
COMMISSION ON CARE

1575 I Street, NW
Washington, DC 20005

March 10, 2016

Dear Commissioners,

Thanks to all of you who were able to attend the meeting last week in Dallas. To those who were unable to attend, we missed you! For the benefit of all, I would like to summarize the outcomes of the meeting, and next steps as we focus on delivering a high quality final report with recommendations that are advisable and feasible to the President and all key stakeholders of veterans' healthcare.

My opening comments outlined a number of issues that are relevant to the work we need to complete within the, now, 24 business days before our deadline for providing final input to the Report. I want to highlight some of the key points:

1. The Commission was created to chart the course of veterans' health care for the next 20 years (now 18 years).
2. We have not been asked to predict the future of health care (an impossible task), but to set a path for veterans' health care in the context of expected changes in the health care industry.
3. We have been asked to substantially improve veterans' health care in a way that is advisable and feasible (bold, but doable).
4. We need to be thoughtful about our recommendations, since change is inherently disruptive, and we want to mitigate the risks of negative impact on the approximately nine million veterans enrolled with VHA or the nearly seven million veterans who this year used the VHA for their care.
5. We need to consider but not be deterred by the political environment we are operating in. We want our report to be acted upon, and to avoid being another report that sits on a shelf—Number 138!
6. Our Commission is composed of a diverse group of incredibly accomplished leaders with diverse views on what should be done to address the problems of the current VA health system. As indicated in our Guiding Principles, coming to consensus is critical to our success, and will require compromise. We need to avoid extreme positions and an unwillingness to change our mind or we will not be successful in having our recommendations acted upon.
7. Change, especially in government, is almost always incremental, so we need to create a path that allows leadership and governance to implement a series of three-year plans that move VHA forward.

8. There are three major options/scenarios to improve veterans' healthcare: fix the current VHA; move to a payor-only role for VHA, transitioning out of the delivery of health care; or move to a more integrated high-performing, community-based network model, utilizing resources of VHA and increased resources of the private sector.
9. The VHA has a number of strengths that we need to consider in our deliberations, including: clinical quality that compares favorably with the private sector; patient satisfaction levels that are on par with the private sector; staff who are dedicated to serving veterans; access to organized and integrated care models for low income veterans; significant academic and disaster capacity; and some best in class services (e.g., mental health, polytrauma, rehabilitation).
10. The internal operational performance/capabilities of VHA/VA require significant improvement, including: the leadership and governance models, and system support services (e.g., human resources, information technology, contracting, supply chain, performance management, process improvement, and facility planning and construction management). Regardless of the end point of the change process over the next 20 years, the performance of these critical functions needs to be addressed.
11. We need to create a path to excellence that inspires and excites our stakeholders, rather than divides and disturbs them. We need to finalize a report that veterans and their families, VSOs, VHA staff and partners, VA leaders, Congress and the President accept, with a commitment to implement our recommendations.
12. I don't believe a payor-only recommendation is advisable or feasible. It is conceivable that VHA could become only a payor in the future, but if we recommend it now, the report recommendations, because of that vision, will likely be dismissed. A recommendation of that kind would not only provoke a strong backlash from stakeholders, but further demoralize VHA staff and exacerbate recruitment and retention challenges.

We had a robust discussion of these concepts and the "Vision for Delivery of Healthcare to Veterans" document. We made significant progress, including consensus on many important dimensions of the future state of veterans' health care, and the next steps in our work plan. Highlights include:

1. The idea of creating a vision for VHA during the next 18 years, rather than a definitive end state of where veterans' health care will be in 20 years (since we can't predict that far ahead). The vision statement should be inspirational and aspirational, and should include the following concepts: partnering with veterans and their families to design the future state; reducing "stovepipes" that inhibit the assimilation of veterans into society; creating community-based integrated networks to improve access and choice for veterans and to provide service that is high quality, veterans-centric, and organized.

2. Agreement that VHA should move to a more integrated care network model.
3. Agreement on the concept of installing a VHA board to provide consistent guidance and support for the process of transforming health care delivery for veterans
4. Each community will require a different solution given the variation in population, healthcare resources, and VHA facilities and services. To design the solutions for each community will require more advanced administrative capabilities within VA (e.g., contracting, care coordination and quality monitoring), and high functioning VHA system for services (e.g., human resources, information technology and process improvement) to effectively execute the complex change process.
5. The work groups will report out at our next meeting, so all Commissioners can see the progress and preliminary findings of each work group, and provide input on appropriate next steps. Work groups will focus on how each of the major systems within their charge needs to change to support the path toward more integrated networks of care.
6. We will ask the economists to provide an “order of magnitude” assessment of the cost implications of a few different scenarios, including an integrated model that allows non-veterans to use VHA services and veterans to have greater use of community services (with different cost assumptions), as well as the costs of a model with very limited VHA services.

At our upcoming meetings, we will spend the majority of our time on group discussion to build further consensus on our vision and the path to get there. However, we also have a few presentations that will be included in our agendas. These include:

1. A more thorough presentation by our economists
2. Work Group reports
3. Presentations/discussions with Dr. Shulkin, Rep. Jeffrey Miller (Chair of House Veterans Affairs Committee), and another member of the HVAC.

Thanks again for your diligence, passion and resilience as we complete our very important and challenging assignment. Please let me know if you have any questions or issues with this information.

Best,



Nancy