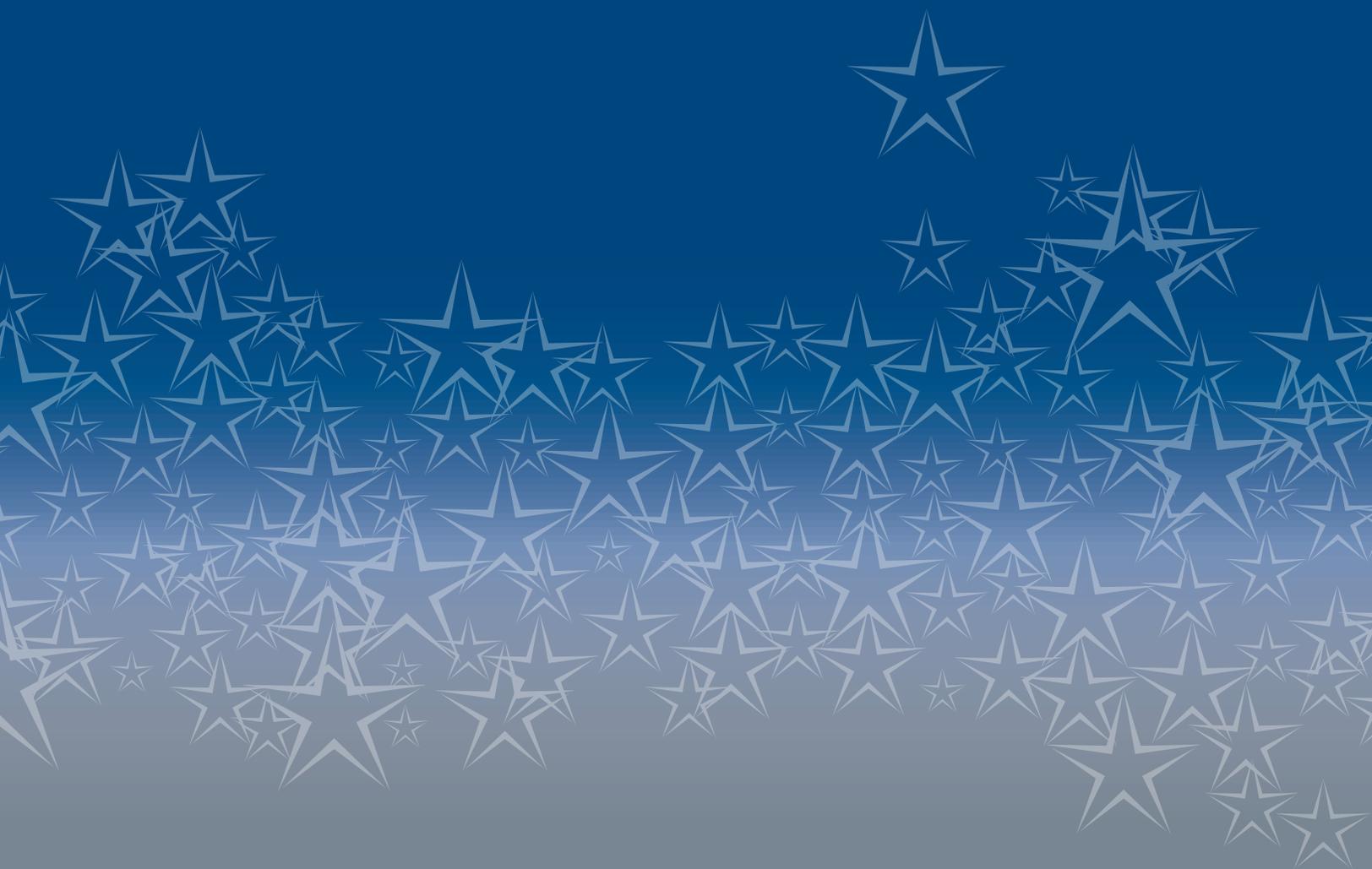


Commission on Care

Interim Report



COMMISSION ON CARE

December 4, 2015

COMMISSION ON CARE

Interim Report of the Commission on Care

December 4, 2015

Commission on Care
1575 I Street, NW
Washington, DC 20005



commissiononcare.sites.usa.gov

COMMISSION ON CARE

1575 I Street, NW ▪ Washington, DC 20005

The Commission on Care is pleased to submit the enclosed interim report. In response to the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Section 202, the Commissioners, with assistance from Commission staff, have reviewed the *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs (Independent Assessment Report)*, prepared by CMS Alliance to Modernize Healthcare (CAMH) in accordance with VACAA, Section 201.

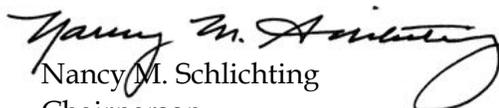
The Veterans Health Administration (VHA), the largest health care system in the United States, plays the vital role of meeting the health care needs of many of those who have served in our country's uniformed services. With that in mind, the breadth and depth of the *Independent Assessment Report* – which includes more than 4,000 pages and a total of more than 500 specific recommendations, including more than 180 major recommendations – is not surprising. The Commission recognizes that it would be premature to formulate any opinions without having first considered the full scope of the *Independent Assessment Report* and any issues related to its content. Additionally, there are many key issues yet to be considered, such as leadership and governance, eligibility, and cost, all within the context of a dynamic, rapidly changing industry. The Commissioners want to give these issues the careful scrutiny they merit; therefore, no recommendations are included in this interim report.

To date, the Commission has been working to analyze the *Independent Assessment Report* and to gain a thorough understanding of the scope of VHA's responsibilities, including those that reach beyond the traditional bounds of health care. This interim report outlines some of the Commission's findings regarding the *Independent Assessment Report*, including examples of areas that were not addressed in the report but may be considered as the Commission formulates recommendations. The interim report identifies practical, regulatory, and statutory barriers that may need to be considered and ameliorated as part of the implementation of any future recommendations. The report also includes guiding principles the Commission has set to steer its deliberations and decision making, as well as core issues that frame the Commission's work.

As the Commission moves forward, its work will be shaped by an unwavering commitment to ensuring eligible veterans are offered quality, accessible health care. The Commissioners recognize this vision can be realized best by taking a systems approach; thus, in the coming months, the Commission will formulate recommendations that are systemic in nature. Recognizing the vast majority of the recommendations included in the *Independent Assessment Report* are of an operational nature, the Commissioners will consider how those manifold recommendations can be incorporated, as appropriate, within the structure of its systems-oriented approach.

The Commission has an important task ahead of it as it formulates the recommendations that will comprise its final report. Ensuring veterans are cared for is a sacred responsibility. The Commissioners believe the Federal Government has a duty to fulfill its obligation to provide timely access to quality care. The Commission is committed to making well-informed recommendations that are not only feasible and advisable, as outlined in VACAA, but also form the basis of a Department of Veterans Affairs health care system that is sustainable in both the short and long term. The Commissioners are confident the recommendations put forth in the Commission's final report will ensure VHA continues to provide vital services for veterans and to play a role in health care industry innovation.

The Commission wishes to thank all who have contributed to this interim report and the work completed so far. The Commissioners look forward to sharing recommendations in the final report.


Nancy M. Schlichting
Chairperson

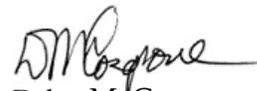

Delos M. Cosgrove, MD
Vice Chairperson

TABLE OF CONTENTS

INTRODUCTION.....1

Commission Charge 1

Interim Report Focus 1

VETERANS HEALTH ADMINISTRATION BACKGROUND2

INDEPENDENT ASSESSMENT.....5

THE COMMISSION ON CARE.....7

Composition of the Commission 7

Guiding Principles 8

Activities of the Commission 9

EVALUATION OF INDEPENDENT ASSESSMENT 12

Areas Not Covered in the Report 12

Barriers to Transformation 13

Health Care Trends..... 15

**OUTLINE FOR DATA PROCESSING AND RECOMMENDATION
DEVELOPMENT..... 17**

Areas of Focus for Framing Discussion 17

Timeline for Final Report..... 18

APPENDIX A: GUIDING AND ENABLING DOCUMENTS..... 21

APPENDIX B: ACRONYM LIST..... 30

THIS PAGE INTENTIONALLY LEFT BLANK

INTRODUCTION

Commission Charge

Section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) established the Commission on Care and charged it “to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of [VACAA].”¹ As a component of this charge, the Commission also is to evaluate and assess the results of an independent, private-sector assessment mandated in Section 201 of VACAA.²

Since the September 1, 2015, release of the *Independent Assessment of the Health Care Delivery Systems and Management Process of the Department of Veterans Affairs* (referred to subsequently as the *Independent Assessment Report*) the Commission has worked to evaluate the reports’ findings, data, and recommendations. After preliminary evaluation, the Commission acknowledges the report appears to address the identified important aspects of Department of Veterans Affairs’ (VA’s) health care delivery needing review as identified in the statutory mandate. The work by the CMS Alliance to Modernize Healthcare (CAMH), unprecedented in scope and detail, forms a revealing and essential component for understanding the VA network of health care delivery. The Commission acknowledges the work of both CAMH as well as the Institute of Medicine (IOM), which produced the section of the report on access standards.

Interim Report Focus

In response to the Commission’s initial analysis, this interim report does the following:

- Outlines the Commission’s guiding principles
- Identifies examples of areas for consideration not addressed in the independent assessment
- Identifies examples of barriers to transformation
- Identifies examples of trends in health care
- Outlines areas of focus for framing discussions
- Highlights a timeline for the final report

¹ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, § 202, 128 Stat. 1754.

² Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, § 201, 128 Stat. 1754.

VETERANS HEALTH ADMINISTRATION BACKGROUND

The Veterans Health Administration (VHA), operating within a sweeping statutory framework, is the nation's largest and most complex health care delivery system, with an annual operating budget of more than \$60 billion.³ It serves approximately 6.6 million unique patients, of whom 5.8 million are veterans, at more than 160 medical centers and more than 1,000 affiliated health care sites across the United States.⁴ Services provided encompass more than 92 million outpatient visits, 707,000 inpatient admissions, and 271 million prescriptions filled each year.⁵ With more than 290,000 staff members, including 24,000 physicians and 63,000 nurses, VHA employs one out of every nine civilian federal employees.⁶ VHA augments its staff with more than 760,000 volunteers.⁷ As the largest single provider of health care professional training in the country, VHA rotates more than 120,000 trainees through the system each year.⁸

In the decades since World War II, VHA's mission has grown increasingly complex. Its primary function, as expressed in law, remains "to provide a complete medical and hospital service for the medical care and treatment of veterans."⁹ VHA continues to carry out the longstanding statutory missions of education and training of health personnel and medical research, as mandated by law.¹⁰ An evolving statutory landscape has, however, substantially expanded the scope of VHA's health care mission. For example, in response to veterans' experiences during and after the Vietnam War, Congress directed VHA to establish counseling centers "situated apart" from VA health facilities. VA now operates approximately 300 *Vet Centers* across the country.¹¹ Under subsequent statutory requirements, VHA has established extended-care service programs;¹² a program of grants and per diem payments to assist homeless veterans;¹³ targeted programs to provide long-term traumatic brain injury rehabilitation,¹⁴ suicide prevention,¹⁵ sexual trauma counseling,¹⁶ and caregiver support;¹⁷ medical emergency

³ Department of Veterans Affairs, *FY 2016 President's Budget Request*, accessed November 23, 2015, <http://www.va.gov/budget/docs/summary/Fy2016-BudgetRollout.pdf>.

⁴ Department of Veterans Affairs Veterans Health Administration, *VHA Healthcare Overview*, accessed November 23, 2015, <http://vaww.ush.va.gov/USH/docs/VHAOverview.pptx>.

⁵ *Ibid.*

⁶ *Ibid.*

⁷ *Ibid.*

⁸ *Ibid.*

⁹ Functions of Veterans Health Administration: In General, 38 U.S.C. § 7301 (2012).

¹⁰ Functions of Veterans Health Administration: Health-Care Personnel and Training Programs, 38 U.S.C. § 7302 (2012). Functions of Veterans Health Administration, 38 U.S.C. § 7303 (2012).

¹¹ Eligibility for Readjustment Counseling and Related Mental Health Services, 38 U.S.C. § 1712A (2012).

¹² Eligibility for Hospital, Nursing Home, and Domiciliary Care, 38 U.S.C. § 1710B (2012).

¹³ Grants, 38 U.S.C. § 2011 (2012). Per Diem Payments, 38 U.S.C. § 2012 (2010). Authorization of Appropriations, 38 U.S.C. § 2013 (2014).

¹⁴ Traumatic Brain Injury: Comprehensive Program for Long-Term Rehabilitation, 38 U.S.C. § 1710D (2012).

¹⁵ Transfers for Nursing Home Care; Adult Day Health Care, 38 U.S.C. § 1720F (2012).

¹⁶ Counseling and Treatment for Sexual Trauma, 38 U.S.C. § 1720D (2012).

¹⁷ Assistance and Support Services for Caregivers, 38 U.S.C. § 1720G (2012).

preparedness centers;¹⁸ geriatric research, education, and clinical centers;¹⁹ centers for mental illness research, education, and clinical activities;²⁰ centers of excellence targeted at Parkinson's disease,²¹ multiple sclerosis,²² and epilepsy;²³ and a national center for preventive health.²⁴ Recognizing the potential within the VA health care system to assist in responding to national disaster, Congress directed VHA to undertake a fourth major mission: medical emergency preparedness, which necessarily requires close coordination with other government departments.²⁵

Among VHA's many missions, Congress has highlighted VHA's unique capability to provide specialized clinical services to veterans.²⁶ These services treat the lasting physical effects of military service such as amputation care, prosthetic and sensory aid services, blindness rehabilitation, polytrauma and traumatic brain injury care, spinal cord injury care, environmental exposure care, and post-deployment health screening. VHA also provides services to heal the invisible wounds of war and the emotional effects of military service. These services include readjustment and military sexual trauma counseling, post-traumatic stress disorder and substance abuse treatment, residential rehabilitation, and suicide prevention. Additionally, VHA manages programs that focus on special groups within the veteran population, such as rural veterans, homeless veterans, American Indian and Alaska Native veterans, women veterans, and those requiring long-term care and support services. VHA's extended-care programs encompass nursing home and residential care as well as home and community-based services. VHA also provides an array of support services for the caregivers of certain veterans.²⁷

The Commission acknowledges the challenges inherent in managing a health care delivery system of the VHA's size, scope, and complexity. Those challenges are magnified given VHA's work to meet standards governing health care in the private sector while operating under federal laws and regulations not specifically designed to ensure smooth operation of processes such as governing procurement and contracting; personnel hiring, compensation, advancement, discipline, and dismissal; budgeting; capital improvement and leasing; and physical and cyber security. Finally, VHA is not simply a health care provider but also an institution with major

¹⁸ Medical Emergency Preparedness Centers, 38 U.S.C. § 7325 (2011).

¹⁹ Geriatric Research, Education, and Clinical Centers, 38 U.S.C. § 7314 (2012).

²⁰ Centers for Mental Illness Research, Education, and Clinical Activities, 38 U.S.C. § 7320 (2011).

²¹ Parkinson's Disease Research, Education, and Clinical Centers, 38 U.S.C. § 7329 (2012).

²² Multiple Sclerosis Centers of Excellence, 38 U.S.C. § 7330 (2006).

²³ Epilepsy Centers of Excellence, 38 U.S.C. § 7330A (2012).

²⁴ National Center for Preventive Health, 38 U.S.C. § 7318 (2011).

²⁵ Medical Preparedness Centers, 38 U.S.C. § 7328 (2012).

²⁶ Management of Health Care: Other Requirements, 38 U.S. Code § 1706(b)(1) (2012) outlines specialized clinical services provided by VHA: "the Secretary shall ensure that the Department (and each geographic service area of the Veterans Health Administration) maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that (A) affords those veterans reasonable access to care and services for those specialized needs."

²⁷ Department of Veterans Affairs, Veterans Health Administration, *VHA Healthcare Overview*, accessed November 23, 2015, <http://vaww.ush.va.gov/USH/docs/VHAOverview.pptx>.

responsibilities for the education of the nation's health workforce, for the conduct of medical research, and for providing emergency response services to the nation.

The Commission recognizes the VA health system has had many accomplishments and made many contributions to U.S. medicine. VHA researchers have been recognized with three Nobel prizes and seven Lasker awards and have been responsible for vital clinical breakthroughs. These accomplishments include pioneering the first liver transplant, inventing the implantable cardiac pacemaker, developing the nicotine patch, demonstrating that a daily aspirin dose reduces heart attack death, engineering bionic ankle-foot prosthesis, and showing the effectiveness of a vaccine against shingles.²⁸ VHA is recognized for high-quality clinical preventive services²⁹ and has been recognized for innovation such as development of its electronic health record system, quality management approach, and health care ethics program. Based on data collected for the VA, among veterans who actively use health care services, VHA scores comparably to private industry on patient satisfaction in both the outpatient and inpatient settings.³⁰ Its consolidated mail-out pharmacy system consistently scores highest in patient satisfaction among mail-out pharmacy services.³¹

Despite these successes, there is widespread concern that VHA is not providing the level of service, efficiency, and quality that veterans deserve and the American public expects. In response to well-publicized deficiencies in veterans' access to medical services; mismanagement, and even deception, in record-keeping and accountability; and an organizational culture that failed to support VA core values, Congress took action to improve veterans' access to health care services by passing VACAA.

²⁸ Department of Veterans Affairs, Veterans Health Administration Office of Research and Development, *Historical Accomplishments*, accessed November 23, 2015, <http://www.research.va.gov/about/history.cfm>.

²⁹ See generally, Phillip Longman, *Best Care Anywhere: Why VA Healthcare is Better Than Yours* (Sausalito, California: PoliPoint Press, 2007).

³⁰ Department of Veterans Affairs, Veterans Health Administration, *VHA Healthcare Overview*, accessed November 23, 2015, <http://vawww.ush.va.gov/USH/docs/VHAOverview.pptx>.

³¹ VA's mail-order pharmacy has had the highest satisfaction score in the J. D. Powers annual rating from 2010-2015; however, it is not included in the official rankings because it serves only Veterans and their families. Department of Veteran Affairs, *VA Mail-Order Pharmacy Receives Highest Score in Mail Order Segment of J. D. Power Study*, accessed November 23, 2015, <http://www.blogs.va.gov/VAntage/16040/va-mail-order-pharmacy-receives-highest-score-in-mail-order-segment-of-j-d-power-study/>. J.D. Power, *Pharmacy's Focus on Customer Satisfaction Sets the Bar for the Healthcare Industry*, accessed November 23, 2015, <http://www.jdpower.com/press-releases/2015-us-pharmacy-study>.

INDEPENDENT ASSESSMENT

Section 201 of VACAA required VA to contract with private-sector entities to “conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities” of VA.³² The legislation further specified 12 areas to be examined in depth through the independent assessment:

- Demographics
- Health Care Capabilities
- Care Authorities
- Access Standards
- Workflow–Scheduling
- Workflow–Clinical
- Staffing/Productivity
- Health Information Technology
- Business Processes
- Supplies
- Facilities
- Leadership

As part of the effort, IOM completed a review of access standards and published its findings, *Transforming Health Care Scheduling and Access: Getting to Now*.³³ To carry out the remaining 11 assessments, manage a team of independent contractors, and provide an integrated view of the findings, VA engaged CAMH. The assessment team conducted site visits to VHA facilities, analyzed existing data, directed data calls and surveys, and reviewed prior evaluations that examined critical functions of VHA. The assessment team also engaged veterans service organizations (VSOs) to ascertain veterans’ priorities and needs, and engaged external experts on health care leadership and organizational transformation to gain insight into factors that lead to positive and lasting change within complex health care delivery systems like VHA. The results of the independent assessment, presented in the *Independent Assessment Report*, were delivered to VA on September 1, 2015, and released to the public shortly thereafter.³⁴ The assessment resulted in more than 4,000 pages of findings and insights about current operations and mapped suggestions for VHA’s future. It includes more than 180 major recommendations responding to the following four systematic findings that affect the ability of VA to deliver world class health care and services for veterans:

- A disconnect in the alignment of demand, resources, and legal authorities
- Uneven bureaucratic operations and processes
- Nonintegrated variations in clinical and business data and tools
- An absence of empowered leaders due to a lack of clear authority, priorities, and goals

³² Veterans Access, Choice, and Accountability Act of 2014, Act, Pub. L. No. 113–146, § 201(a)(1).

³³ Institute of Medicine, *Transforming Health Care Scheduling and Access: Getting To Now*. (Washington, DC: The National Academies Press, 2015). This report is also published as Assessment D in Volume II of *Independent Assessment of the Health Care Delivery Systems and Management Process of the Department of Veterans Affairs*.

³⁴ Department of Veterans Affairs, *Independent Assessment of the Health Care Delivery Systems and Management Process of the Department of Veterans Affairs*, accessed November 23, 2015, http://www.va.gov/opa/choiceact/factsheets_and_details.asp.

The *Independent Assessment Report* recommends that VHA adopt a systems approach to address its most challenging problems. The report also advocates that a systems approach would best address the interdependency of people, processes, and technology required to deliver high quality, accessible, and cost-effective health care that meets the expectations and needs of eligible veterans. The Commission will use a systems approach to formulate its recommendations to ensure they are feasible, advisable, and executable.

THE COMMISSION ON CARE

Composition of the Commission

VACAA Section 202 outlines the process for appointing members of the commission. The 15 members were appointed as follows:

- Speaker of the House of Representatives Appointees: David P. Blom, Delos M. Cosgrove, and Darin S. Selnick
- Minority Leader of the House of Representatives Appointees: Michael A. Blecker, Lucretia M. McClenney, and Charlene M. Taylor
- Majority Leader of the Senate Appointees: Thomas E. Harvey, Stewart M. Hickey, and Martin R. Steele
- Minority Leader of the Senate Appointees: Ikram U. Khan, Phillip J. Longman, and Marshall W. Webster
- Presidential Appointees: Nancy M. Schlichting, David W. Gorman, and Joyce M. Johnson

Section 202 outlines certain characteristics to be reflected among the commissioners. Members of the Commission whose backgrounds relate to the respective requirements are listed below:

- Veterans: Commissioners Blecker, Cosgrove, Gorman, Harvey, Hickey, Johnson, McClenney, Selnick, Steele, Taylor, and Webster
- VSO Representation: Commissioners Blecker, Gorman, Hickey, McClenney, and Selnick
- Senior Management Experience for Private Integrated Health Care Systems: Commissioners Blom, Cosgrove, Schlichting, Taylor, and Webster
- Familiarity with Government Health Care Systems: Commissioners Gorman, Hickey, Johnson, and Khan
- Familiarity with VHA: Commissioners Blecker, Gorman, Harvey, Hickey, Johnson, Longman, McClenney, Selnick, and Steele

Guiding Principles

To fulfill its statutory mandate, the Commission is conducting an independent review of VA health care, including a comprehensive evaluation and assessment of access to health care at VA.³⁵ In undertaking this task, the Commission will be guided by the following principles:

- Deliberations and final recommendations of the Commission will be data driven and decided by consensus. The Commission has been gathering, and will continue to gather, information as needed to carry out its duties, including, but not limited to, requesting necessary information from other federal agencies.
- In formulating prospective recommendations, the Commission will consider its stakeholders to include veterans, VHA beneficiaries, and their respective family members, as well as VA employees and U.S. taxpayers. The Commission will also consider the perspectives of VSOs, Congress, and interested federal agencies.
- The Commission will focus on ensuring eligible veterans receive health care that offers optimal quality, access, and choice.
- The Commission will use an integrated systems approach.
- Recommendations will be actionable and sustainable, focusing on creating clarity of purpose for VA health care, building a strong leadership/governance structure, investing in infrastructure, and ensuring transparency of performance.
- The Commission's recommendations will consider systems related to providing VA health care. The Commission will identify ways VHA can effectively integrate its services with the Department of Defense (DoD) and community care partners. It will also ensure appropriately defined roles of various VA health care academies (medical, nursing education, and research) in providing quality care.
- The Commission is committed to promoting an employment culture that supports open communication without fear of reprisal within VHA. Recognizing that such a working environment is essential for creating systemic change, the Commission's recommendations will be consistent with this commitment.
- The Commission will collaborate as needed with the president of the United States, the secretary of veterans affairs, Congress, and VSOs to ensure its recommendations are feasible, advisable, and executable.

These organizing principles provide a solid foundation for the Commission's work and support its ability to put forth implementable and sustainable recommendations that are customer-centric and value-based. These recommendations will provide for the health care needs of the nation's eligible veterans, now and in the future.

³⁵ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No.113-146, § 202(b)(1) and (2).

Activities of the Commission

The Commission held public meetings on four occasions prior to the publication of this report. Content addressed at each meeting is listed in the following table.

September 21-22, 2015	
Assessment A: Demographics	RAND Corporation <ul style="list-style-type: none"> ▪ Christine Eibner
Assessment B: Health Care Capabilities	RAND Corporation <ul style="list-style-type: none"> ▪ Peter Hussey, PhD
VA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> ▪ Bob McDonald, Secretary ▪ Sloan Gibson, Deputy Secretary ▪ David Shulkin, MD, Under Secretary for Health
Assessment C: Care Authorities	RAND Corporation <ul style="list-style-type: none"> ▪ Michael D. Greenberg
Assessment I: Business Processes	Grant Thornton LLP <ul style="list-style-type: none"> ▪ Lane Jackson ▪ Aamir Syed ▪ Sharif Ambrose
Assessment E: Scheduling Workflow	McKinsey & Company <ul style="list-style-type: none"> ▪ Kurt Grote, MD ▪ Alex Harris ▪ Pooja Kumar
Assessment F: Clinical Workflow	McKinsey & Company <ul style="list-style-type: none"> ▪ Kurt Grote, MD ▪ Gretchen Berlin
Assessment G: Staffing/Productivity/Time Allocation	Grant Thornton LLP <ul style="list-style-type: none"> ▪ Peter Erwin, PhD ▪ Hillary Peabody ▪ Erik Shannon
Assessment J: Supplies	McKinsey & Company <ul style="list-style-type: none"> ▪ Kurt Grote, MD ▪ Robin Roark, MD
Assessment K: Facilities	McKinsey & Company <ul style="list-style-type: none"> ▪ Vivian Riefberg ▪ John Means
VHA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> ▪ Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning

September 21-22, 2015 (continued)

Assessment Leadership

CMS Alliance to Modernize Healthcare

- Stephen Kirin
- Jay Schnitzer, PhD, MD

McKinsey & Company

- Vivian Riefberg

Assessment H: Health IT

MITRE Corporation

- Aparna Durvasula
- Glenn Himes

McKinsey & Company

- Celia Huber
- Vivian Riefberg

October 6, 2015

Eligibility

Veterans Health Administration

- Stephanie Mardon, Chief Business Officer
- Kristin Cunningham, Director, Business Policy Affairs

2014 Choice Act/2015 Enhancement to Choice/Care in the Community, Current State

Veterans Health Administration

- Stephanie Mardon, Chief Business Officer
- Kristin Cunningham, Director, Business Policy Affairs

Future State of VA Community Care/ Care in the Community

Veterans Health Administration

- Joe Dalpiaz, Director, Network 17
- Baligh Yehia, MD, Senior Health Advisor to the Secretary of Veterans Affairs
- Gene Migliaccio, Deputy Chief Business Officer, Managed Care

Academic Affiliations

Veterans Health Administration

- Robert Jesse, MD, Chief, Office of Academic Affiliations
- Karen Sanders, MD, Deputy Chief, Office of Academic Affiliation Long-Term Care
- Richard Allman, MD, Chief Consultant, Geriatrics and Extended Care Services

October 19–20, 2015

Independent Assessment, Perspective on VA Health Care, and Q&A/Panel Discussion

- Brett Giroir, MD, Senior Fellow, Health Policy Institute, Texas Medical Center
- Gail Wilensky, PhD, Senior Fellow at Project HOPE
- Jonathan Perlin, MD, Chief Medical Officer and President, Clinical Services at Hospital Corporation of America

October 19–20, 2015 (continued)

Women's Health	Veterans Health Administration <ul style="list-style-type: none"> Patricia Hayes, PhD, Chief Consultant, VA Women's Health Services
Mental Health	Veterans Health Administration <ul style="list-style-type: none"> David Carroll, Executive Director, Mental Health Operations Harold Kudler, MD, Chief Mental Health Consultant
Homelessness	Veterans Health Administration <ul style="list-style-type: none"> Anne Dunn, Deputy Director, VHA Homeless Program Office
Assessment D: Access	Institute of Medicine <ul style="list-style-type: none"> Michael McGinnis, MD Marianne Hamilton Lopez
VACAA Section 203	Northern Virginia Technology Council <ul style="list-style-type: none"> Ken Mullins
Scheduling	Veterans Health Administration <ul style="list-style-type: none"> Michael Davies, MD, Executive Director of Access and Clinic Administration Program
MyVA Support Services Excellence Overview	Department of Veterans Affairs <ul style="list-style-type: none"> Bob Snyder, Executive Director, MyVA Task Force Tom Muir, Director, Support Services

November 16–17, 2015

Health Care Economics/Finance	<ul style="list-style-type: none"> Mark Yow, Acting Chief Financial Officer, VHA Paul Mango, McKinsey & Company Gail Wilensky, PhD, Senior Fellow at Project HOPE
Academic Affiliations	Association of American Medical Colleges <ul style="list-style-type: none"> Atul Grover, PhD, MD, Chief Public Policy Officer John E. Prescott, MD, Chief Affiliations Officer Matthew Schick, JD, Director, Government Regulations & Regulatory Counsel
VHA Clinical Matters	Veterans Health Administration <ul style="list-style-type: none"> Lucille Beck, PhD, Deputy Chief Patient Care Services Officer, Rehab and Prosthetic Services Donna Gage, PhD, RN, Chief Nursing Officer, Veterans Health Administration

EVALUATION OF INDEPENDENT ASSESSMENT

One of the challenges the Commission faces as it deliberates the effectiveness of VA health care is the need to consider the complex nature of the VA system. There are certainly aspects of VA health care that can be compared with private-sector care, such as provider-related issues, quality of care, patient safety, access, and patient satisfaction. The VA health care system, however, has a broader mission than its private-sector counterparts. Beyond providing medical care for veterans, the VA system also includes congressionally mandated components in areas such as research, emergency preparedness, medical education, and homelessness that render the system expansive and unique.

To set the stage for making recommendations, given the breadth of what constitutes VA health care, the commission created five workgroups to focus its consideration of the respective recommendations for the 12 areas included in the *Independent Assessment Report*. The health care alignment workgroup is focused on demographics (Assessment A), health care capabilities (Assessment B), care authorities (Assessment C), and access standards (Assessment D). The health care operations workgroup is focused on access standards (Assessment D), workflow-scheduling (Assessment E), workflow-clinical (Assessment F), and staffing productivity (Assessment G.) The health care data, tools, and infrastructure workgroup is focused on health information technology (Assessment H), business processes (Assessment I), supplies (Assessment J), and facilities (Assessment K). The health care leadership workgroup is focused on all the previously mentioned assessments and leadership (Assessment L). The last workgroup is focused on health care trends as they relate to all of the assessment areas.

Areas Not Covered in the Report

The Commission identified important areas not mentioned in the *Independent Assessment Report*. The following are examples:

- The report does not provide projected demographics past 2024, yet VACAA Section 202 calls for the Commission to project to 2035.
- Although account was taken of VSO perspectives, the critically important voice of individual veterans is largely absent; in addition, the VSO perspective presented in the report does not necessarily capture the experience of homeless veterans.
- The report does not discuss implications of VA's requirement to provide long-term care to the fast-growing population of aging veterans.
- No cost data are provided (to include no cost data on clinical services, social services and supports, long-term care, and VHA's other three missions).

- The report does not mention the congressionally mandated missions of education and training, research, and emergency preparedness, which are important because of how these mandates are intertwined with the provider mission.
- The report lacks analysis of (a) eligibility, to include the reported 10 percent of unique VA health care users who are non-veterans; (b) the scope of health benefits afforded veterans; and (c) alternative mechanisms to fund veterans' care.
- The report data are insufficient to support understanding the makeup of the veteran (priority-group) cohorts that are eligible for but do not use VA care. Such data are vital, as they relate to understanding more fully why some veterans use VA, yet others do not.

Barriers to Transformation

Practical Barriers

The following are examples of perceived practical barriers to implementing recommendations in the *Independent Assessment Report*:

- VHA's antiquated information technology (IT) infrastructure and lack of enterprisewide strategy for IT inhibit substantial, integrated change in all areas of the organization.
- Without IT systems in place to provide a means to determine VA cost data that would permit like-kind comparisons with private-sector costs, it is impossible to make fully informed judgments about providing versus buying care or ultimately to make data-driven judgments about how best to deliver care to veterans in the future.
- VA lacks strong education and training plans for staff at all levels, as well as operations, organizations, technology, and funding to develop and grow leaders.
- The current financial management systems, lacking easily accessible data and analytic tools, do not permit data tracking and analytics necessary for leadership to effectively manage resources at the level of detail and timeliness required or gain insights into financial performance across the system.
- VA lacks policies to facilitate consistent collaboration with DoD and community partners.
- There is currently no objective mechanism for evaluating the utility and need of health care facilities within the context of health care delivery design.
- From a human capital perspective, VHA has a culture of risk-aversion, lack of engagement, and low morale that inhibits implementation of high-performing services throughout the enterprise.

Statutory and Regulatory Barriers

VHA administrators face challenges in trying to reduce costs because they lack the sophisticated, automated cost-accounting systems that allow their private-sector peers to identify and evaluate cost-saving targets. Sensitivity to containing health care costs and maximizing value has led private-sector health care executives to find savings through mechanisms such as merging facilities, purchasing physician practices, downsizing hospital operations, and shifting to less expensive ambulatory centers and retail health clinics.

VA is an executive department governed by statutes that can affect operational success. The agency is a complex system in a government setting with rules that make sense for many government operations, but may create challenges in a health care system. Consequently, VHA is an organization that would benefit from unique statutory relief. The VA health care system has evolved under governance of a congressional board of directors, resulting in a situation in which administrators navigate around laws that constrain sound management and thwart their ability to achieve systemic transformation. Below are several examples:

- Under Section 510(b) of Title 38, U.S. Code (“The Secretary may not in any fiscal year implement an administrative reorganization”), if facilities consolidation would reduce facility workforce by as little as 15 percent, a detailed report and justification must be provided to Congress in advance of any action. This report-and-wait requirement complicates management of a more than \$60 billion medical care budget for which executives must win congressional approval not only for any major construction work but also to lease outpatient clinic space of any substantial size.³⁶
- Although VHA has vast unused and underutilized real estate holdings in the form of buildings on the grounds of many of its older health care facilities, it may not simply dispose of properties, and is forced to maintain these older structures, constrained by a prescriptive statutory roadmap.³⁷
- The constraints of the federal personnel system make it difficult to hire health care professionals in a timely manner.³⁸ Recent history highlights the vulnerability of a health care system when, for example, relatively low-paid scheduling clerks cannot be retained. The personnel system is not suited to meeting the dynamic requirements of a health care system. A provision of law setting the term for appointment of the VA under secretary for health (who serves as the chief executive officer) further constrains the system.³⁹

³⁶ Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104 (2012). Compounding VHA’s leasing challenges, the Congressional Budget Office construes long-term leases to be capital leases, thus requiring large increases in budget authority.

³⁷ Authority for Transfer of Real Property, 38 U.S.C. § 8118 (2012). Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122 (2012). Enhanced-Use Leases, 38 U.S.C. § 8161 (2012).

³⁸ Pay, 38 U.S.C. § 7431 (2010). VHA’s Title 38 employment authorities are limited in scope and constrained by pay caps.

³⁹ Office of the Under Secretary for Health, 38 U.S.C. § 7306 (2011).

- These statutory and regulatory barriers even extend to issues such as parking. A section of VA's governing law, Title 38 of the U.S. Code, is devoted to parking facilities – authorizing the use of parking fees, but identifying categories of persons who may and may not be charged.⁴⁰

As it continues its work in the months ahead, the Commission will examine ways in which fundamental statutory changes would advance large-scale transformation and support the ability to be responsive in a rapidly and continuously changing industry.

Health Care Trends

In its deliberations, the Commission will consider some key assumptions about health care trends that will affect the future of veterans' health care, such as those noted below.

- Health care is transitioning from a volume model, often driven by fee-for-service health care plans, to a value model that reduces unnecessary care and the costs associated with it. Development of clinical pathways, standardization, and better end-of-life management improve the quality of care for the individual patient and also may contribute to overall cost containment.
- Health care will continue to shift from inpatient to outpatient care for many medical and surgical procedures and care processes, which will increase the need for investment in outpatient centers and will result in excess inpatient capacity in U.S. hospitals.
- Health care will be increasingly coordinated and integrated to drive a more holistic approach to care, to improve quality and clinical outcomes, and to reduce cost.
- Health care will be more focused on health and wellness, and will continue to provide advanced treatment for illness and injury.
- Health care organizations will become larger and more comprehensive in their capabilities due to mergers, acquisitions, and strategic partnerships. This process will enable them to meet the new demands of health care delivery.
- The Affordable Care Act will create access to insurance and organized health care delivery for millions of Americans who were previously uninsured, including many veterans.
- Consumers will pay more of the cost of care due to high-deductible insurance plans, which will create a greater need for affordability in health care, new pricing strategies to attract patients, and innovative solutions to deliver care.
- Technology will rapidly change health care in both the clinical approaches to care and the ways information is made available to the care team, the patient, and family members. Technology will be a differentiator for health care systems and hospitals and

⁴⁰ Parking Facilities, 38 U.S.C. § 8109 (2012).

will be sought by consumers who want and need the most contemporary approach to the delivery of care.

- Health care is ripe for disruption, and there will be many nontraditional organizations that become leaders in health care (e.g., digital technology companies and retail pharmacies) to drive rapid clinical improvement and lower-cost options for patients and payers.
- Demand for behavioral and mental health services is increasing, yet there is a shortage of key mental health professionals. There is also a shortage of primary care providers. These shortages are not only in the VA health care system but also in the private-sector health care market.

OUTLINE FOR DATA PROCESSING AND RECOMMENDATION DEVELOPMENT

Areas of Focus for Framing Discussion

Several core issues will serve as a framework for discussion and deliberation as the Commission develops recommendations for its final report. In considering these issues, the primary determining factor will be making sure recommendations provide for timely, effective health care for veterans.

- **Business Model**

- VHA needs a clearly defined business model to identify the services VA will provide directly and the services it will purchase from the private sector. VHA could be a comprehensive provider of all health care services for all eligible veterans, a provider of service-related health care services with coordination of community health care services for all eligible veterans, or a provider that follows some other model.
- Cost to provide care at VA facilities and elsewhere, and projected cost increases based on technology, inflationary trends, and the effects of issues such as insurance premiums and deductibles, must be considered in determining the optimal approach.
- The Commissioners will consider how trends of private-sector health care organizations, such as increased complexity due to mergers and acquisitions, may affect VA purchased care options.

- **Philosophy:** VA/VHA will need to follow a philosophy that considers relevant principles and practices from MyVA, the *Blue Print for Excellence*, and the *Independent Assessment Report* in ways that inspire, focus, and simplify the work ahead through an integrated systems approach.

- **Role of VHA Central Office:** The role of VHA central office needs to be defined, addressing issues such as whether it should have a centralized or decentralized governance structure, how big it should be, what the scope of central office activities should be, what leadership philosophy should be followed, and what accountability model should be implemented.

- **VHA's Role within VA:** Among the issues to be considered is whether VHA should follow a typical business-unit model, accessing centralized VA functions such as IT, or function as a separate integrated health system that also is integrated with other VA services and functions, but has full capabilities on its own.

- **Change Framework:** The Commission will identify the essential infrastructure functions needed to create transformational change and excellence for VHA. Some examples of these functions include the following:
 - Efficient, effective, and people-focused human resources processes
 - High-performing and skilled project management/performance improvement capabilities to support business and clinical process improvement
 - An integrated finance team to support cost awareness and effective support for buy/sell decisions
 - Health care IT leadership to create interoperability, contemporary capabilities for classifying medical conditions using the current International Statistical Classification of Diseases and Related Health Problems coding system (ICD-10), and decision support
 - An integrated platform to reduce cost and enhance coordination and quality of care

- **Leadership:** VHA must attract and retain effective leaders and give them appropriate authority to create and execute strategic and transformational initiatives. The Commission will consider how this ideal can be accomplished. It also will consider what governance model will engage talented leaders who can provide appropriate expertise, accountability, and oversight that drives the transformation process during the next 5-10 years. Succession planning should be addressed.

- **Stakeholder Transparency:** Among the VHA pillars of performance (people, quality and safety, service, academics, and cost), those that are most important should be identified for inclusion in a VHA dashboard. Appropriate performance metrics should be chosen to provide stakeholders with full transparency.

- **Role as an Academic Organization:** The Commission will consider how any recommended changes might affect the VHA's role in providing veteran-specific research on spinal cord injury, traumatic brain injury, amputations, and other service-specific injuries. It will also consider how recommended changes might affect the education component of VHA's mission.

Timeline for Final Report

According to VACAA Section 202, the Commission is to issue a final report 90 days after the completion of this interim report. It has become clear that adhering to this deadline would substantially frustrate realizing the objectives Congress set forth in establishing the Commission. Although the Commission has been pursuing an aggressive schedule, the magnitude of the work before it will not allow the Commission to develop the kind of recommendations it is charged with producing, which are supposed to both remedy the systemic problems hampering VHA today and position the system to meet the needs of the future. Although the Commission had met the requirement for having a quorum of members (eight) in August 2015, the full commission was not convened until October 19, 2015. The *Independent Assessment Report*, a 4,000-page document, was not delivered until September 1, 2015.

VACAA Section 202 requires the Commission to review the assessment, with its more than 180 major recommendations and approximately 300 additional recommendations that identify what needs to be addressed to reform veterans' health care. Reviewing and analyzing a report of this magnitude is in itself a considerable undertaking; however, of even greater magnitude is the charge to the Commission to identify a pathway to the future and develop an effective plan to determine how reform will take place.

In the spirit of the guiding principles created by the Commission, which demonstrate a commitment to improving the quality and accessibility of care veterans receive, the Commission is seeking an extension to June 15, 2016 to file its final report. This extension would enable the Commission to provide a comprehensive review with executable recommendations and to meet the expectations of the various stakeholders. For example, additional time would allow the Commission to bring the veterans' collective voice to its final report. Currently, the Commission has received feedback from a limited number of VSOs. More time will allow for more VSOs to provide feedback, and will allow the Commission time to collect feedback directly from veterans.

With adequate time to properly vet its recommendations, the Commission will contribute meaningfully to the conversation regarding health care received through VHA by the women and men who have served our nation. The Commission is committed to producing recommendations that will enhance and support reform already in progress within the VA health care system, as well as providing recommendations that create new avenues for enabling VHA to provide the dynamic health care system America's veterans deserve.

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX A: GUIDING AND ENABLING DOCUMENTS

Veterans Access, Choice, and Accountability Act of 2014

TITLE II—HEALTH CARE ADMINISTRATIVE MATTERS

SEC. 201. INDEPENDENT ASSESSMENT OF THE HEALTH CARE DELIVERY SYSTEMS AND MANAGEMENT PROCESSES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) INDEPENDENT ASSESSMENT.—

(1) ASSESSMENT.— Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into one or more contracts with a private sector entity or entities described in subsection (b) to conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department. Such assessment shall address each of the following:

(A) Current and projected demographics and unique health care needs of the patient population served by the Department.

(B) Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans.

(C) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

(D) The appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.

(E) The workflow process at each medical facility of the Department for scheduling appointments for veterans to receive hospital care, medical services, or other health care from the Department.

(F) The organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.

(G) The staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following:

(i) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week.

(ii) The time spent by such health care provider on matters other than the case load of such health care provider, including time spent by such health care provider as follows:

(I) At a medical facility that is affiliated with the Department.

(II) Conducting research.

(III) Training or supervising other health care professionals of the Department.

(H) The information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.

(I) Business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third-party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

(i) To avoid the payment of penalties to vendors.

(ii) To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.

(iii) To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.

(iv) To increase the accuracy and timeliness of Department payments to vendors and providers.

(J) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department, including the following:

(i) The prices paid for, standardization of, and use by the Department of the following:

(I) Pharmaceuticals.

(II) Medical and surgical supplies.

(III) Medical devices.

(ii) The use by the Department of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services.

(iii) The strategy and systems used by the Department to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to Veterans Integrated Service Networks and medical facilities of the Department.

(K) The process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.

(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.

(2) PARTICULAR ELEMENTS OF CERTAIN ASSESSMENTS. –

(A) SCHEDULING ASSESSMENT. – In carrying out the assessment required by paragraph (1)(E), the private sector entity or entities shall do the following:

(i) Review all training materials pertaining to scheduling of appointments at each medical facility of the Department.

(ii) Assess whether all employees of the Department conducting tasks related to scheduling are properly trained for conducting such tasks.

(iii) Assess whether changes in the technology or system used in scheduling appointments are necessary to limit access to the system to only those employees that have been properly trained in conducting such tasks.

(iv) Assess whether health care providers of the Department are making changes to their schedules that hinder the ability of employees conducting such tasks to perform such tasks.

(v) Assess whether the establishment of a centralized call center throughout the Department for scheduling appointments at medical facilities of the Department would improve the process of scheduling such appointments.

(vi) Assess whether booking templates for each medical facility or clinic of the Department would improve the process of scheduling such appointments.

(vii) Assess any interim technology changes or attempts by Department to internally develop a long-term scheduling solutions with respect to the feasibility and cost effectiveness of such internally developed solutions compared to commercially available solutions.

(viii) Recommend actions, if any, to be taken by the Department to improve the process for scheduling such appointments, including the following:

(I) Changes in training materials provided to employees of the Department with respect to conducting tasks related to scheduling such appointments.

(II) Changes in monitoring and assessment conducted by the Department of wait times of veterans for such appointments.

(III) Changes in the system used to schedule such appointments, including changes to improve how the Department –

(aa) measures wait times of veterans for such appointments;

(bb) monitors the availability of health care providers of the Department; and

(cc) provides veterans the ability to schedule such appointments.

(IV) Such other actions as the private sector entity or entities considers appropriate.

(B) MEDICAL CONSTRUCTION AND MAINTENANCE PROJECT AND LEASING PROGRAM ASSESSMENT. – In carrying out the assessment required by paragraph (1)(K), the private sector entity or entities shall do the following:

(i) Review the process of the Department for identifying and designing proposals for construction and maintenance projects at medical facilities of the Department and leases for medical facilities of the Department.

(ii) Assess the process through which the Department determines the following:

(I) That a construction or maintenance project or lease is necessary with respect to a medical facility or proposed medical facility of the Department.

(II) The proper size of such medical facility or proposed medical facility with respect to treating veterans in the catchment area of such medical facility or proposed medical facility.

(iii) Assess the management processes of the Department with respect to the capital management programs of the department, including processes relating to the methodology for construction and design of medical facilities of the Department, the management of projects relating to the construction and design of such facilities, and the activation of such facilities.

(iv) Assess the medical facility leasing program of the Department.

(3) TIMING. – The private sector entity or entities carrying out the assessment required by paragraph (1) shall complete such assessment not later than 240 days after entering into the contract described in such paragraph.

(b) PRIVATE SECTOR ENTITIES DESCRIBED. – A private entity described in this subsection is a private entity that –

(1) has experience and proven outcomes in optimizing the performance of the health care delivery systems of the Veterans Health Administration and the private sector and in health care management; and

(2) specializes in implementing large-scale organizational and cultural transformations, especially with respect to health care delivery systems.

(c) PROGRAM INTEGRATOR. –

(1) IN GENERAL. – If the Secretary enters into contracts with more than one private sector entity under subsection (a), the Secretary shall designate one such entity that is predominately a health care organization as the program integrator.

(2) RESPONSIBILITIES. – The program integrator designated pursuant to paragraph (1) shall be responsible for coordinating the outcomes of the assessments conducted by the private entities pursuant to such contracts.

(d) REPORT ON ASSESSMENT. –

(1) IN GENERAL. – Not later than 60 days after completing the assessment required by subsection (a), the private sector entity or entities carrying out such assessment shall submit to the Secretary of Veterans Affairs, the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Commission on Care established under section 202 a report on the findings and recommendations of the private sector entity or entities with respect to such assessment.

(2) PUBLICATION. – Not later than 30 days after receiving the report under paragraph (1), the Secretary shall publish such report in the Federal Register and on an Internet website of the Department of Veterans Affairs that is accessible to the public.

(e) NON-DEPARTMENT FACILITIES DEFINED. – In this section, the term “non-Department facilities” has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 202. COMMISSION ON CARE.

(a) ESTABLISHMENT OF COMMISSION. –

(1) IN GENERAL. – There is established a commission, to be known as the “Commission on Care” (in this section referred to as the “Commission”), to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of this Act.

(2) MEMBERSHIP. –

(A) VOTING MEMBERS. – The Commission shall be composed of 15 voting members who are appointed as follows:

(i) Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

(ii) Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a veteran.

(iii) Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a veteran.

(iv) Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a veteran.

(v) Three members appointed by the President, at least two of whom shall be veterans.

(B) QUALIFICATIONS. – Of the members appointed under subparagraph (A) –

(i) at least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code;

(ii) at least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;

(iii) at least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)));

(iv) at least one member shall be familiar with the Veterans Health Administration but shall not be currently employed by the Veterans Health Administration; and

(v) at least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.

(C) DATE. – The appointments of members of the Commission shall be made not later than 1 year after the date of the enactment of this Act.

(3) PERIOD OF APPOINTMENT. –

(A) IN GENERAL. – Members shall be appointed for the life of the Commission.

(B) VACANCIES. – Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING. – Not later than 15 days after the date on which eight voting members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS. – The Commission shall meet at the call of the Chairperson.

(6) QUORUM. – A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON AND VICE CHAIRPERSON. – The President shall designate a member of the commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.

(b) DUTIES OF COMMISSION. –

(1) EVALUATION AND ASSESSMENT. – The Commission shall undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs.

(2) MATTERS EVALUATED AND ASSESSED. – In undertaking the comprehensive evaluation and assessment required by paragraph (1), the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201, including any findings, data, or recommendations included in such assessment.

(3) REPORTS. – The Commission shall submit to the President, through the Secretary of Veterans Affairs, reports as follows:

(A) Not later than 90 days after the date of the initial meeting of the Commission, an interim report on –

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(B) Not later than 180 days after the date of the initial meeting of the Commission, a final report on –

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(c) POWERS OF THE COMMISSION. –

(1) HEARINGS. – The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES. – The Commission may secure directly from any Federal agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

(d) COMMISSION PERSONNEL MATTERS. –

(1) COMPENSATION OF MEMBERS. –

(A) IN GENERAL. – Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission.

(B) OFFICERS OR EMPLOYEES OF THE UNITED STATES. – All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES. – The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF. –

(A) IN GENERAL. – The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION. – The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES. – Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES. – The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) TERMINATION OF THE COMMISSION. – The Commission shall terminate 30 days after the date on which the Commission submits the report under subsection (b)(3)(B).

(f) FUNDING. – The Secretary of Veterans Affairs shall make available to the Commission from amounts appropriated or otherwise made available to the Secretary such amounts as the Secretary and the Chairperson of the Commission jointly consider appropriate for the Commission to perform its duties under this section.

(g) EXECUTIVE ACTION. –

(1) ACTION ON RECOMMENDATIONS. – The President shall require the Secretary of Veterans Affairs and such other heads of relevant Federal departments and agencies to implement each recommendation set forth in a report submitted under subsection (b)(3) that the President –

(A) considers feasible and advisable; and

(B) determines can be implemented without further legislative action.

(2) REPORTS. – Not later than 60 days after the date on which the President receives a report under subsection (b)(3), the President shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of

Representatives and such other committees of Congress as the President considers appropriate a report setting forth the following:

(A) an assessment of the feasibility and advisability of each recommendation contained in the report received by the President.

(B) For each recommendation assessed as feasible and advisable under subparagraph (A) the following:

(i) Whether such recommendation requires legislative action.

(ii) If such recommendation requires legislative action, a recommendation concerning such legislative action.

(iii) A description of any administrative action already taken to carry out such recommendation.

(iv) A description of any administrative action the President intends to be taken to carry out such recommendation and by whom.

APPENDIX B: ACRONYM LIST

ACRONYM	DEFINITION
CAMH	CMS Alliance to Modernize Healthcare
DoD	Department of Defense
IOM	Institute of Medicine
IT	Information Technology
VA	U.S. Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VHA	Veterans Health Administration
VSO	Veterans Service Organization

COMMISSION ON CARE

CHAIRPERSON

Nancy M. Schlichting

VICE CHAIRPERSON

Delos M. Cosgrove, MD

COMMISSIONERS

Michael A. Blecker

David P. Blom

David W. Gorman

Thomas E. Harvey

Stewart M. Hickey

Joyce M. Johnson, DO

The Honorable Ikram U. Khan, MD

Phillip J. Longman

Lucretia M. McClenney

Darin S. Selnick

Martin R. Steele

Charlene M. Taylor

Marshall W. Webster, MD

EXECUTIVE DIRECTOR

Susan M. Webman

