
COMMISSION ON CARE

MEETING MINUTES FOR NOVEMBER 16-17, 2015

The Commission on Care convened its meeting on November 16-17, 2015, at the ASAE Conference Center, 1575 Eye Street, NW, in Washington, DC.

Commissioners Present:

Nancy M. Schlichting – Chairperson
Toby M. Cosgrove – Vice Chairperson
Michael A. Blecker
David P. Blom
David W. Gorman
Stewart M. Hickey
Joyce M. Johnson
Ikram U. Khan
Phillip J. Longman
Lucretia M. McClenney
Darin S. Selnick
Martin R. Steele
Charlene M. Taylor
Marshall W. Webster

Commission Staff Identified:

Susan Webman – Executive Director
John Goodrich – Executive Officer
Sharon Gilles – Designated Federal Officer (DFO)

Department of Veteran Affairs (VA) Presenters:

Lucille Beck – Deputy Chief, Patient Care Services, Veterans Health Administration (VHA)
Donna Gage – Chief Nursing Officer, VHA
Mark Yow – Acting Chief Financial Officer, VHA

Other Presenters:

Atul Grover – Chief Public Policy Officer, Association of American Medical Colleges (AAMC)
John Prescott – Chief Academic Officer, AAMC
Matthew Shick – Director, Government Relations and Regulatory Counsel, AAMC
Paul Mango – Director, McKinsey & Company
Gail Wilensky – Senior Fellow, Project HOPE

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The Commission on Care meeting opened at 8:35 a.m.

Welcome/Opening Remarks

Ms. Nancy Schlichting (Chairperson) opened the meeting and welcomed everyone present.

VHA Chief Financial Officer

Mark Yow provided an overview of the financial structures and status of the VHA in response to a series of questions posed to him by the Commission before the meeting. The first asked what the cost implications are to implement the VA Choice programs. The program has two types of cost: implementation and recurring.

In response to a request for a comparison between VA and the private sector, Mr. Yow noted that a direct comparison is difficult because of the uniqueness of VHA's programs compared to the private sector and the age of VHA systems. Medicare provides a universally-accepted rate to which VHA can make a comparison; VA also has found that competitiveness varies largely based on episode of care and location. In terms of calculating costs, the Department uses the VHA Enrollee Healthcare Model to drive 90 percent of budget requirements, looking at trends in VHA and the private sector to identify emerging types of care, patterns of care, and treatments. This model ties together data from the Department of Defense (DoD) with age- and sex-adjusted data.

Mr. Yow provided the Commission with an overview of how funding flows from the VA Central Office (VACO) to the VISNs and ultimately down to the VA medical centers (VAMCs). Additionally, Mr. Yow explained how the current funding structure works. VA receives an advanced appropriation from Congress every two years, which both removes concerns when a continuing resolution is in place, but also makes projecting future needs more difficult than a yearly appropriation. Moreover, the budget is further split into three separate appropriations, which makes managing it even more difficult.

The Commission discussed financial and budgetary topics within VHA and posed questions to Mr. Yow. Items discussed included:

- The implementation process for VA Choice Act programs
- Specifics of VA's contracts with third party administrators
- Specifics of VA's Care in the Community programs
- The structure of contracting and budgeting systems within VA
- Comparing costs in VA to the private sector
- The budgetary impact of vacant positions

Economic Trends in Health Care

Paul Mango, of McKinsey & Company, presented an overview of current economic trends in health care. Mr. Mango provided a history of health systems management, leading to the modern era, which has been focused on expanding scope of care to all Americans. The primary payers for the current system are consumers, their employers, and the government. While employers have historically paid for the majority of consumer's costs, the current system sees consumers taking on more of health care expenses.

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There are two key factors driving the health care industry: an economic dependence on the commercially insured and a cross-cutting subsidy between commercial and government-sponsored patients. Currently, the largest areas of growth are in pharmaceuticals and care outside of the hospital—ambulatory surgeries, laboratory diagnostics, etc. The funding needs of health systems are vast and complex, and the system as a whole is best characterized by high fixed costs, thin margins, and sensitivity to shifts in volume. To survive in this environment, health systems price above their costs, try to attract more volume, and measure quality as a function of the outcome of an episode of care. Health systems are also increasingly becoming insurers as well, which changes motivations in the system.

The foremost trend affecting the private-sector health care industry is a severe strain on the intramural cross-cutting subsidy. Employers are trying to isolate, minimize, or fix their liability for health care expense, meaning consumers are starting to pay more of the bill, leading them to become more interested in cost and necessity. The government side, on the other hand, is moving in the opposite direction to a more managed system. Providers are finding it difficult to simultaneously address both of these shifts, which come with different expectations, success factors, and economics. Several prominent mergers between insurers are also on the horizon, as small market share companies are finding tight margins and an increased legislative burden difficult to manage. Furthermore, the industry is seeing other trends such as a decrease in retiree benefits, growth in outpatient care, and an increased interest in digital medical devices and telemedicine.

The Commission discussed current economic trends in health care and posed questions to Mr. Mango. Items discussed included:

- How the health care industry has changed over time
- The relationship between health care and insurance
- The impact of legislation on economic trends in health care
- Economic incentives that influence VHA and the American health care system
- Demographic influences on VHA and the American health care system

Federal Health Care Programs

Gail Wilensky, of Project HOPE [with extensive experience in public and private health care], provided an overview of federal health care programs. Spending on health care has a major effect on the federal budget, with its impact set to increase over time. During the next decade, health care spending in the forms of Medicare, Medicaid, and other mandatory health care is projected to double while discretionary spending remains flat. In Medicare, beneficiaries can expect to draw significantly more in program benefits than they have directly contributed, causing expenditures to greatly exceed dedicated program revenue.

In terms of Medicare specifically, the way providers are paid is changing, moving away from small-unit fee for service to value-based purchasing. The system itself is still in flux, with many pilot projects underway, mixed accountable care organization results and an increasing number of seniors choosing private plans over traditional Medicare. Future Medicare changes include an anticipated doubling of the eligible population from 2010 to 2030, and projected increased spending.

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TRICARE provides civilian health care benefits for military, retirees, and dependents. TRICARE currently uses Medicare reimbursements rates with a minimal focus on provider net value or utilization, mimics Medicare Fee-for-Service with minimal patient engagement, and misses opportunities to provide better outcomes due to political expediency. To address the issues facing TRICARE and provide recommendations, the Military Compensation and Retirement Modernization Commission was created, providing a final report to the President and Congress in January 2015. Among its recommendations were increased access, choice, and value, and allowing beneficiaries to choose from a selection of commercial insurance plans offered through a DoD health benefit plan.

Entitlement spending pressures will force changes to Medicare, Medicaid, and Social Security, while DoD will pressure TRICARE to change. The changes to these programs, combined with the changing private care marketplace, will force VA to resolve its role in delivering care to veterans.

The Commission discussed the impact of federal health care programs on the federal budget, and posed questions to Ms. Wilensky. Items discussed included:

- How changes to Medicare could affect opportunities for VHA
- The relationships between various federal health care programs and VA

Day 1 closing remarks were provided by Ms. Schlichting and the meeting was adjourned at 12:47 p.m.

Day 2 of the Commission on Care meeting opened at 8:32 a.m.

Association of American Medical Colleges (AAMC) Presentation

Atul Grover, John Prescott, and Matthew Shick provided an overview of AAMCs' partnership with VA. The AAMC is a collection of medical schools, teaching hospitals and health systems, and academic and scientific societies that provide patient care, conduct research, and train medical professionals. In their partnership, VA and AAMC are indispensable training centers for the nation's future health care workforce, laboratories of innovation, and centers of clinical care.

Established by policy memorandum in 1946, the VA-Academic partnership facilitates a large overlap between the private and public sectors, with 70 percent of VA physicians having a faculty appointment, and two out of every three physicians going to the VA during their schooling or training. For veterans, the AAMC provides a unique set of essential services, including critical standby capacity and cutting-edge research, while the veterans serve as a unique population that present special medical and psycho-social needs. One current crisis that the VA-AAMC partnership is helping to address is the shortage of VA physicians. This shortage is a harbinger of an anticipated nationwide shortage of physicians, meaning that the two groups will need to work together to rapidly train and prepare tomorrow's doctors.

Some challenges that hinder addressing this crisis are due to VA contracting constraints. The complicated VA contracting system presents a regulatory and bureaucratic burden that slows down the entire process. Contracting with academic medicine is different from buying other goods and services, and requires special consideration as well as streamlining of the bureaucracy. Another challenge for the academic affiliations is that Medicare Graduate Medical Education (GME) caps are blocking VA from expanding its own GME slots. Legislative action is

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needed to address this issue. Other barriers include VAMC leadership gaps and that appointments as AAMC faculty are perceived as a conflict of interest.

The VA plan to consolidate community care in VA Choice helps address some of these concerns. Academic affiliates are considered part of the VA “Core Network” and are treated as a direct extension of VA care. Better care coordination will also help eliminate some of the challenges of collaborating between VA and academic centers. VA Choice will also eliminate inconsistencies between third-party administrators, eliminate some duplication of efforts, and eliminate conflicting rates under the Patient-Centered Community Care program.

The Commission discussed VA’s partnership with the AAMC, and posed questions to the presenters. Items discussed included:

- The specifics of how affiliations work on the local level
- The benefits of academic affiliations and joint ventures for both VA and AAMC
- The financial and contracting structures behind academic affiliations
- Integration of VA and AAMC facilities
- How academic affiliations integrate with the greater VA mission
- Future challenges facing VA/AAMC partnerships

Nursing in VA

Donna Gage, Chief Nursing Officer (CNO) for VA, provided an overview of nursing. Nurses are the largest workforce within VHA and vital to VA carrying out its mission. While providing an overview of how VA nursing is structured, Ms. Gage highlighted the changes necessary to improve VA nursing. A comprehensive systems approach will unify nursing from the lowest levels in the organization to the highest, with the Office of Nursing Services (ONS) incorporating this approach. The CNO role was recently elevated to serve as a voice and leadership role for nurses at the executive level. The CNO will help ONS move from a policy-centric viewpoint to involvement with operations and increase and improve communications with the field. Culturally, VA nursing will need to shift from a traditionally siloed approach to increased collaboration, and eliminate fear and distrust through empowered staff and shared decision making.

Allowing nurses to practice to the full extent of their education and training is another area of focus for the ONS. Proposed changes that promote this will increase access to care, ensure continuity of the highest quality of care, and improve the ease of recruiting of advanced practice registered nurses (APRNs). Further expansion of academic practice partnerships, post-baccalaureate residencies, nurse practitioner residency programs, and post-doctoral fellowships will improve the desirability of VA nursing positions and help recruitment. Beyond recruitment of nurses, retention is another area of focus for ONS. Factors that are critical in improving retention of highly skilled nurses include recognition, professional satisfaction, quality of professional relationships, professional development opportunities, and compensation.

Finally, improving data and technology will help facilitate better patient outcomes. ONS will integrate evidence-based practice and research into clinical and operational processes; establish new ways of achieving high-quality, effective, and efficient care; monitor performance metrics and adopt best practices for continuous improvement; and collaborate with other disciplines in research endeavors.

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The Commission discussed nursing within VA, and posed questions to Dr. Gage. Items discussed included:

- VHA Nursing policies and standards
- The effect of state and federal laws on nursing within VHA
- The state of nursing leadership within VHA
- The roles nurses play within VA medical facilities
- How VA nursing compares with the private sector
- How nurses fit into various VA programs

Rehabilitative Services

Lucille Beck, Deputy Chief for Patient Care Services, provided an overview of rehabilitative programs within VHA. VHA's mission in rehabilitative services is to maximize veterans' independence and ability to maintain their highest levels of function. This mission is carried out through various programs that help address veterans' medical, rehabilitative, and prosthetic needs.

VA's polytrauma system of care was developed from the previous traumatic brain injury system in response to the needs of the newest cohort of veterans from Iraq and Afghanistan and their injuries from combat service. VA helps DoD provide rehabilitation in the areas of spinal cord injury, blindness, brain injury, and amputation. The system today is interdisciplinary, integrated, and encompasses the whole country with five polytrauma rehabilitation centers, 76 support clinics and 50 polytrauma points of contact. The program focuses on ensuring quality through outcome measures, using benchmarks from the private sector and participating in longitudinal database reporting.

The amputation system of care provides post-acute rehabilitation for amputees injured in Iraq and Afghanistan and is collocated with the polytrauma system of care. The program uses a robust amputation clinic system and advanced technologies to manage more than 40,000 amputees. VA is the only national health care system which has completely integrated rehabilitation services for patients with visual impairments, and has upgraded and expanded its continuum of care within the last ten years.

Hearing loss and tinnitus are among the top conditions for which veterans are receiving service-connected care; VA's audiology services are comprehensive and serve as a model to a growing private-sector and government initiative to improve audiological care. VA treats both acute and rehabilitative spinal cord injury conditions, and can provide comprehensive care because it isn't bound by various insurance limitations that hinder many in the private sector. VA's prosthetics and sensory aids provide veterans in all areas of rehabilitative services with both off-the-shelf and custom products, and have seen increased utilization in recent years.

The Commission discussed VA's patient care services, and posed questions to Ms. Beck. Items discussed included:

- The steps that make up the rehabilitative process
- Case management and coordination of care in VA's rehabilitative programs
- VA's relationship with the DoD in rehabilitative care
- Factors that influence VA being at the forefront of rehabilitative care

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- The future of VA's rehabilitative care programs

Closing remark/comments were provided by Commission members.

The meeting was adjourned at 12:27 p.m.