.

After multiple usability studies, we launched the Podimetrics Remote Temperature Monitoring System, which includes the Podimetrics SmartMat, a home-based medical device that looks for signs of inflammation within the feet, which may signal a developing DFU or foot infection. The device is FDA cleared and is manufactured in the United States. The SmartMat is easy to use –

requiring only 20 seconds of contact (i.e., standing on the SmartMat) per day from the comfort of the Veteran's home – and transmits the data securely for analysis without the need for WiFi or a mobile device.

Our journey as a company would not have happened without the partnership and collaboration with VHA. In 2017, a groundbreaking clinical trial led and published by VHA clinicians found the SmartMat technology/program correctly identified 97% of DFUs on the bottom of either or both feet an average of 37 days prior to clinical presentation, owing to strong patient engagement.[13]

By 2020, based on promising quality improvement data from two VA Medical Centers (VAMC), VHA's Innovation Ecosystem partnered with Podimetrics to pilot this solution and launched The Initiative to End Diabetic Limb Loss, which supplied at-risk Veterans with SmartMats. The program integrated under VHA's telehealth podiatry services nationally under the leadership of Dr. Jeffrey Robbins, VHA's National Chief of Podiatry, and Suzanne Shirley, former Director of Strategic Partnerships within VHA's Office of Healthcare, Innovation & Learning. Thanks to this committee's leadership and funding from the 2020 CARES Act, $7 million was made available to pilot a remote temperature monitoring program.

VA investigators subsequently evaluated the results of the nascent program for 924 Veteran participants from 2019 - 2021.[14] The study showed a remarkable 37% reduction in mortality within 12 months alone, equating to one Veteran's life saved for every 23 Veterans who participated.[15] Though the study was equivocal on amputations and hospitalizations, the mortality reduction was not surprising given the alarmingly high 71.4% five-year mortality rate for Veterans who suffer from a DFU.[5]

The success of The Initiative to End Diabetic Limb Loss led to the development of VHA's current Remote Temperature Monitoring (RTM) Program with the goal of increasing the adoption of this lifesaving preventive care at VA healthcare facilities across the nation. This has allowed for improvements to clinical protocols and standardization of care over time. In a March 2024 briefing to the U.S. Senate Military Construction and VA Appropriations Subcommittee, with fewer than 6% of clinically eligible Veterans enrolled through the prior twelve months, VHA estimated the program saved US taxpayers $99.9 million in unnecessary medical care even though fewer than 6% of clinically eligible Veterans had been enrolled in the program for at least one year.[15]

The Opportunity to Serve More Veterans

The feedback from VHA providers and Veterans has been overwhelmingly positive. In a recent survey of 132 VHA providers who have prescribed the Podimetrics SmartMat program, 100% responded they would recommend the program to other VA healthcare centers and providers, and 99% would recommend the program to new Veteran patients.[16] Similarly, in a recent survey of 1,527 Veterans utilizing the SmartMat, 93% responded as either "satisfied" (22%) or "very satisfied" (71%), with an average satisfaction score of 4.6 out of 5.[16]

While Podimetrics partnership with VHA's RTM Program has made significant progress in lowering amputations among Veterans and saving taxpayers millions of dollars, more work needs to be done to ensure this clinically proven model is accessible to those Veterans who are most vulnerable. A number of challenges have been observed by both VHA leaders and clinical staff.

First, at-risk Veterans do not have equal access to the RTM Program. A recent study by VA investigators demonstrated VHA facilities that participated in the RTM Program were disproportionately urban and served Veterans with better access to care.[17] Furthermore, enrolled Veterans within a given participating VAMC had shorter drive-times to specialty care and were less likely to be low income.[17] This represents a barrier to access of best practice at both the regional and program level that dramatically limits the savings and mortality benefit to our Veterans.

Second, not surprisingly, prescribing clinicians are overwhelmingly VHA Podiatrists (Doctors of Podiatric Medicine) owing to their training, their awareness of the program, and current procurement guidelines. Unfortunately, only half of currently eligible Veterans are receiving their podiatric care within the VA healthcare system, and as a result, never get offered the RTM Program. This acts as a substantial barrier for Veterans at the cost of considerable taxpayer dollars and human life.

Third, siloed budgets challenge VHA's ability to rationally control clinical spending. For example, while SmartMats are covered and managed by the Prosthetics & Sensory Aids Services (PSAS), the primary beneficiary of the clinical savings is Medical Care via reductions in inpatient and outpatient utilization, surgical costs, and more. The program now becomes a source of cost to PSAS – often at the facility level – which serves as a large barrier to savings and outcomes improvement. VHA facilities have cited they do not have the financial resources to support expansion of the preventive program.

Fourth, VHA operates with the same incentive structure as fee-for-service health systems. Facilities with higher caseloads receive greater funding than facilities with lower caseloads, even if the reduction in volume is solely due to increased preventive care. Similarly, clinicians with higher workload credit have greater job safety than clinicians with lower workload credit. *The challenge is that the workload or volume credit for an amputation in the operating room vastly exceeds the credit for the prevention of an amputation (or a hospitalization, etc…).* Until workload credit for proven preventive practices are appropriately incentivized, delivering preventive care is not viable.

Lastly, given the requirement to maintain adequate work volumes, VA facilities often report a self-limited size of their program due to insufficient clinical support resources. In the absence of changes to the incentives for prevention as mentioned above, additional staff may be required at the VISN level to ensure efficient program management for facilities. However, the hyperbolic statement one can make is that the VA Healthcare system already has all the staff it

needs to deliver preventive care; clinicians are just too encumbered providing treatment for complications they could have prevented.

Conclusion

The potential to fully deploy VHA's RTM Program to all eligible Veterans in just one year has the potential to save taxpayers an estimated $1.78 billion.[15] This is in addition to the 5,000 lives saved.[14]

VHA and Podimetrics' collaboration on this program is proof that the agency can deliver considerable cost savings for American taxpayers without sacrificing the integrity of the healthcare services available to our Veterans.

Those who wore the uniform of our nation should not walk into a VA hospital one day and leave the next in a wheelchair – or worse – especially when we possess the technology and capability to change this outcome.

Thank you for the opportunity to testify today. I look forward to answering any questions you may have.

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Prepared Statement of Jeff DiLullo

PHILIPS

STATEMENT OF

JEFF J. DILULLO

CHIEF EXECUTIVE OFFICER

PHILIPS NORTH AMERICA

BEFORE THE

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS' AFFAIRS

ON

"HARNESSING BIOMEDICAL INNOVATION: MODERNIZING VA HEALTHCARE FOR THE FUTURE"

APRIL 1, 2025

Chairman Bost, Ranking Member Takano, and distinguished members of this critical committee, it is a profound honor to appear before you today. My name is Jeff DiLullo, and I have the privilege of serving as the Chief Executive Officer (CEO) of Philips North America, leading a dedicated team of close to 17,000 professionals. I'm proud to share that 17 percent of the team I lead in this region are veterans.

Philips is committed to advancing medical technology with one unwavering purpose: **improving lives**. We are driven by innovation, expanding access to quality care, and ensuring that every solution we develop is built from the ground up with patient safety and quality at its core. For over 50 years, Philips has been a steadfast partner to the U.S. Department of Veterans Affairs (VA), working to break down barriers to healthcare, deliver cutting-edge solutions, and ensure that those who have sacrificed for our country receive the world-class care they have earned. Today, when a veteran walks into a VA Medical Center (VAMC), it is highly likely they will interact with a Philips device; from a patient monitor, heart monitor, ultrasound device, Magnetic Resonance Image (MRI), Computed Tomography (CT), or more. Philips is proud of our deployment of technology at VA, which actively helps deliver superior healthcare.

The matter before us today—leveraging innovation to better serve our nation's veterans—is not just policy; it is a moral imperative. We must get this right. The VA must have the resources, the tools, and the capabilities to deliver the best possible care, as quickly as possible, to those who selflessly wore the uniform of the United States of America.

For me, this mission is deeply personal. I served as an Army Ranger and am a proud graduate of the United States Military Academy at West Point. But more important, I am a proud military father. Every morning, my daughter puts on the uniform of the U.S. Army, answering the same call to serve. One day, like so many who came before her, she will transition to veteran status and rely on the VA for healthcare. This work is not just business for me—it's personal.

History of Innovation & Partnerships at Philips

For over 100 years, Philips has been driving innovation across various domains of healthcare, ensuring that patients receive the highest quality of care. One of the key areas where Philips has made significant strides is in diagnostic imaging. Technologies such as advanced MRI, CT, and ultrasound systems developed by Philips have revolutionized the way diseases are detected and monitored, enabling earlier and more accurate diagnoses across the globe. These innovations improve patient outcomes and enhance the efficiency of healthcare providers by reducing the time and costs associated with diagnostic procedures.

In addition to diagnostic imaging, Philips is a leader in patient care solutions. We have developed cutting-edge patient monitoring systems that provide real-time data to healthcare professionals, allowing for timely interventions and better management of critical conditions. Philips' telehealth solutions have also expanded access to healthcare, particularly in remote and underserved areas, by enabling virtual consultations and remote monitoring. Furthermore, Philips' health informatics platforms integrate data from various sources to provide comprehensive insights into patient health, facilitating personalized treatment plans and improving overall care coordination.

Since 2020, Philips has led the Tele-Critical Care (TCC) program at the VA, where we empower the clinical staff of VAMCs to use tele-health to remotely monitor VA patients in Intensive Care Units (ICU) across the VA network. With nearly 92%[1] of VA facilities identifying clinical staffing vacancies, especially in more remote and suburban areas and within medical specialties, having the ability to leverage VA staff from other, more robustly staffed facilities, is critical to delivering timely healthcare.

Before exploring additional technology that would assist the VA in delivering on America's promise to care our nation's veterans, it is vital to understand that Philips is engaged with other federal agencies as well. Philips is proud to leverage our experiences and lessons learned elsewhere to benefit the VA. For example, in concert with the Department of Defense

(DOD),[2] Philips innovated the Rapid Analysis of Threat Exposure (RATE) technology, which is a groundbreaking Artificial Intelligence (AI) early warning system designed to detect infectious diseases before symptoms appear. Philips RATE leverages off-the-shelf wearable devices, such as an Oura ring or a Garmin watch, to monitor nearly 150 different vital signs and biomarkers of our active duty servicemembers, to identify subtle physiological changes that may indicate infection.

This type of innovation and technology has proven effective in predicting infections up to 48 hours before symptoms manifest. By providing early alerts, Philips RATE helps to contain the spread of diseases, ensuring better health outcomes and enhancing military readiness. In a military context, Philips RATE can digitize the health of our military force, giving battlefield commanders the ability to see the health and fatigue status of the warfighters, which ultimately leads to a more lethal military force. In a clinical setting, such as an ICU unit at a VA medical center, Philips RATE can help to ensure the clinical staff remain healthy and prevent them from spreading illness to immune compromised veteran patients.

Philips and the medical technology industry have continued to innovate and have many capabilities, today, that can modernize VA healthcare for the future. These are innovations that can better assist the VA in reducing clinical burnout, bring care closer to veterans and increase efficiencies that allow clinicians to spend more time with the patient and bring the best possible care to our nation's veterans. Additionally, we are thankful for the opportunity to share recommendations on how this Committee can support the VA in streamlining procurement to speed the pace of innovation at the VA.

We are all here for the same reason – we share a passion for bringing the best possible healthcare to our nation's heroes. We believe that taking these steps will bring better healthcare outcomes for veterans, streamlined clinical workflows for clinicians and a more efficient federal agency for the American Taxpayer.

Modernizing VA Healthcare for the Future

MODERNIZING CARE DELIVERY with VIRTUAL NURSING

The Department of Veterans Affairs has successfully implemented its enterprise-wide TCC Program, formerly known as Tele-ICU, to support high-acuity patients in intensive care units across the VA healthcare system. Powered by Philips, this program has established a robust and secure infrastructure that enables remote critical care nurses and intensivists to provide real-time decision support and timely interventions for bedside clinical teams. The success of the TCC Program showcases the VA's capability to leverage virtual care technologies to improve patient outcomes and enhance the quality of care for veterans in critical settings.

The VA can build on this success by expanding virtual nursing support to lower-acuity care settings, such as medical-surgical units, stroke units, and emergency departments (EDs), which would offer more resources to clinicians and certainly yield better care for the 9.1 million veterans utilizing the largest healthcare network in America. These areas require timely intervention and monitoring. Without a nationwide Virtual Nursing and Sitter Services program, bedside nurses face increasing workloads that can lead to burnout and potential delays in patient care. In critical situations, like stroke units and EDs, early intervention can be the deciding factor between recovery and long-term disability. Virtual Nursing could provide essential clinical oversight, ensuring timely assessments, medication reconciliation, and discharge planning support – all of which contribute to improved patient outcomes and reduced hospital re-admissions.

Failing to extend Virtual Nursing beyond the ICU could pose significant risks for the VA. Without a structured program, the ability to monitor and intervene proactively for patients at risk of deterioration is limited, increasing the likelihood of preventable complications and adverse events. Staffing shortages further strain bedside nurses, resulting in longer wait times and inefficiencies in patient care. Additionally, the lack of a standardized approach leads to

disparities in care quality, as some facilities may implement fragmented virtual care solutions without the benefit of a cohesive strategy.

By learning from the TCC program, the VA can develop a lower-acuity **Virtual Nursing program** that leverages existing technology and infrastructure. Such a program could relieve on-premises and overworked nursing staff of time-consuming tasks, allowing the VA to leverage and extend the skills of clinicians in critical, specialty, or lower-acuity care settings regardless of location by providing support in areas like triage, admission assessments, patient rounding, and medication reconciliation. Leveraging its existing telehealth infrastructure and integrating with Electronic Health Records (EHR) systems, the VA can provide remote clinical decision support in real-time. A nationally managed platform would standardize virtual care solutions across the VA, enabling experienced nurses to offer remote assistance, enhance clinical collaboration, and improve patient monitoring. This proactive investment in virtual care would lead to better patient safety, reduced hospital complications, and increased staff satisfaction, ensuring that veterans receive high-quality care while optimizing the efficiency of the VA's resources.

EXTENDING RADIOLOGICAL EXPERTISE at VA

Currently, the way the Department of Veterans Affairs manages its radiology departments is with each department relying primarily on its own resources and expertise. This isolation is a significant disservice to veteran patients, as it prevents them from benefiting from the clinical skill sets of radiology staff at other facilities and is an antiquated way of practicing medicine. Often, new or less experienced radiology technicians have questions about operating complex equipment, capturing different types of images, or how to adjust patients to achieve better-quality scans, particularly during late night or holiday shifts. In these situations, the lack of access to experienced specialists can lead to delays in care and potential quality issues. Without the ability to collaborate and leverage expertise across VA facilities, veterans—especially those in rural or understaffed areas—may not receive the timely and high-quality care they deserve.

Creating a network that connects all VA radiology departments would allow facilities to share resources and expertise whenever needed, ensuring a more consistent standard of care for all veterans. By implementing a centralized network or system, the VA could facilitate real-time support and training opportunities for staff, enabling them to consult with specialists across the system when they encounter challenges. This collaboration would greatly enhance the quality of radiology care, particularly for veterans in rural and understaffed facilities, ensuring they receive the same level of expertise and attention as those in larger urban centers.

In addition to improving the diagnostic process, this network would streamline workflows, reduce wait times, and minimize the need for repeat imaging, all of which would contribute to better overall veteran patient satisfaction. By harnessing advanced technology and fostering collaboration, the VA can create a more efficient radiology service that meets the needs of all veterans. The VA has demonstrated its expertise in deploying and leveraging this kind of virtual care platform with the success of the TCC program. Applying this approach to radiology, veterans in underserved areas would gain access to the "big city level of care," significantly improving their diagnostic experiences and health outcomes while ensuring that no veteran is left behind in receiving the care they rightfully deserve.

The **Philips Radiology Operations Command Center** (ROCC) is an innovative solution that brings together imaging experts and technologists from various VA locations to work more effectively and collaboratively. This FDA-cleared remote scanning platform allows radiological specialists in a central command center, located at a VAMC, to connect with technologists operating imaging machines in real-time. The ROCC allows and enables VA clinicians to communicate, talk, and even video call each other, which means experts can remotely view and fine-tune imaging exams while seeing the scanner's controls at the same time. This approach not only improves the quality of images but also ensures more accurate diagnoses and a smoother workflow, all while ensuring patient privacy and safety remains a top priority.

Implementing the ROCC, or a similar system, in the VA, would greatly benefit both healthcare providers and veteran patients. With real-time expert support, the need for repeat imaging is reduced, diagnoses are sped up, and patient care improves overall. For the Imperial College Healthcare, an organizational unit within the National Health Services (NHS) of Wales and England, ROCC has doubled training speed and capacity to 2 radiographers trained per session instead of 1, yielding a 133% increase in the number of radiographers trained on MRI Cardiac Stress Imaging within 4 weeks. With ROCC, 40% of exams resulted in removal of unnecessary sequences, shortening the exam and optimizing the patient experience. ROCC has also provided 11% reduction (7 minutes) in the average scan time for routine Cardiac MRI exams, as well as a 9% reduction (6 minutes) in the average scan time for complex Cardiac MRI Stress perfusion exams. Imperial College of Healthcare has seen a 0% recall rate for ROCC-aided exams and a 54% reduction in overall recall number year-over-year (YoY). This system also helps ease staffing shortages by allowing one radiology expert to assist multiple locations, making sure even rural or underserved facilities have access to top-notch imaging expertise. Moreover, the platform provides valuable on-the-job training for technologists, enhancing their skills and ultimately enabling the VA to deliver faster, more accurate, and efficient care to veterans across the country.

MODERNIZING CANCER DIAGNOSIS with DIGITAL PATHOLOGY

Being told you might have cancer is one of the most terrifying moments any patient can face, especially veterans, who often experience a heightened risk due to hazardous exposures during their service. The uncertainty and fear that comes with this moment absolutely requires a swift and accurate diagnosis.

At the heart of cancer diagnosis is the pathologist, the first line of defense in identifying malignancies. Today, most pathologists still place a biopsy between two pieces of glass creating a slide that is then examined under a microscope. As a result, the diagnostic process remains slow and inefficient, delaying treatment for patients in urgent need of answers. For veterans, the stakes are high. The VA has found that veterans face a 25-to-76 percent higher

risk of certain cancers due to service-related exposures, making timely diagnoses even more critical.

Compounding these challenges, VA policy requires that any potential cancer biopsy be reviewed by two pathologists from different VA hospitals. This mandate necessitates the physical transportation of biopsy slides between facilities, often hundreds of miles apart, further delaying diagnoses and preventing timely intervention. These delays can be agonizing for veterans and their families, who are left waiting in uncertainty, while their condition may worsen.

One of the most promising advancements transforming the pathology field is the complete digitization of the pathology process. **Philips Digital Pathology** is revolutionizing disease diagnosis by allowing pathologists to analyze high-resolution digital slides remotely and in real-time collaboration. Digital Pathology enhances efficiency, collaboration, and accuracy by seamless data sharing. The result is accelerated workflows, and better patient outcomes—particularly for those facing life-threatening conditions.

Philips has formed a strategic partnership with Ibex to drive innovation in this space and to globally commercialize clinically proven, AI-powered digital pathology solutions. This partnership improves reporting efficiency by 27%, driving 37% productivity gains, improving consistency and accuracy, and enhancing diagnostic confidence to catch cancer in its earliest stages.

Today, Philips Digital Pathology is a solution being used by leading academic medical centers like NYU Langone and Stanford Medicine. It is already operational in 44 of the 170 VA Medical Centers, delivering measurable benefits by reducing the time veterans and their families must wait for critical diagnoses. However, like many technology adoptions within the VA, implementation has been incremental, spreading facility by facility as clinicians witness and share its impact firsthand.

PACT ACT & FOUR-DIMENSIONAL PULMONARY SCREENINGS at VA

Every day, thousands of veterans struggle with undiagnosed and untreated breathing problems, grappling with symptoms like shortness of breath, cough, and wheezing. Traditional diagnostic tests, such as Pulmonary Function Tests (PFTs) and standard imaging, often fail to identify the underlying causes of these symptoms, leaving our heroes to suffer in silence. The surge in beneficiaries under the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxins (PACT) Act has only intensified this crisis, overwhelming an already strained system with limited providers and testing availability. As a result, veterans and their families experience delays in diagnosis and inadequate care, undermining the sacrifices they have made for our nation.

Currently, patients with undiagnosed shortness of breath or dyspnea often face a diagnostic journey spanning 18to-24 months and involving multiple tests – including PFTs, chest X-rays, and CT scans. For severe cases, this journey may involve invasive open lung biopsies that come with costs up to $30,000, on top of the long recovery period for the patient. This approach is not only daunting for our veterans, but it also highlights the urgent need for less invasive diagnostic options.

Acknowledging the need for faster, affordable, and less invasive ways to identify and diagnose lung disease, Philips, in concert with our partner, 4DMedical, innovated an FDA-cleared **cardiopulmonary software** that can transform standard CT imaging into a detailed four-dimensional image. This advanced technology allows VA clinicians to better assess pulmonary function and leads to faster diagnoses and less invasive procedures. By leveraging this four-dimensional lung screening, VA can improve health outcomes for veterans and reduce dependency on taxpayer resources.

This innovation empowers clinicians by providing tools to quickly assess lung health and prioritize those needing specialized care. Philips, in partnership with 4DMedical, is committed to transforming the way we diagnose and treat respiratory conditions in veterans.

The platform plays a key role in aiding clinicians in the diagnosis, particularly for veterans, helping with the early detection of conditions like chronic obstructive pulmonary disease (COPD), deployment-related respiratory disease (DRRD), interstitial lung disease (ILD), asthma, pulmonary fibrosis, and lung cancer

This non-invasive approach reduces costs associated with unnecessary procedures, accelerates diagnosis and expedites treatment, significantly enhancing the overall patient experience. The impact is so profound, we have heard stories of veterans seeking out this technology on their own, outside of VA provided care, and at their own personal expense. For instance, a case study involving a 41-year-old veteran with a history of deployment to Iraq showcased how the four-dimensional scan provided critical insights after nearly two decades of inconclusive testing, validating symptoms and confirming a likely diagnosis of DRRD without invasive procedures.

By embracing advancements like this four-dimensional lung screening, utilizing the Philips CT, we are exemplifying the textbook definition of modernizing healthcare at the VA and leaning into the future—all for the benefit of our nation's veterans. We must continue to champion these technologies to ensure that every veteran receives the timely and effective care they rightfully deserve.

CREATING a TELE-ULTRASOUND NETWORK & LEVERAGING EXPERTISE at VA

The Department of Veterans Affairs currently faces a significant challenge due to the lack of access to ultrasound experts, which impacts the quality of care provided to veterans. The absence of a nationally deployed Tele-Ultrasound Program limits the ability of clinicians and sonographers to collaborate in real-time, receive immediate support, and access live training. As a result, many ultrasound exams are performed without the benefit of specialized guidance, leading to delays in diagnosis, workflow inefficiencies, and an increased need for repeat imaging.

In 2021, the VA's Market Area Health Systems Optimization (MAHSO[3]) initiative developed 96 draft market assessments across the 18 VA Veterans Integrated Service Networks (VISNs). These assessments were part of the VA Maintaining Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, which aimed to identify opportunities for improving healthcare delivery. One key recommendation from the September 2021 report emphasized the need for designating and equipping select clinic exam rooms with advanced telehealth technology, including ultrasound equipment, to enhance telehealth services.

In 2024, VISN 17 acquired Philips Collaboration Live tele-ultrasound solution for a Point of Care Ultrasound (POCUS) Training Program. Collaboration Live is currently being used to remotely train VA clinicians on tele-ultrasound. There remains significant potential to expand this program and extend it to clinical use cases.

Without a secure and integrated tele-ultrasound solution, VA clinicians and sonographers struggle with limited access to remote imaging experts, decision support, and training opportunities. This lack of resources negatively impacts diagnostic accuracy and patient outcomes, leading to longer wait times for specialist input and increased reliance on repeat imaging due to suboptimal scans. Furthermore, staffing shortages and the absence of on-demand training resources hinder VA clinicians' ability to stay current with evolving ultrasound techniques and best practices.

Implementing a secure, real-time tele-ultrasound solution would dramatically enhance clinical collaboration, improve workflow efficiency, reduce costs, and ultimately provide veterans with better, faster, and more precise care. By leveraging advanced technology, the VA can ensure that all clinicians have the support they need to deliver high-quality ultrasound services, regardless of their location.

Philips Point-of-Care Ultrasound (POCUS) with **Collaboration Live** is a groundbreaking tele-ultrasound solution that significantly enhances real-time communication and

collaboration among healthcare professionals. Integrated directly into Philips ultrasound systems, it allows VA clinicians and technologists to connect instantly through secure text chat, audio calls, webcam video sharing, screen sharing, and remote system control—all without the need for extra software or hardware. This seamless connectivity ensures that our dedicated healthcare providers can access remote expertise in an efficient manner, improving the quality of ultrasound exams, training, and service support.

For the VA healthcare system, POCUS offers vital benefits that directly impact the care of our veterans. It enables faster and more accurate diagnostics, enhances clinician training, and minimizes system downtime. With remote consultations, imaging specialists can provide real-time decision support, elevating the speed and quality of care that veterans receive. On-demand training keeps Veterans Health Agency (VHA) clinicians up to date with the latest protocols while keeping costs manageable.

Built on Philips' secure Reacts cloud-hosted platform, Collaboration Live prioritizes data security and patient privacy. The system does not collect or store any patient data, and screen-sharing sessions automatically remove sensitive information to comply with VA security standards. With a user-controlled, encrypted access model, this platform is a safe and effective way to expand the VA's ultrasound capabilities. It empowers our clinicians to deliver faster, more precise, and higher-quality care for veterans across the nation, enhancing the healthcare experience for those who have served our country.

Deploying a VA enterprise-wide Tele-Ultrasound program would transform the way ultrasound services are delivered, resulting in faster, better care for our veterans. By streamlining clinical workflows, ultrasound clinicians can work more efficiently and effectively, ensuring that patients receive timely diagnoses and treatments. In addition, this program would likely lead to cost savings for the VA and American taxpayers by reducing the need for repeat imaging and optimizing resource utilization. A 30-patient study demonstrates that Collaboration Live enabled 100% of patient consultations to be conducted using tele-health; these patients felt they had better access to healthcare through tele-health delivered

with Collaboration Live. This study also confirmed that physician assessment found that 90% of consultations were equivalent to an in-person visit.[4]

VA NATIONAL ENTERPRISE IMAGING SYSTEM

The Department of Veterans Affairs currently relies on multiple disconnected, on-premises imaging systems across its VISNs and VAMCs, and various diagnostic specialties. This fragmented approach makes it difficult for healthcare providers to efficiently store, retrieve, and share medical images such as X-rays, MRIs, and ultrasounds. Each medical specialty, such as radiology, cardiology, pathology, point-of-care ultrasound, dental imaging, ophthalmology, endoscopy, clinical video, radiation oncology and dermatology, relies on its own distinct Picture Archiving and Communication System (PACS), with no standardized imaging platform across the VA.

As a result, these disparate systems hinder integration, complicating imaging exchange, artificial intelligence deployment, and long-term image archiving. In some cases, such as radiology, standardization is required at the VISN level, but with 18 VISNs nationwide, significant variation still exists. In other specialties like cardiology, each of the 170 VAMCs independently procures its PACS, further exacerbating inconsistencies. This lack of interoperability places an undue burden on clinicians, making it difficult to access, manage, and collaborate on medical imaging across specialties and geographic locations—ultimately impacting the quality of care provided to our nation's veterans.

The lack of a unified imaging system leads to delays in patient care, inefficiencies in clinical workflows, and inconsistent data across facilities. This fragmentation also hampers interoperability with the DOD and community healthcare providers. As a result, veterans receiving care outside VA must often transport their diagnostic images via film or compact disc due to the absence of a national enterprise imaging system which facilitates bilateral image exchange.

With the VA handling over 25 million imaging studies (exams) annually, its outdated on-premises infrastructure cannot keep pace with the growing demand. Modernization efforts require migrating approximately 80 petabytes of imaging data to a cloud-enabled platform capable of supporting over 90,000 concurrent users, integrating AI-driven automation, and maintaining compliance with security and regulatory standards. Without a scalable, vendor-neutral, and AI-enhanced enterprise imaging solution, the VA risks continued inefficiencies, higher costs, and compromised care for millions of veterans who depend on timely and accurate medical imaging.

To provide veterans with the highest standard of care, the VA should modernize its imaging infrastructure to enable seamless data sharing across its facilities, the DoD, and community healthcare providers within the Community Care Network (CCN). The **Philips Image Management System** offers a scalable, AI-enabled platform that integrates imaging data across clinical specialties, improving access, management, and analysis of high-resolution clinical images and scans. The Philips Image Management System enhances clinical collaboration, optimizes workflow efficiency, and increases diagnostic accuracy while ensuring interoperability through advanced visualization, health imaging exchange, and multimodal data integration.

Philips has already demonstrated its ability to scale effectively within the VA; currently, nine of the VA's 18 VISNs have standardized on Philips radiology PACS. Additionally, 77% of VA facilities rely on Philips imaging clinical application platforms, while 65% of VHA facilities utilize Philips cardiovascular informatics solutions. By adopting the Philips Enterprise Imaging Solution, or a similar technology from another vendor, the VA can potentially eliminate the inefficiencies of disconnected imaging systems, ensure faster and more accurate diagnoses, and provide veterans with the seamless, high-quality healthcare they deserve.

Streamlining & Modernizing VA Procurement

For leading healthcare technology innovators like Philips, the process of introducing cutting-edge products and solutions into the VA healthcare system is significantly slower than in the private sector. In our experience, the VA typically takes 18 months to procure new medical imaging equipment and an additional 24 to 36 months to deploy that equipment for clinical use. **As a result, the total time from when a VISN or VAMC submits a request for new imaging equipment to when it's available for veterans' care often exceeds three years**.

Consequently, breakthrough advancements in biomedical equipment are usually not implemented in the VA until they are already common in commercial healthcare, stifling innovation, limiting veterans' access to cutting-edge technology, and creating inefficiencies. Medical imaging technology encompasses diagnostic equipment such as MRI systems, CT scanners, and X-ray machines, as well as therapeutic tools like Image Guided Therapy (IGT) labs used for cardiac procedures, stroke treatment, and surgeries. Additionally, biomedical equipment includes crucial devices like physiological monitors, anesthesia machines, ventilators, and health IT applications that provide lifesaving support and real-time decision-making capabilities. However, veterans often lack access to the latest diagnostic, therapeutic, and monitoring technologies due to several inefficiencies in the VA's procurement and deployment processes.

The VA's procurement path for medical imaging technology typically goes through the VA National Acquisition Center (NAC), where requirements from VISNs and VAMCs are consolidated into a few large procurements each year. While this strategy aims to create competition and lower costs through volume discounts, the consolidation process places a heavy burden on clinical, biomedical engineering, and procurement staff, leading to delays as one requirement can hold back an entire group. This lengthy procurement timeline—averaging 18 months—means the VA rarely obtains the most innovative technology.

Moreover, the cumbersome Federal Risk and Authorization Management Program (FedRAMP) process complicates the integration of new medical technologies. Equipment manufacturers must secure FedRAMP authorization to connect their solutions to the VA's IT infrastructure. This process is often confusing and costly, particularly for IT cloud solutions, resulting in delays as VA clinicians and industry partners navigate regulatory challenges. FedRAMP was established to ensure cloud computing services meet rigorous security standards, but its complexities can hinder timely access to necessary innovations.

Funding and accounting practices within the VA also interfere with the efficient deployment of newly procured medical equipment. Different funding sources, such as Medical Services appropriations for equipment purchases and Medical Facilities appropriations for construction, may not align, causing further delays in installation. Additionally, the management of capital funding versus operating funding complicates decisions regarding buying versus leasing equipment.

To improve the situation, best practices should be adapted with the needs of veterans, caregivers, and clinicians in mind. Collaborating more effectively with industry can lead to quicker implementation of innovative technologies, ensuring veterans receive timely and compliant care. For medical equipment procurements, commercial Group Purchasing Organizations (GPOs) streamline processes by offering clinicians a choice of several vendors for various technology categories, which expedites decision-making and reduces costs through volume purchases.

Congress can modernize and enhance flexibility within the VA procurement process by streamlining the FedRAMP authorization process for clinical IT solutions, simplifying the NAC consolidation process for acquiring advanced medical imaging technology, and exempting the VA from Federal Acquisition Regulation (FAR) Part 16. This exemption would enable VAMCs to select from a pre-awarded list of preferred vendors under Multiple Award Contracts. Additionally, amending 41 U.S.C. § 4106(c) to exempt innovative solutions

in healthcare settings from stringent regulations would allow for vendor selection based on clinical judgment and proper justification.

FAST TRACK to BREAKTHROUGH INNOVATION at VA

The VA has a proud history of innovation that has transformed patient care and improved the lives of veterans. In fact, the VA played a pivotal role in developing the first-ever pacemaker, successfully implanted in 1958, which revolutionized cardiac care. The VA is also credited with creating Tylenol (acetaminophen), a safer pain relief option that has become a cornerstone of modern medicine. Furthermore, the VA has advanced prosthetics, designing modern artificial limbs that greatly enhance mobility and quality of life for veterans. In recent years, the VA has taken significant strides in telehealth, expanding access to healthcare for veterans, especially in rural areas.

The Office of Healthcare Innovation and Learning (OHIL) leads the VA's efforts to develop and implement new healthcare solutions, services, and funding models that align with its mission to provide exceptional care to Veterans. OHIL comprises three core programs: SimLEARN, which includes the National Simulation Center, the VHA Innovation Ecosystem, and the Center for Care and Payment Innovation. Together, these programs form a collaborative team that has successfully designed, developed, tested, and scaled numerous healthcare innovations across the VA. Additionally, OHIL is part of the VHA Discovery, Education, and Affiliate Networks (DEAN), which collaborates with the VA Office of Academic Affiliates and the Office of Research and Development to enhance the VA's capacity as a learning organization that accelerates innovation.

In September 2022, the VA launched the Accelerating VA Innovation and Learning (AVAIL) initiative, a multi-award contract vehicle aimed at supporting and enhancing the VA's ongoing healthcare innovation efforts. AVAIL focuses on five key innovation areas: Personalized Care, Data Transformation, Digital Health, Immersive Technology (Extended Reality), and Care and Service Delivery. This initiative aims to augment the VA's ability to

design, develop, and test novel solutions within its healthcare environment, ensuring they create meaningful value for clinicians, administrators, caregivers, and veterans before broader deployment. While AVAIL has the potential for a five-year, $650 million contract, current utilization and funding stand at $29 million, which is below expectations for this important innovation initiative.

Congress should consider empowering the VA Office of Healthcare Innovation and Learning with increased funding and directive to identify faster ways of identifying innovative life-saving technology. Additionally, Congress can require an annual report from VA OHIL to this Committee on its annual activity.

Closing: Chairman Bost, Ranking Member Takano, thank you so very much for hosting this important hearing today. I also want to express our sincere appreciation for the staff of this committee, who work tirelessly to ensure our nation's veterans have a VA that works for them. As we discuss the critical innovations needed to enhance the care provided to our nation's veterans, I want to emphasize that Congress and the House Committee on Veterans' Affairs will be hard-pressed to find a better innovation partner and friend for the VA than Philips. We have a longstanding commitment to supporting the VA, the U.S. servicemembers, veterans, and their families, and we take pride in being part of this vital community.

At Philips, our corporate goal is to bring better care to more people around the world. We believe there is no better population to support and advocate for than our veterans. We are not just a company that talks about support; we actively put our resources behind it. We are proud to partner with organizations such as The American Legion, the Veterans of Foreign Wars, the Elizabeth Dole Foundation, and the Medal of Honor Society and Foundation, empowering them to make a difference in the lives of those who have served our country. Together, we can ensure that our veterans receive the innovative healthcare solutions they deserve, and we look forward to continuing this important work alongside all of you.

For more information about Philips North America, this testimony, or our support for the 18 million U.S. veterans, please contact Mr. Matthew Shuman, Director of Congressional & Military Affairs for Philips at Matthew.Shuman@philips.com.

Prepared Statement of Sai Parthasarathy

My name is Sairam Parthasarathy and I am a Professor of Medicine and Chief of the Division of Pulmonary Allergy Critical Care and Sleep Medicine at the University of Arizona in Tucson AZ. I have previously served at two VA Hospitals—Edward J. Hines VA Hospital in Hines, Illinois as well as the Southern Arizona VA Healthcare System—for a total of 11 years of service as a Pulmonary-Critical Care-and-Sleep physician. I have also served as Section Chief for Pulmonary, Critical Care, and Sleep Medicine from 2004 to 2007 and subsequently as the Associate Chief of Staff for Research at the Southern Arizona VA Healthcare System in Tucson, Arizona. Currently, I serve as one of the Directors on the Board of Directors for the VA Non-Profit Foundation affiliated with the Southern Arizona VA Healthcare System called the Biomedical Research and Education Foundation of Southern Arizona, Tucson, AZ. I am board certified in Pulmonary, Critical Care and Sleep Medicine.

I have a broad area of research expertise with a special focus on **implementation science in the area of sleep medicine.** The approach of implementation science entails harnessing new biomedical innovations to the bedside and clinics to benefit patients everywhere – including veterans. Hence, I believe that I can speak to the topic in hand, which is regarding, *"Harnessing Biomedical Innovation: Modernizing VA Healthcare for the Future."*

A wealth of scientific knowledge is being generated by biomedical research, especially in the area of sleep and circadian science that has cross-cutting benefits to veterans health. In order for us to realize the return on investment for such scientific knowledge and to improve the health of the veterans and the Nation, especially with the extent to which chronic diseases afflict our people, there is a dire need to disseminate and implement – or simply put, **"harness"** – these research findings into day-to-day clinical practice. It is frequently reported that a time lag of 17 years transpires before 15 percent of medical research reaches day-to-day clinical practice in order to benefit both veterans and civilians. Such harnessing has evolved into the science of implementation and the Veterans healthcare System and affiliated University partnerships are well poised to thoughtfully harness and implement these innovations into the real—world. Implementation science takes into account the healthcare providers' work-related burden in a busy clinic or hospital and the validity and applicability of the scientific findings to that context. The ability to get clinics to adopt these approaches and maintain them over time is another crucial aspect that needs to be taken into thoughtful consideration. We need to carefully assess metrics that will measure the process of implementation and the return on investment for us to exercise proper financial stewardship. We need to identify barriers for implementing these medical innovations and identify facilitators to enable the successful implementation and return on investments. Enabling artificial intelligence (AI/ML) approaches to assist with such implementation (or harnessing efforts) will be in keeping with dissemination and implementation science while shifting the task from the busy healthcare providers to machines that can work hand in hand with them.

One such example is in the area of obstructive sleep apnea. Sleep apnea is very common in Veterans and is characterized by repetitive obstruction of the throat, snoring and temporary cessation of breathing that are associated with low oxygen counts during sleep. Sleep apnea – and insomnia – has been associated with heart attacks, strokes, high blood pressure, road traffic accidents, poor outcomes in individuals with traumatic brain injury/PTSD, depression/suicidality, and even death. However only 1 in 4 individuals with sleep apnea are diagnosed and the remaining 75 percent are left undiagnosed. We have refined a machine learned algorithm developed by researchers at MIT and embedded it into the electronic medical records system of our University of Arizona healthcare system that can identify individuals with high likelihood of sleep apnea and alert the healthcare provider to that fact and enable them to, in a facile manner, place an order for a diagnostic test or sleep study. Moreover, treatment of sleep apnea with CPAP machine that delivers pressurized air to keep the throat open has been associated with reduction of motor vehicle accidents, improvements in blood pressure, reduction of cardiovascular mortality, however, only 2/3rds of patients with sleep apnea are adherent. There are not enough providers or caregivers to support an CPAP adherence promotion program. This unmet need is being addressed by us as we are in the process of developing an AI/ML approach for algorithms – developed previously through funding from VA HSR&D portfolio and PCORI—to help veterans and civilians to be adherent to CPAP therapy. There are similar machine-based approaches that can deliver cognitive behavioral therapy for insomnia – another common sleep disorder with huge implications to mental health. Researchers at the University of Arizona are also

testing a Department of Defense supported Virtual Reality Military Operational Neuropsychological Assessment system that can use deep neural network learning and AI approaches to identify individuals with neuropsychological issues that include PTSD.

In summary, there are numerous approaches to successfully identify and treat patients with chronic medical conditions such as sleep apnea using implementation science and AIML approaches. The time is now to harness the biomedical advances to benefit health of veterans using AI/ML and targeting sleep would enable us to touch many organ systems and thereby improve overall physical and even mental health.

STATEMENTS FOR THE RECORD

Prepared Statement of U.S. Department of Veterans Affairs

Chairman Bost, Ranking Member Takano, and distinguished members of the Committee. Thank you for the opportunity to submit this written testimony on behalf of VA. This testimony details our progress and commitment to ensuring Veterans receive high-quality health care through cutting-edge medical technology. We will discuss our ongoing efforts to modernize technology, with a particular focus on procuring and using of state-of-the-art biomedical technology equipment.

VA remains steadfast in its mission to provide world-class health care to the Nation's Veterans. State-of-the-art biomedical technology—ranging from advanced imaging systems like magnetic resonance imaging and computed tomography scanners to therapeutic devices such as radiation therapy machines—plays a critical role in achieving this goal. Our policies and programs, including the High-Tech Medical Equipment (HTME) initiative and our collaboration with the Department of Defense (DoD), reflect a strategic approach to equipping VA medical facilities with the necessary tools to diagnose, treat, and monitor Veterans effectively.

VA's procurement of state-of-the-art biomedical technology is primarily managed through the HTME program, with the National Acquisition Center within the Office of Procurement, Acquisition, and Logistics providing oversight. This program, operating under an Indefinite Delivery, Indefinite Quantity contract framework, ensures centralized purchasing of high-cost, high-tech equipment such as radiology systems, ultrasound machines, and nuclear medicine devices.

A pillar of our procurement strategy is VA-DoD Health Care Resources Sharing Agreements, which allow us to share advanced health care equipment with DoD facilities while reducing costs and improving access for Veterans in underserved regions. VA's Community Care Network is another critical resource that allows VA to deliver world class health care for Veterans through community providers that use cutting-edge biomedical technology.

The Veterans Health Administration (VHA) also engages and co-develops with U.S. industry at the forefront of biomedical innovations, ensuring that industry products receive critical clinical feedback for best fit with VA health care and enhancing competitiveness on the global market. In 2025, VA is slated to open a state-of-the-art biomanufacturing facility designed to be optimally integrated with hospital infrastructure and used to evaluate and incorporate emerging biotechnology solutions into clinical care.

A recent example of VA's efforts to leverage cutting-edge biomedical innovation is our National Equipment Contract (NEC). Established through NEC on October 7, 2024, VA will be allowed to procure the Edison Histotripsy medical device, a first-of-its-kind, non-invasive, sonic beam therapy platform capable of destroying targeted liver tumors at a sub-cellular level, and that the Food and Drug Administration approved on March 13, 2024. NEC allows for streamlined equipment access for all VHA facilities, aligned with the Clinically Driven Strategic Sourcing principles, to leverage advanced technologies for Veteran care.

On February 1, 2025, VA also awarded a new contract to procure Da Vinci Surgical Robots that allow VA to provide minimally invasive surgery using robot-assisted techniques to improve surgery outcomes. The contract includes the Da Vinci 5 Dual Console along with previous generation consoles. As of March 28, 2025, VA operates 164 Da Vinci robots across 84 sites. The approach aims to reduce patient recovery time and also enhances precision during operations.

In conclusion, VA's procurement and use of state-of-the-art biomedical technology equipment reflect our unwavering dedication to Veterans. Through the HTME program, general procurement policies, and VA-DoD partnership, we are equipping our health care system to meet today's demands and tomorrow's challenges. We appreciate the Committee's interest on this topic.

Prepared Statement of iXpressGenes

Chairwoman Miller Meeks, Ranking Member Brownley, and Distinguished Members of the Committee:

Thank you for the opportunity to submit testimony on this critical and deeply personal issue.

I am John Schmitt, the CEO of iXpressGenes, but before that, I was a soldier. I served over 20 years in the United States Army, with two combat tours in Iraq as a Blackhawk helicopter pilot, maintenance test pilot, and company commander. I have seen firsthand the toll that trauma takes—not just on the battlefield, but in the lives of those who return home. I've watched fellow service members struggle, and I've also experienced the long, uncertain road of recovery that too many veterans face. And while I have been fortunate to have weathered the storm well, many have not, and it is for those who continue to suffer, and in the memory of those no longer with us, that I continue my life of service. What drives me and the company is a commitment to using every tool at our disposal to fundamentally transform trauma care forever.

I am also more than the CEO of my company. I was fortunate enough to receive a master's degree from Vanderbilt University School of Medicine in Microbiology and Immunology as well as gain almost 10 years of DoD weapon system acquisition experience, including as an ACAT1 product manager. So, as I submit this testimony, I can say with confidence that I understand the problem set, the economics, the challenges of scale, and I can speak with authority to the science and the power of using RNA dysregulation profiling technology, specifically in context of our Trauma Autoimmune Indicator (TAI) test, to revolutionize the way we care for veterans. This technology has the power to detect trauma-induced changes in the body long before symptoms arise, allowing us to intervene early, prevent chronic conditions, and dramatically improve outcomes. Additionally, it is a powerful tool for clinicians to inform ongoing care, access emerging therapy modalities, and conduct continuous monitoring to prevent mental health relapses.

A System That is Failing Veterans

We owe it to our veterans to do better and I am grateful to the Committee for your dedication and focus on doing so. Despite previous efforts including increased investment in mental health services, outcomes have not improved proportionately. According to the Government Accountability Office (GAO), mental health spending at the VA increased by over 60 percent between 2015 and 2022, yet suicide rates among veterans have remained tragically high and continue to increase.

Even more troubling, many veterans face wait times of two to 3 months or longer to access mental health services—completely unacceptable care when a servicemember is in crisis. The system remains reactive, relying on subjective self-reporting and crisis intervention after conditions have already worsened. This approach leads to missed opportunities for early intervention and contributes to rising healthcare costs over the long term.

We cannot continue down this path. We need a new approach—one that recognizes the profound connection between the brain and body and that leverages objective, science-based tools to identify risks before they escalate.

Why RNA Transcription Profiling is the Solution

RNA transcription profiling is that solution. This technology analyzes gene expression patterns to create an objective, quantifiable snapshot of a person's immune response and physiological health. It detects subtle changes at the molecular level, providing real-time insights into the body's response to trauma, stress, and inflammation.

Until recently, RNA transcription profiling was largely confined to research labs and high-cost clinical environments. The potential was always there, but the technology was difficult to scale, expensive to implement, and required specialized expertise. It wasn't practical for widespread use in routine healthcare settings.

That's no longer the case. Advances in biotechnology, computational biology, bioinformatics, and artificial intelligence have made it possible to deliver this technology in a low-cost, high-volume format that is ready for real-world application. The barriers that once made RNA transcription profiling inaccessible have been eliminated.

Introducing the Trauma Autoimmune Indicator (TAI) Test

At iXpressGenes, we've taken this powerful technology and developed the Trauma Autoimmune Indicator (TAI) test—a simple, science-driven tool that detects trauma-induced inflammation and immune dysregulation before clinical symptoms appear.

And if clinical symptoms have already appeared, it serves as a powerful clinical tool to inform treatment effectivity.

The Trauma Autoimmune Indicator (TAI) test works by leveraging RNA transcription profiling to detect clear, trauma and stress induced changes in the body before symptoms become clinically significant. It begins by identifying changes in gene expression patterns triggered by trauma and chronic stress, providing an objective snapshot of the body's physiological response. Initial TAI screenings establish a baseline for trauma-related health, allowing providers to monitor inflammation and track the veteran's progress over time. As treatment progresses, TAI data enables personalized care by guiding individualized treatment plans and ensuring that interventions are tailored to the veteran's specific needs. Furthermore, regular TAI screenings play a critical role in preventing relapse and chronic conditions by detecting early signs of recurring trauma-related issues, allowing providers to adjust care strategies and maintain long-term progress. This proactive, data-driven approach ensures that veterans receive continuous, evidence-based care that evolves with their changing health needs.

Why This Matters for Veterans

Veterans face unique and complex healthcare challenges, particularly when it comes to mental health. PTSD, depression, and anxiety often go undiagnosed or untreated until they become debilitating. The current system relies too heavily on subjective assessments, which miss the physiological changes that accompany trauma.

TAI changes this paradigm. It provides objective, measurable data that empowers clinicians to identify risks and intervene early, before a veteran spirals into crisis. This approach can dramatically improve outcomes by preventing the progression of trauma-related conditions and reducing the need for costly long-term care.

The potential for impact is enormous. Research shows that incorporating biomarker-based approaches into mental health protocols can reduce PTSD symptom severity by 30–40 percent through earlier intervention and more personalized care (Smith et al., 2023).

The Technology is Here. The Time is Now.

We're no longer talking about theoretical solutions or future promises. The technology is ready, and the science is sound.

iXpressGenes has validated the effectiveness of the TAI test in clinical blind studies and is prepared to commercialize it within the next 30 days. At a retail price of $225 per test, TAI screening is affordable, scalable, and ready to be deployed across the VA healthcare system.

We've barely scratched the surface, and everything is pointing in one direction—toward a future where objective, physiology-based approaches are the standard in mental healthcare. The opportunity to transform the lives of veterans is in front of us, and this is the moment for action.

Bold Moves to Validate and Adopt High-Impact Technologies

We cannot afford to hesitate. If we are serious about modernizing VA healthcare and improving outcomes for veterans, we must:

1. Validate High-Impact Technologies Quickly: Establish pathways for rapid evaluation and validation of innovative technologies like TAI.
2. Adopt Proven Innovations Without Delay: Once validated, technologies with demonstrated impact should be integrated swiftly into VA protocols.
3. Dismiss What Doesn't Work: Be willing to pivot away from approaches that fail to deliver measurable benefits, ensuring that resources are directed where they can have the greatest impact.

This is not the time for incremental changes. Immediate action is required to move from reactive care to a proactive, prevention-based model that protects the health and well-being of our veterans.

Seizing the Future with Confidence

For me, this isn't just about science or technology. It's about ensuring that the men and women who have served this Nation receive the care they deserve. We have the tools, the data, and the opportunity to transform the future of veteran healthcare.

In my last 10 years of military service serving as an acquisition corps officer, I watched great technology die in the Valley of Death. The risk and investment of bridging this technology is very minimal because I intentionally structured the program we have built in a way to maximize the chance that it would cross the Valley

of Death intact. This is why I strongly urge the Committee to support bold limited pilots of novel technologies like ours and ensure there is advocacy for adoption should the technology prove effective.

The science is here. The technology is ready. The time to act is now.

Thank you for the opportunity to share this vision. I look forward to working with the Committee to ensure that veterans receive the quality care they have earned.

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Prepared Statement of Geneoscopy

Thank you for the opportunity to provide written testimony in response to the Committee's hearing on modernizing healthcare at the Department of Veterans Affairs (VA). As discussed at the hearing, it is imperative that veterans have more options for healthcare and greater access to healthcare technologies and innovations. As Chairman Bost succinctly put it, "[v]eterans can't afford to wait." We would like to discuss speeding the delivery of cutting-edge technologies and innovative diagnostics for colorectal cancer screening further below.

Colorectal Cancer is the Second Deadliest Cancer in the U.S.

Colorectal cancer causes more than 50,000 deaths annually. Of particular concern is the significant increase in the incidence of colorectal cancer among younger Americans. Since 1994, cases of early onset colorectal cancer (i.e., colorectal cancer diagnosed before the age of 50) have increased by 51 percent, and since 2004, there has been a rapid shift in mortality patterns, with colorectal cancer moving from being the fourth leading cause of cancer-related deaths among young men and women to now being the leading cause in men and the second leading cause in women.[1]

Colorectal Cancer Can Be Prevented Through Regular Screening

Colorectal cancer is the most preventable cancer if people get screened for it regularly. Colorectal cancer almost always develops from precancerous polyps (abnormal growths, also called adenomas) in the colon or rectum. If you can find and remove the precancerous polyps through screening, you can head off cancer before it develops. Fortunately, routine colorectal cancer screenings for Americans aged 45 years and older are a very effective intervention to detect precancerous polyps so that they can be removed before they develop into cancer, thereby preventing colorectal cancer.[2] A New England Journal of Medicine study concluded that the more adenomas found during screening, the less cancer is subsequently diagnosed.[3]

Screening can also identify early stage cancer. When colorectal cancer is found at an early stage, before it has spread, it is more treatable, and the 5-year relative survival rate is about 90 percent. The percentage of individuals diagnosed with advanced-stage colorectal cancer has increased from 52 percent in the mid–2000's to 60 percent in 2019.[4] Survival rates are lower when cancer has spread outside the colon or rectum.[5] Unfortunately, many patients avoid screening, and so their cancer is diagnosed at later stages. Approximately 40 percent of patients fail to get screened in part because they do not want to have a colonoscopy, which is the gold standard for colorectal cancer screening in the U.S. Colonoscopies are frequently met with patient aversion due to the required bowel preparation, sedation, and potential time away from work.[6]

Despite this highly effective approach to disease prevention, one in four adults aged 45 to 75 are not getting screened as recommended. In 2021, only 19.7 percent, or fewer than four million out of 19 million eligible adults aged 45–49 were up to

[1] https://www.nbcnews.com/health/health-news/colon-cancer-deaths-younger-men-women-report-rcna134084
[2] https://www.cdc.gov/chronicdisease/programs-impact/pop/colorectal-cancer.htm
[3] https://www.nejm.org/doi/full/10.1056/NEJMoa1309086
[4] https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21772
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[6] https://www.sciencedirect.com/science/article/pii/S2211335519300750

date with their colorectal cancer screening.[7] As such, it is essential that more colorectal cancer screening options be available to people aged 45 and older and that such tests be accessible and affordable for all who are eligible for screening.

New FDA-Approved, Non-Invasive Colorectal Cancer Screening Tests

An alternative to colonoscopy for average-risk patients is non-invasive screening tests, like Geneoscopy's ColoSense, which can be used at home. ColoSense can play a critical role in addressing access to care challenges by reducing barriers to early detection, particularly among hard-to-reach populations where access to care is limited, such as rural communities. Traditional screening methods, like colonoscopies, can be inaccessible due to cost, geographic location, or the need for specialized facilities – challenges that disproportionately affect low-income, rural, and minority communities. A non-invasive test such as ColoSense offers a more affordable, convenient, and less intimidating option, increasing the likelihood that patients will seek regular screenings, and as a result detect precancerous polyps and colorectal cancer at earlier stages when it is most treatable.

Everyone is at some risk for developing colorectal cancer, though some groups are at elevated risk. As noted earlier, of serious concern, is that colorectal cancer incidence and mortality rates among people ages 45–54 have increased in recent years. The percentage of all individuals diagnosed with colorectal cancer who are under the age of 55 doubled from 11 percent in 1995 to 20 percent in 2019.[8] In 2021, the U.S. Preventive Services Task Force (USPSTF) lowered the recommended age for people to begin colorectal cancer screening from 50 to 45.[9] With that change, 17 million more people entered the recommended screening cohort. Clearly, there is an urgent need to increase screening efforts.

Expanding Access to Colorectal Cancer Screening in the VA & Building Public-Private Partnerships

Expanding access to colorectal cancer screening is one of the VA's stated goals, with the VA diagnosing an estimated 4,000 new colorectal cancer cases each year.[10] The VA recognizes the role new technologies can play in colorectal cancer detection, having introduced artificial intelligence (AI) tools through its National Colorectal Cancer Screening Program (NCSP) to aid in the detection of pre-cancerous polyps.[11]

Geneoscopy believes the VA can build on these important efforts by speeding the adoption of newly approved technologies and devices. As technological innovations in the field of colorectal preventive screening and diagnostics advance, more effective screening modalities become available. Top-line data from the CRC-PREVENT clinical study for Geneoscopy's test demonstrated 93 percent sensitivity for colorectal cancer and 45 percent sensitivity for AA in average-risk individuals.[12] In addition, ColoSense's ability to detect AA does not materially erode for the youngest screening bracket of 45–49-year-olds as occurs in other screening methods.[13] This finding may lead physicians to choose different screening modalities for different patient demographics. When it comes to screening, more choice is better, and the best colorectal cancer screening test for a given patient is the one that physicians will use. Geneoscopy's clinical trial showed that the new technology worked successfully for people across demographic groups all over the country and has the real promise to advance the vital goal of increasing access to healthcare innovation for historically underserved populations. In Geneoscopy's trial, 30 percent of participants had an income below $50,000 annually, 9 percent were on Medicaid, and 5 percent were from rural areas.[14]

There are a few key hurdles to bringing life-saving cancer screening tests to patients. First, getting approval by the Food and Drug Administration (FDA); second, qualifying for coverage and payment by the Centers for Medicare and Medicaid Services (CMS) and being adopted by other Federal agencies, like the VA; and third, inclusion in the USPSTF screening recommendations given that commercial insurers generally will not cover a test until it is included in USPSTF guidelines. Start-up companies like Geneoscopy take risks when developing new technologies and face

[7] https://www.cdc.gov/pcd/issues/2023/23—0071.htm
[8] https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21772
[9] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
[10] https://news.va.gov/129165/expanding-colorectal-cancer-screening-treatment/
[11] https://news.va.gov/122055/va-colonoscopies-ai-increase-polyp-detection/
[12] https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P230001
[13] https://doi.org/10.1158/1940–6207.CAPR–20–0294
[14] https://pubmed.ncbi.nlm.nih.gov/37870871/

the "valley of death" when coverage and guidelines inclusion do not come quickly after FDA approval.

We are glad the committee recognizes these challenges companies like Geneoscopy face. We were encouraged by Rep. McGarvey's mention of expanding public-private partnerships and pilot programs by granting the VA the ability to make advance market commitments and use Other Transaction Authority (OTA). This kind of predictability and flexibility would help innovators like Geneoscopy get across the "valley of death" while speeding care delivery to veterans. ColoSense received FDA approval through the Breakthrough Devices Program in May 2024 and still faces a significant delay for CMS coverage nearly a year later. Further, there has been no movement by the USPSTF or the National Committee for Quality Assurance (NCQA) to update their colorectal cancer screening guidelines, which is thwarting commercial insurance coverage. The VA can bridge this gap to the benefit of veterans and in the process incentivize medical innovation. We too want to see "partnership[s] where the VA and industry develop solutions collaboratively that ultimately save money, generate revenue and provide better healthcare for our veterans."[15]

About Geneoscopy

Geneoscopy was founded in 2015 with a vision to improve how gastrointestinal diseases are prevented, detected, and treated. My sister, Dr. Erica Barnell, and I co-founded Geneoscopy after Erica developed a groundbreaking technology to isolate and interrogate stool-derived eukaryotic RNA while she was pursuing her MD/PhD at Washington University School of Medicine in St. Louis, Missouri. Geneoscopy's initial product is ColoSense, a noninvasive colorectal cancer screening test that detects colorectal cancer and high-risk precancerous polyps—advanced adenomas.[16] Designated a Breakthrough Device by FDA, ColoSense received FDA approval on May 3, 2024.[17]

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[15] Rep. Morgan McGarvey, "Harnessing Biomedical Innovation: Modernizing VA Healthcare for the Future," *Bloomberg Government*, p. 35, https://www.bgov.com/next/news/SU3B9X0799MP.

[16] https://pubmed.ncbi.nlm.nih.gov/11916153/

[17] https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P230001