

# **COMMISSION ON CARE**

## **MEETING MINUTES FOR FEBRUARY 8-9, 2016**

The Commission on Care convened its meeting on February 8-9, 2016, at the Marriott at Metro Center, 775 12<sup>th</sup> Street, NW, in Washington, DC, and The American Legion Washington Office, 1608 K Street, NW, in Washington, DC.

### **Commissioners Present:**

Nancy M. Schlichting – Chairperson  
Toby M. Cosgrove – Vice Chairperson  
Michael A. Blecker  
David P. Blom  
Thomas E. Harvey  
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 on Care Staff Identified:**

Susan M. Webman – Executive Director  
John Goodrich – Designated Federal Officer  
Monica Cummins – Alternate Designated Federal Officer  
Beth Engiles – Program Analyst  
Sherrie Hans – Program Analyst

### **Department of Veteran Affairs (VA) Presenters:**

David Shulkin – Under Secretary for Health  
Lisa Freeman – Director, VA Palo Alto Health Care System, Veterans Health Administration (VHA)  
Heather Woodward-Hagg – Acting National Program Director, Veterans Engineering Resource Centers (VERCs), VHA

### **Other Presenters:**

Robert E. Burke – Subject Matter Expert and Analyst  
Aparna Durvasula – MITRE Corporation  
Billy Maynard – Health Net Federal Services  
David McIntyre – TriWest Healthcare Alliance  
Patrick Ryan – Former Staff Director and Chief Counsel, House Veterans Affairs Committee  
Jon Gardner – Former Director, Tucson VA Medical Center, VHA  
Joleen Clark – Former Network Director, VISN 8, VHA

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**The Commission on Care meeting opened at 12:08 p.m.**

## **Opening Remarks**

Nancy Schlichting (Chairperson) opened the meeting, welcomed everyone, thanked everyone for their work, and gave an overview of the agenda.

## **Construction Management**

Lisa Freeman provided an overview of her experience in leadership and construction management. Ms. Freeman discussed Palo Alto's Lean system and how they have applied it to health care. The medical center always includes a veteran on its Rapid Process Improvement Workshops and the medical center's Veteran and Family Advisory Council are embedded in all of the major health care system committees.

Nearly every special emphasis program that exists in VA is provided through the Palo Alto health care system. The Commission discussed Palo Alto's programs and posed questions to Ms. Freeman. Items discussed included:

- The recent \$2.5 billion investment in the medical center including the polytrauma center, parking structures, radiology expansion, a research building, and an ambulatory care expansion
- Pushing the bulk of the non-specialty, non-high end, high-intensity care closer to where veterans live
- Partnering with communities on specialty care to bring specialists to patients, rather than transferring from level-of-care to level-of-care
- The role of the Lean coach at Palo Alto in the transformation at Lucile Packard Children's Hospital

## **VISN and Field Leadership Perspectives**

Lisa Freeman, Joleen Clark, and Jon Gardner provided an overview of their experience working within VHA. Ms. Clark emphasized that she used her autonomy to get things done, noting that health care and a bureaucratic government do not mix well. The two are completely different and it is difficult to run a health care organization within bureaucratic rules. Human resources rules and regulations that were written in the 1950s are suffocating the ability of current health care providers to be flexible and adapt to the real world in real time. Trying to get something productive accomplished in the field is a "beating your head against the wall" scenario. The decentralized Kenneth Kizer model changed after a new leadership team came into VA with its own way of doing things. Mr. Gardner said that the core issue in VA right now is leadership. VA is losing its field leadership month by month and year by year. One factor may be that performance bonuses were lost for five years as well as retention bonuses. It's also important that all of the medical centers hear the same messages coming from leadership. There is a crisis in leadership and a need for Lean at the central office level. Mr. Gardner emphasized the need for VA to interact with the private sector for continuous education opportunities for VA executives.

The Commission discussed the role of leadership within VHA and posed questions to the presenters. Items discussed included:

- Legislative relief to allow the VISN to run like a medical group so that it's not bound by Office of Personnel Management (OPM) rules and Office of Management and Budget (OMB) rules on personnel and acquisition

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- Increased local autonomy
- Putting VHA under Title 38
- Practices used by departmental heads to make things happen in health care organizations
- Getting leadership commitment for Lean while engaging all of the staff at a facility
- Policy and oversight remaining in the central office and operations moving down to local level
- The public sector becoming/being/remaining an inspired workforce
- Continuous improvement with regard to construction and physical plant so that the need for upgrades does not become overwhelming

## Implementation of Choice

Billy Maynard spoke on the implementation of the Choice program. For 28 years, Health Net Federal Services has established and maintained supplemental private-sector health care capabilities necessary for public-sector entities like VHA and the Department of Defense (DoD). Health Net has supported nearly 40 different health care related VHA contracts. Health Net is the longest-serving TRICARE managed care support contractor. Within Regions 1, 2, and 4 there are more than 100,000 veterans participating in episodes of care that were authorized under the Choice program. Five thousand new authorizations are being created by the VHA every day. In the twelve months since the Choice program was launched, Mr. Maynard's organization went from zero to 2,850 personnel to support the Choice program. He said that his company's highest priority is to fulfill its Choice program responsibilities. Success will be achieved only when veterans perceive, and are able to expeditiously navigate, the integration and intersection of VHA and community care as one system.

David McIntyre spoke to the Commission about access. Mr. McIntyre said that the processes in the VHA needed to be standardized after the passage of Choice. Opening up the aperture in the architecture of the process was a critical component of making Choice work for veterans. TriWest re-footprinted itself and created cells of operation by Veterans Integrated Service Network (VISN). The cells are staffed by veterans or the family members of veterans. TRICARE was designed for elasticity. Every market is different and maximizing the federal dollar is critical. VHA is required by federal budget rules to document and justify the care that has been purchased on behalf of the taxpayer outside of its own facilities. The 60-day limitation on care was corrected and the paperwork difficulties in the program are being reworked. Part of TriWest's job is to develop the networks that stand side-by-side with the VA medical centers (VAMCs).

The Commission discussed the role of third-party companies in implementing the Choice program and posed questions to the presenters. Items discussed included:

- Administrative costs around access and delayed payments to providers
- Whether the TRICARE system would be able to withstand the number of veterans who would use it
- TRICARE beneficiaries receiving the opportunity to go to any Medicare provider
- National and local care integration
- Refining the referral process
- Leveraging the academic institutions
- Educating veterans about whether VAMCs can handle their needs

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- Challenges related to not having integrated clinical information systems
- Electronic medical records

## Update on VHA

David Shulkin, Under Secretary for Health, provided the update. The VA system is very different from the health care that Dr. Shulkin had previously been involved in running. The VA has the responsibility to manage health more holistically (physical, mental, social, and economic). Many innovative firsts occurred at the VHA— liver transplant, nicotine patch, pacemaker, CAT scan, EMR, barcoding of medications, and the study of aspirin's impact on heart health. Decisionmaking in the VHA is a very slow process and there is very little reward for taking a risk. There is almost no succession planning in the VHA. It is difficult to get people from the private sector (with external perspectives) into the VHA, despite the fact that VA is the largest trainer of medical professionals in the country. Dr. Shulkin outlined five of his priorities:

1. Access and the wait time crisis – The VHA will announce a Declaration of Access on February 27. The goal is to go to same-day primary care throughout the system by the end of the year. The recall system will be eliminated.
2. Staff – VHA has the second lowest score among federal agencies in terms of staff engagement. The VHA currently has 43,000 open clinic positions. Leadership and Lean training sessions are being provided to staff, as well as other support programs.
3. Best practices – Learn from innovations and standardize practices.
4. The future delivery system will be in the form of a high performance network.
5. VHA must regain the trust and confidence of veterans.

The Commission discussed the status of the VHA and posed questions to Dr. Shulkin. Items discussed included:

- VHA's outsourcing costs
- VHA's efforts to eliminate unneeded facilities despite one of the missions of VHA being to provide care in case of an emergency
- Integration of VHA medical records with community care record systems
- Emphasizing the dissemination of best practices
- Frequent changes of leadership in the VHA and the lack of applicants for high-level jobs in the VHA
- VHA needs the ability to spend money flexibly and have the authority to pay leaders market rate salaries

## Commission Discussion

Several commissioners provided overviews of their visits to VA medical facilities. The Commission discussed the facility visits and posed questions to the presenters. Items discussed included:

- VHA leadership should be inspiring employees to come to work every day rather than instilling a sense of fear and dread
- The core competencies of the VHA
- Introduction of the Lean process
- IT development in VHA
- Fragmentation in medical homes – greater choice means greater cost share
- The messiness of the Choice Card program

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The Commission discussed the roles of MITRE, the Independent Assessment, and VERC in VHA health care with Aparna Durvasula (MITRE) and Heather Woodward-Haag (VERC). Items discussed included:

- Creating simplicity around strategies of improvement
- MITRE's look across the assessments
- The Health Systems Engineering Program's (HSEP's) methodological approaches for intentional design of enterprise systems by focusing on the customer, mapping out the journey of the customer, and thinking about the processes that can be put into place to support that customer's journey
- The efforts of the HSEP in training VHA employees
- The lack of integration between service delivery and the service channels
- The HSEP approach has focused on what improvements can be made without a large IT upgrade
- Specifics about the upcoming visioning exercise
- What transformational approaches need to be embraced at the leadership level
- The reliance of the assessment on the systems approach and systems engineering

**Day 1 closing remarks were provided by Chairperson Schlichting, and the meeting was adjourned at 6:29 p.m.**

**Day 2 of the Commission on Care meeting opened at 8:33 a.m.**

## **Opening Remarks**

Chairperson Schlichting opened the second day of the meeting, welcomed everyone back, and gave an overview of the agenda. She said the Commission was going to go through a process during the day to clarify a vision for VHA through twenty years down the road. The Commission should create a path that will allow those who are leading to see that transformational, impactful change is feasible.

## **Feasibility, Advisability, and the Statutory Pay-As-You-Go Act of 2010**

Patrick Ryan talked to the Commission about the meaning of the term "feasibility," as used in section 202 of the Choice Act and by way of providing the Commissioners guidance on how to understand what the statute means by recommendations that are "feasible and advisable." He explained that the term, as used in the context of legislative recommendations, must be understood within the framework of the body of laws governing the federal budget. He noted, in that regard, the Congressional Budget Office (CBO) reviews any legislation to be taken up by Congress, and that CBO's assessment of the budget impact of that legislation routinely affects what is "feasible."

Mr. Ryan cited the example of prior efforts to enact legislation that would have required Medicare to reimburse VA for the cost of care VA furnishes to Medicare-eligible veterans. He noted that an important distinction is, while VHA health care funding is deemed "discretionary" spending, Medicare benefits are "mandatory" in nature. Therefore, under "pay-as-you-go" budget rules, legislation that would have the effect of increasing Medicare spending would require Congress to offset that so-called "direct spending" by cutting other mandatory spending by a like amount. CBO's analysis of the proposal (to establish "Medicare subvention") was that its enactment would result in Medicare incurring additional spending of approximately \$25 billion

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a year. "PAYGO" rules would require Congress to offset that increase by increasing taxes, or cutting other mandatory spending, by a like amount. The implication was that the proposal was not feasible.

Mr. Ryan observed that VHA is facing a future with limited resources in a world without an appetite for more taxation. There is excess spending in the health care industry and the future will be about making choices and avoiding duplication of care when possible.

After Mr. Ryan's presentation, the commissioners discussed the veterans' health care delivery system, with some wondering if a new system is required. It was commented that the most efficient approach might be to first design a system, conduct fiscal analyses on that model, and then tweak the model to achieve the desired result. It was noted that VHA will need to think of "future vision scenarios" and evaluate those scenarios in a data-driven and methodical manner, and that transformational thinking and fiscal realities are two different things. Balancing the two would be a challenge for those aiming to improve the VHA system.

The view was expressed that any proposal that could be characterized as "privatization" of the VHA would most likely be a political non-starter. "Privatization" was described as meaning the dismantling of government-owned and operated facilities devoted to the care of veterans, and VHA acting as a payer like the Centers for Medicare and Medicaid Services (CMS).

One commissioner expressed the viewpoint that there may not be enough capacity in the overall health care system to care for the special needs of veterans if the VHA is privatized. A privatized system would be more fragmented and may not be very good at serving mental health needs or the needs of the indigent. Another commissioner countered that privatization was the ongoing trend of government getting out of the delivery-of-services business. Privatization would entail the VHA engaging in more contracting than it currently does. The increase in contracting would occur as the VHA seeks to expand partnerships with community providers. Regardless of whether the VHA care might ultimately be privatized, there was agreement among commissioners that VHA care needs to be more integrated into community care. Such integration would produce benefits for both the VHA and community health care providers. It was observed that VHA in many ways outperforms the rest of the health care system. The view was expressed that identifying core competencies within the VHA would allow markets to design the best models for care. Many commissioners agreed with the view that the situation is complex. Some commissioners noted that privatization does not offer a simple path to a solution, given, for example, that it is unlikely that the private sector would immediately embrace poor veterans with complex health and social problems.

## **Future Vision for VHA**

Robert Burke led a discussion on the Commission's future vision for VHA. Dr. Burke presented a strawman mission statement for the VHA and asked the commissioners to consider all components of the statement. Dr. Burke explained the rules of a Delphi exercise regarding a strawman statement and encouraged Commission members to focus on developing an overall vision rather than diverging into a discussion of the details. The purpose of the exercise was to determine where commissioners agreed and disagreed. The commissioners also discussed what they think may be missing from their approach so far. The commissioners worked through the Delphi process, looking at general assumptions, rationales for transformation, design elements, and future strategy.

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Discussion included whether to take a national approach and exercising caution when using of the term “integrated.” Some noted that veterans need to have “equal” options for care no matter where they live. The strawman mission statement presupposed that an independent parallel delivery system will still exist.

The strawman statement:

Provide a system of community-based, as locally determined, health care services that provide comprehensive, affordable, and timely health services that are of high quality for all enrolled veterans across the cycle of the veteran’s life. Quality care begins at enrollment and ends only at the end of life. The VHA or its local affiliate will continue to offer a full range of health care services that are patient managed care.

To validate the strawman statement, the commissioners were asked to review individual assumptions and indicate whether they agreed or disagreed with each. The assumptions are listed below, followed by a number which represents the number of commissioners in agreement with that statement.

## Assumptions about Health Care in 2036

- The health care landscape will be dominated by large statewide and national nonprofit and for profit health systems. **(14\*)**
- Most physicians will be employed by health systems and large group physician organizations. **(14\*)**
- There will be significant growth in outpatient centers for a wide range of medical and surgical needs. **(14\*)**
- There will be widespread use of telehealth and other technological advances for remote and immediate care, including care in the home. **(14\*)**
- There will be declining inpatient care due to major advances in genomics, biologic drugs, non-invasive medical procedures, and less invasive surgical procedures. **(13\*)**
- Health information will be controlled by the patient, with online access to appointment scheduling, provider communication, health care results, clinical information, and guidance for self-care. **(13\*)**
- There will be greater competition for health care employees, especially physicians, nurses, pharmacists, and homecare specialists as care shifts to companies that offer attractive compensation, benefits, and career growth opportunities. **(13\*)**
- There will continue to be significant financial pressure on all payers and providers due to the rising cost of health care, which will drive a constant focus on value (lower cost and higher quality). **(13\*)**
- Medicare, Medicaid, and other subsidized care under ACA will lead to an increasingly large share of care funded by the government (75% to 90%). **(12\*)**
- There will be interoperability of health information at all points of access to care. **(11\*)**
- Health care will be increasingly consumer-focused, with a disruption of traditional providers by companies that increase access and convenience, lower cost, improve clinical outcomes, and use technology in innovative ways. **(11\*)**
- Health care will be a coordinated with multiple community providers to ensure a holistic approach to patient needs, including medical and behavioral health care, health and wellness services, home care, and socioeconomic support services (transportation, housing, education, social services). **(9\*)**

\* Represents the number of commissioners in agreement with the statement.

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- There will be a model of health care for veterans that are driven by the Iron Triangle (a.k.a. Triple Aim) of quality, access, and cost factors.† (7\*)
- There will be significant blurring of the lines between provider and payer, with insurance companies providing health care, and health systems owning insurance companies. (5\*)
- The construction of new health care facilities will require lower cost, but more importantly buildings with higher adaptability and safety-oriented designs. (2\*)

## A Rationale for Change/Transformation for Veterans Health Care

- The VHA is a large, complex organizational model with tremendous variation in all performance metrics. (14\*)
- VHA has a leadership crisis in recruiting and retaining leaders as evidenced by the high number of vacancies in key positions, high turnover in most senior positions, little investment in leadership systems for development and succession planning, toxic culture, and low credibility of leadership. (14\*)
- There is a lack of infrastructure (operational systems, support systems, information systems, and facilities) to drive efficiency and effectiveness of health care. (13\*)
- VHA should ensure that contract non-VA care provider's networks possess the tools and resources to deliver timely care upon receipt of veteran referrals.† (12\*)
- VHA cannot furnish all health care to enrolled veterans in a timely high-quality manner. (12\*)
- VHA should make public its VA reports indicating the number of veterans waiting beyond the access-to-care standards.† (11\*)
- There will be relatively more capacity in the private health care system, relative to local markets, that could meet the needs of veterans. (10\*)
- The Affordable Care Act and the Veterans Choice Act create new options for insurance coverage and community health care for veterans. (10\*)
- Funding model for executive pay creates risk-averse approach to leadership. This is partially due to a focus on short-term budgets rather than long-term investments to create a high performing health system. (10\*)
- Using the standard from National Health Quality Forum, or similar organization, VA should determine the volume of cases to achieve "Center of Excellence" standards for each specialty and either partner or outsource VA patients when the volume does not exist or meet the standard. The VA should determine which hospitals in a VISN qualify as Centers of Excellence. Similarly, if a VHA Hospital has achieved the status of a Center of Excellence, the VHA should be encouraged to keep the center and if it has excess capacity, offer the excess capacity to the community. (7\*)
- There is a large group of veterans who choose not to receive health care from the VHA. Determine the population who do rely on the VA and develop programs for this population. (6\*)
- The demographic changes taking place within the population of veterans require major redistribution of VHA facilities with very significant investment in new facilities. More importantly, the proposed reduction on veteran's population will drop from 21.4 million to 14.5 million. (2\*)
- VA should ensure that VA facilities understand how to deliver non-VA care through patient-centered community care or traditional fee-based care models and that non-VA care coordination teams are properly staffed to make outside referrals.† (2\*)

\* Represents the number of commissioners in agreement with the statement.

† Commissioners agreed that this statement should move to the Design Elements category.

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## What are the Required Design Elements for Future State/Transformation?

- A compelling and inspirational vision that focuses on providing the best health care for veterans, creating societal engagement in veterans' assimilation from military service, and embracing veterans and supporting them with every resource available in communities across the country. **(14\*)**
- Highly effective and sustained leadership to drive the process. **(14\*)**
- An absolute commitment to meeting the needs of veterans, especially the most vulnerable with behavioral and socio-economic challenges. **(13\*)**
- A plan that takes a systems approach to be flexible by incorporating change, for all components required to successfully implement the plan and create the desired results. **(13\*)**
- Investment in change management capabilities, including resources to develop and manage the plan for transformation over multiple years. **(13\*)**
- A program will design, grow, implement, and evaluate options for care in the community. **(12\*)**
- Support from governance to drive the change process. **(12\*)**
- The funding required to "fix" VHA is massive, including major investments in existing and new facilities, information technology, and support services (e.g., human resources, performance management).<sup>††</sup> **(11\*)**
- Review, streamline and/or change eligibility rules to create easy access and understanding of coverage for veterans. **(9\*)**
- Similar to military base closure process (BRAC), VHA create and implement an office to evaluate and recommend changes to VHA facilities aligned with future vision of a system of care for veterans. **(6\*)**
- A unified strategy/vision that is transparent, understood, embraced, and can be supported by all key stakeholders. **(5\*)**
- Design and implement a dashboard or other format for ease in understanding by the veteran and the American public and report the information on a twice-a-year basis. **(1\*)**
- A design team (such as MyVA? VHA Office of Policy and Planning? or VA OSI?) who will create the structure/operating model for a system of care. **(0\*)**

## Future Strategy

- VA closes low utilized sites of care and partners under a purchased care agreement with community providers. **(13\*)**
- Congress remains a critical partner making appropriations, authorizations, and overseeing operations within all VA programs. **(12\*)**
- A new organizational structure is created within VHA to oversee, manage, and monitor the performance of the networks, with a focus on quality, customer service, access, and cost. This team would also work with the Commission to determine appropriate VHA facility changes. **(11\*)**
- The role of VHA is to coordinate, provide support services, and ensure that veterans receive the care they need. VA establishes a case manager/navigator role to assure coordinated care. **(10\*)**
- A Design Team composed of VHA leaders, outside health care leaders, veterans, and governmental leaders defines the markets and determines the process to establish the integrated networks for health care delivery. **(9\*)**

\* Represents the number of commissioners in agreement with the statement.

<sup>††</sup> Commissioners agreed that this statement should move to the Rationale for Change/Transformation category.

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- Veterans are served by high performing health care networks including existing VHA facilities, private health systems/providers, military facilities, and other public health care facilities. **(7\*)**
- Veterans “lock in” to one benefit system during an annual open enrolments season. **(5\*)**
- VA becomes an independent ACO. Veterans chose VA as their provider. **(5\*)**
- VA becomes a specialty hospital for the population of veterans and other services are delivered through community partners **(0\*)**

## Criteria for VA Provided Services

- Services that manage and coordinate the overall health of veterans across their lifespan. **(10\*)**
- Limited expertise and/or access to care in the community. **(1\*)**
- The service provides management of military-related conditions/disorders. **(0\*)**

## Criteria for Community-Provided Services

- Expertise and/or access to care is available in the community. **(14\*)**
- High quality, patient-centered options exist in the community. **(14\*)**
- Facility operational efficiency may be gained by purchasing in the community. **(12\*)**
- Military-specific cultural sensitivity not required. **(1\*)**

Following the Delphi exercise, the commissioners continued their discussion on the future vision of VHA. The Commission debated the issue of whether VHA should be a payer like CMS, remain a provider, or be both payer/provider.

The idea of gradually moving toward a payer-only model generated more disagreement than any other topic of discussion. Issues discussed included:

- The advantage of VHA becoming a payer-only system being the full integration of veterans into the private medical system as versus changing the delivery system resulting in the unintended consequences including sacrificing cultural competency and a risk of veterans completely disappearing in the private health care system if VHA stops being a provider. Some commissioners acknowledged that there is a danger that veterans and VHA employees will lose the sense of camaraderie that makes the current system unique.
- Some commissioners expressed concern that the trend toward physicians working fewer hours in the private sector may curtail the ability of veterans to get timely care if they are diverted into the community health care system. The commissioners also acknowledged that there are some places in the VHA system where the volume of patients for certain procedures/services is too low to provide a satisfactory level of excellence. Building a high performing network within VHA where particular specialties are concentrated in certain centers might be a way to provide better care. The commissioners also asked to determine the population that relies on the VHA, and make an assessment of whether there will be a sufficient population of veterans to use all of the existing facilities in the future.

\* Represents the number of commissioners in agreement with the statement.

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- Another possibility posed by some commissioners for a future VHA is making it a non-profit government organization with a board of directors that makes decisions on revenue streams and which facilities should remain open. It was also suggested that a body (the Medicare Payment Advisory Commission) become a permanent commission working with the VHA to develop policies and regulations, and determine the transitions and changes that must occur to improve VHA. Any future oversight system would be independent and transparent, with benchmarking a necessary component.

Additional points of discussion included:

- Some commissioners believe there are insufficient mental health services in emergency care settings in the private sector, as well as the low level of integration of social services in health care facilities, in contrast with VHA's inpatient mental health services and full-spectrum social services delivery system.
- Commissioners pointed out that with an aging population, the trend toward chronic care instead of acute care, and a shortage of palliative care nurses and physicians, make end-of-life care one of the current challenges in managing a health care network. VHA has been ahead of the national trends on aging and adjusting to the demand for chronic care.
- There was agreement among some commissioners that bolder, more flexible leadership is required at all levels of VHA. Leadership needs to be supported with appropriate pay in order to attract and retain talented people; however, increased pay does not automatically make someone a bold and audacious risk-taker. Leadership improvements need to be overseen by some type of independent governance structure in order to keep leaders focused on driving change forward. Leadership positions like the Under Secretary for Health need to have longer tenures.
- Consideration of VHA's leverage through contracting in terms of how its patients are cared for and how this leverage might be affected by a change to a payer-only system. Continuing the discussion on contracting, a commissioner suggested having an outside entity coordinate VHA contracts might be a way to avoid possible waste, fraud, and abuse.
- Commissioners agreed that veterans fighting through an eligibility adjudication system in order to get the care they need is problematic.

The Commission discussed five design elements for the future of VHA:

1. Compelling and inspirational vision providing the best care for veterans, using every resource available in communities across the country
2. Highly effective and sustained leadership to drive the process
3. Absolute commitment to meeting the needs of veterans, especially the most vulnerable with behavioral and socioeconomic challenges
4. A systems approach that is flexible in incorporating change and investing in change management capabilities
5. Support for changing the oversight of VHA to a nonpolitical entity

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The Commission discussed closing items and next steps. Items discussed included:

- The voice of the patient on governance issues
- The need for a chief information officer for health IT in the VHA and more coordination around IT issues
- The need for the Commission's vision to be inspiring and its mission clear and focused

**Closing remarks and comments were provided by Commission members.**

**The meeting was adjourned at 3:15 p.m.**