

COMMISSION ON CARE

MEETING MINUTES FOR APRIL 18–19, 2016

The Commission on Care convened its meeting on April 18–19, 2016, at the ASAE Conference Center, 1575 Eye Street, NW, Washington, DC.

Commissioners Present:

Nancy M. Schlichting – Chairperson
Toby M. Cosgrove – Vice Chairperson
Michael A. Blecker
David P. Blom
David W. Gorman
Thomas E. Harvey
Stewart M. Hickey
Joyce M. Johnson
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
Sherrie Hans – Program Analyst
Ralph Ibsen – Program Analyst
Gideon Lukens – Staff Economist
Jamie Taber – Staff Economist

Department of Veterans Affairs (VA) Presenters:

Robert McDonald – Secretary
Sloan Gibson – Deputy Secretary
Baligh Yehia – Assistant Deputy Under Secretary for Health
Jennifer Adams – Deputy Director of Payer Relations
Peter Almenoff – Senior Fellow, Center for Innovation
Neil Evans – Co-Executive Director, Connected Health, Veterans Health Administration
Jonathan Nebeker – Deputy Chief Medical Informatics Officer
David Waltman – Chief Information Strategy Officer

Other Presenters:

Garry Augustine – Disabled American Veterans (DAV)
Verna Jones – American Legion
Rick Weidman – Vietnam Veterans of America
Bill Rausch – Got Your 6
Ray Kelley – Veterans of Foreign Wars
Peter Dickinson – DAV
Rene Campos – Military Officers Association of America

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The Commission on Care meeting opened at 8:33 a.m.

Opening Remarks

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

Facilitated Discussion with Veterans Service Organizations

The Commission was led in a facilitated discussion with representatives from several veterans service organizations (VSOs) by Peter Dickinson from Disabled American Veterans (DAV). The discussion focused on the role of the VA health care system, the role of non-VA health care providers, how they fit together, how veterans will access care, and how to strengthen the collaboration between VA and non-VA health care. The VSOs also provided the Commission with information they had collected on veterans' opinions and preferences, as well as the VSOs' thoughts on the strawman document. Items discussed included:

- The data and resources the Commission uses in developing its recommendations
- The future structure and role of the Veterans Health Administration (VHA) and its relationship with private health care
- The veterans experience in VA health care and how the VSOs represent the concerns and wants of the veteran population
- What is the cost and role of choice in VA health care?
- Market trends in American health care and their impact on VHA care
- Unique aspects of VHA care that separate it from other health care systems
- Comparisons between VHA and other public health care programs, including TRICARE and Medicare
- The importance of coordination of care in VA health care
- Current strengths and weaknesses of VA health care, and how to implement best practices and fix problem areas
- How to transform VHA into a modern and efficient health care system
- Feedback the VSOs hear most frequently from veterans
- Anecdotes of episodes of care from VHA facilities around the country
- The results from various economic projection model scenarios of VHA health care
- The results of the VA's recent transformation efforts
- Infrastructure challenges facing VA
- How to implement a strategic focus in VA over a 20-year period

Staff Economists Presentation

Jamie Taber and Gideon Lukens provided an update on their work estimating future costs for VHA. Since the last Commission meeting, the team ran a new scenario through the projection model where VHA would expand care in the community for certain types of care. In this scenario, all care currently provided by the VA would continue to be provided, while expanded care in the community, called Community Delivered Services (CDS), would be provided by an integrated network consisting of providers (i.e., medical practitioners including physicians, mid-level practitioners, therapists, hospitals, and clinics) that are vetted by VA. CDS would be focused on tertiary and quaternary care, but would not provide primary care, special emphasis care, or some types of specialty care. This network of providers would be coordinated and vetted by the VA, and additional nurse navigators would help guide veterans to the appropriate providers inside and outside of VA.

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VA already has a robust care manager program which largely overlaps with the nurse navigators in this scenario. VA's Patient Aligned Care Teams (PACTs) replace episodic care based on illness and patient complaints with coordinated care and a long-term healing relationship. Care managers who guide patients to choose care in and out of the community are a part of these teams, but due to additional work coordinating with community providers, VA would need to hire more of them. The team presented the projected costs for adding these positions. The team also considered giving those with Other-Than-Honorable (OTH) discharges VHA care eligibility. In this scenario, 73 percent of veterans with an OTH discharge would be eligible for VA care based on income and disability criteria consistent with the rest of the veteran population. The team presented the projected costs for adding this cohort.

Finally, the team presented the results of the CDS scenario and explained their findings. The scenario came with a series of assumptions, among them:

- Community care would be priced at Medicare-allowable unit costs
- Veterans would choose to receive 50 percent of all eligible care in the CDS networks
- The shift to CDS networks would be phased in over 5 years
- Improving access, choice, and /or quality of services likely would increase enrollment and induce more reliance of veterans' health care needs on the VA system

It also came with several caveats:

- Estimates did not include savings or costs of reducing or repurposing existing infrastructure
- Impacts on VA's teaching, research, and emergency preparedness missions were not considered
- Medicare-allowable rates were assumed to provide veterans with adequate access in CDS networks
- Unit costs of moving some care out of the VA does not impact the cost of care remaining in the VA
- Other than equipment and national overhead, the costs of care shifting to CDS networks would be phased out of VA facilities concurrently with other effects in the model
- Hiring nurse navigators would be the only additional administrative cost

The Commission discussed the projection model scenario and posed questions to the presenters. Items discussed included:

- The data and methodology that went into creating the team's market analysis and CDS scenario
- How VHA currently coordinates care and how additional resources could improve coordination
- The effect of current health care market trends on VHA's operational costs
- The process by which the Veterans Benefit Administration (VBA) adjudicates eligibility claims
- What form VHA health care would take under the CDS scenario
- The factors that contribute to differences in per-patient cost between VHA and the private sector
- The impact of changing VHA policies on economic projection scenarios

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VA Senior Leadership

Robert McDonald, Sloan Gibson, and Baligh Yehia provided the Commission with updates on VA's recent improvement efforts. Secretary McDonald began by giving an overview of VA and the MyVA transformation. VA continues to be a leader for groundbreaking research, education and training, and excellence in care. Secretary McDonald highlighted several examples of VA's work in these areas, though, VA is first and foremost dedicated to veterans and ensuring they receive the best care possible.

To this end, VHA has increased access to appointments, made progress on the claims backlog and improved the overall veteran experience. To increase access, VHA has added more than four million square feet to its health care footprint in the last two years, increased staff by 17,000 in the last 18 months, and increased after-hours and weekend appointments 12 percent since June 2014. Ninety-seven percent of all appointments are now completed within 30 days of the veteran's preferred date, with the average wait time for a completed primary care appointment down to five days. After peaking in March 2013 at 611,000, the VBA claims backlog decreased 88 percent by November 2015 to 74,383. MyVA also created the MyVA Advisory Committee to learn from industry leaders and improve veterans' satisfaction with their health care.

Secretary McDonald highlighted the twelve breakthrough priorities his team is focusing on. The first eight are veteran-facing priorities:

- Improve the veterans experience
- Increase access to the health care
- Improve community care
- Deliver a unified veterans experience
- Modernize VA's contact centers
- Improve the compensation and pension exam
- Develop a simplified appeals process
- Continue to reduce veteran homelessness

The final four are VA internal priorities:

- Improve employee experience
- Staff critical positions
- Transform the Office of Information and Technology (OI&T)
- Transform supply chain

Secretary McDonald highlighted several of the specific goals and accomplishments MyVA has made toward these priorities and several of the legislative challenges still continuing to face VA. He also stressed the sacred nature of the VA's mission toward "the greatest clients in the world." The Commission discussed the recent transformation efforts of VA and posed questions to Secretary McDonald. Items discussed included:

- Improvements made to VA's electronic scheduling systems
- The challenge of implementing institutional change in an organization with political appointments
- The challenges of the current VA governance structure and potential future changes
- Legislative challenges facing VA in implementing organizational change

Deputy Secretary Sloan Gibson continued the presentation by discussing the VHA's work toward building a high performance network. Traditionally a loose federation of regional systems, VHA strives to become a highly integrated enterprise with an integrated provider and payer model. To reach this goal, VHA must expand its methods of providing quality care,

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emphasize the importance of the “whole health” of the veteran, and adopt a veteran-centric approach to everything it does. Deputy Secretary Gibson summarized this transformation into 12 key efforts:

- Building on VA’s strength – VA outperforms the private sector in many areas
- Adopting a veteran-centric “whole health” approach in everything VA does
- Changing the way VA thinks about Access – MyVA Access
- Becoming more effective and efficient in VA’s core operations
- Modernizing contract centers to improve access
- Enhancing management tools to improve veteran experience and outcomes
- Leveraging scale to share best practices across the VA network
- Modernizing and better leveraging technology, including electronic health records
- Overhauling the health care enrollment process
- Boosting staffing levels – leadership and clinical
- Leveraging VA’s scale to build a world class end-to-end supply chain
- Streamlining care in the community and developing an integrated provider-payer system

Deputy Secretary Gibson, along with several VA employees, explained each of these efforts in detail, highlighting programs such as the MyVA Access Stand Downs, the MyVA Access Declaration, the VistA Scheduling Enhancement (VSE), the Veteran Appointment Request (VAR) mobile scheduling app, VHA call center modernization, Strategic Analytics for Improvement and Learning (SAIL) Value Model, the Promising Practices Consortium and Diffusion Council, and the Enterprise Health Management Platform (eHMP). The Commission discussed VHA’s efforts to become a high performance network and posed questions to Deputy Secretary Gibson. Items discussed included:

- The future of electronic scheduling and what steps are necessary to improve access
- Specific issues regarding appointment scheduling and how to improve it
- How methods of measuring productivity in health care varies between public and private systems
- How to coordinate strategic goals in a nationwide health care system
- Methods for ensuring health care quality statistics are accurate and unbiased
- Differences in care provided at VA medical centers (VAMCs) and community-based outpatient clinics (CBOCs)
- The care coordination relationship between VAMCs and CBOCs
- Specific aspects of the VA’s prototype electronic medical record system

Dr. Baligh Yehia ended the presentation with an overview of VA’s work on transforming VA community care. In late October of 2015, VA submitted to Congress a plan to consolidate programs to improve access to care. Informed by feedback from veterans, VSOs, VA staff and clinicians, and community providers and health care leaders, the plan highlights VA’s goal to deliver a community care program that is easy to understand, simple to administer, and meets the needs of veterans, community providers, and VA staff.

VA is taking immediate steps to improve its stakeholders’ experiences while also planning and implementing long-term improvements for the new community care program. To improve the veterans’ journey, VHA is focusing on six areas:

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- Providing easy to understand eligibility information to veterans, community providers, and VA staff
- Providing veterans timely access to a community provider of their choice
- Coordinating care through a seamless health information exchange
- Supporting accurate and timely payment of community providers
- Implementing a network that provides access to high-quality care inside and outside VA
- Providing quick resolution of questions and issues for veterans, community providers, and VA staff

VHA has driven this transformation from the field, with teams conducting interviews, site visits, and data gathering exercises to inform design, as well as a continued effort to engage key stakeholders to collaborate and drive improvements. Several immediate steps VHA has taken to improve stakeholder experience include working with contract partners to discuss challenges and opportunities to improve the Choice program, expanding the provider network, improving prompt payment of claims, implementing a survey to measure veterans' experience with community care, reducing administrative burdens for providers, and making several rapid changes which Dr. Yehia covered in greater depth. The Commission discussed VA's community care efforts and posed questions to Dr. Yehia. Items discussed included:

- The role of the VA Choice program in delivering care to veterans
- Differences between receiving care in VA facilities and care in the community
- Challenges in improving the continuity of care for veterans when community partners are used
- How to transform VHA into a modern, integrated care network

Day 1 closing remarks were provided by Chairperson Schlichting and the meeting was adjourned at 5:37 p.m.

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

Commission Deliberations

The Commission was led by Chairperson Schlichting in a facilitated discussion about its final report. The discussion focused on reviewing consensus areas and prospective recommendations, soliciting feedback from the previous day's presentations, and planning the final steps before the Commission's final report is due. To frame the discussion, the Commission was provided with a series of prospective recommendations centered on quality and access. Examples of these recommendations included:

- Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement
- Transform organizational structures and management processes to promote decision-making at the lowest level of the organization, eliminate waste and redundancy, promote innovation, and foster the spread of best practices
- Create a modern human capital management system that serves the needs of employees, managers, leaders, and veterans and promotes VHA integration with private-sector health care.
- Transform and consolidate VA's entire supply chain organization and improve enablers required to support the organizational transformation, including IT systems, data

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standardization, and talent management; streamline supply chain activities to achieve cost savings and waste reduction.

- Convene a panel of experts to provide recommendations on eligibility for VA care.
- Empower VA medical facility directors to develop community partnerships to foster the most effective use of underutilized health care resources.
- Transform and consolidate revenue cycle functions to better enable fully integrated veteran care received within VHA and in the local community.
- Continue to serve as the vanguard in telehealth initiatives and ensure cultural access for veterans through the standardization of data collection and reporting for all vulnerable populations and by encouraging clinical and military cultural competency training.

Specific items discussed included:

- The challenges in implementing institutional change in an organization with political appointments and frequent changes in leadership
- How to implement plans to phase out underutilized VA facilities
- The challenges of the current VA governance structure and potential future changes
- The form a potential governing board for VA should take, and what responsibilities it will have. What its relationship with VHA leadership will be and how the board, VHA leadership, and Congress will interact to manage VA health care.
- The importance of the Commission maintaining its balanced, neutral perspective to recommending changes to VHA
- How to ensure the Commission's final report leads to actual change
- Building processes for VHA to reevaluate its mission and conduct regular community needs assessments
- The meaning behind specific words and phrases in the draft final report and how they are intended to be understood outside of the Commission
- The eligibility requirements for accessing VHA care, and how OTH discharges should be addressed from an eligibility viewpoint
- The balance between internal leadership succession and external influence of new ideas
- Problems that plagued past VA transformation efforts and how to avoid them in the future
- How to recruit and retain effective leaders
- How VHA can maximize health care quality while minimizing cost
- How VA will oversee and ensure quality outcomes of care and the importance of moving toward standardized metrics
- How VA health care compares to the community in terms of quality measurement
- How changing science and societal attitudes affect VBA eligibility adjudication
- The state of veteran health disparities within VHA and how to work on eliminating them
- How to improve issues with access to care within the VHA system

VA Senior Leadership

Dr. Baligh Yehia continued his presentation from the previous day, focusing on the longer term steps VHA is taking to improve stakeholder experience in the new community care program. VHA's long-term plan to improve the community care experience can be broken into four phases: plan, design, implement, and optimize. Under the plan phase, VHA will understand stakeholder needs to develop a detailed implementation plan. In design it will develop requirements to support project delivery. In implementation, VHA will roll out new clinical and administrative systems. Finally, VHA will optimize the plan by monitoring results to identify and

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execute improvements. Dr. Yehia went into greater detail on what specifically will happen during each phase.

The program will also include several high-level efforts to improve VHA care. VHA will continue its movement to an integrated health care network, because both VHA health care and community care are critical to ensuring veterans receive the care they need at the right time and place. Dr. Yehia went into detail on the requirements of a Community Care Network request for proposal VHA is developing, including a draft benefits package. VHA will also better use data to improve the outcomes and experiences of veterans, including monitoring of access, health care utilization, provide payments and costs, and quality and safety review. In line with this, a focused effort on improving IT capabilities within VHA as well as the new Health Information Exchange tool will further support community care. Dr. Yehia ended his presentation by covering the legislative needs of the program. The Commission discussed VA's community care efforts and posed questions to Dr. Yehia. Items discussed included:

- The scale and restrictiveness of potential community care networks
- Challenges in coordinating care with the community due to legislative requirements
- How to keep costs down when care is outsourced
- The rationale behind improved integration of care within existing VA programs both in system and in the community
- What legislative steps must be taken for VA to implement better community care programs
- What role eligibility requirements play in managing VHA's costs

Commission Deliberations

The Commission continued its facilitated discussion about its final report, led by Chairperson Schlichting. To frame its discussion, the Commission was provided with a series of prospective recommendations centered on choice, well-being, and governance. The choice and well-being recommendations included:

- Develop fully integrated care networks of VHA and community care providers through which veterans receive coordinated medical care.
- Improve the health and well-being of veterans through the use of technology and health information that is accessible when and where it matters most. Modernize VA's IT infrastructure so that it can provide the foundation needed to support VHA's key business processes.
- Enhance health care value and staff productivity by redesigning VA health care delivery around diseases or conditions that are systemwide priorities, by ensuring staff have adequate resources and training, and utilizing staff to their fullest potential.

For the governance recommendations, the Commission was provided with a background paper summarizing six governance models that exist in the United States and abroad: business board of directors, federal governance board, quasi-government structures, Medicare Payment Advisory Commission (MedPAC), Quadrennial Defense Review (QDR), and the UK National Health Service. Specific items discussed included:

- What role does VHA play in veterans' health care needs and should it continue to be a primary care provider?
- Veterans' reliance on VHA for non-primary care needs, including prescriptions, mental health care, prosthetics, etc.

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- The role of navigation and coordination of care in a health care system
- The challenges facing VHA facilities in rural and underserved areas and the importance of partnering with the community to provide care
- Demographic differences between the American public and the veteran population and how they shape VHA health care
- How to improve issues with access to care within the VHA system
- Improving veterans' choice in accessing health care with consideration of the strengths and limitation of care in the community
- How making changes to veterans' access to care will affect VHA's costs
- The relationship between cost, access, and quality in providing health care
- Helping veterans make informed choices regarding their health care
- What form should a potential governing board for VHA take, and what responsibilities will it have? What will be its relationship with VHA leadership and how will the board, VHA leadership, and Congress interact to manage VHA health care?
- What fiduciary role a potential VA governing board would have
- The challenges in implementing institutional change in an organization with political appointments and frequent changes in leadership
- What would be the administrative requirements of a potential governing board
- Potential regional governance structures VHA should adopt
- How to balance governance at national and local levels
- VHA's priorities in addressing IT problems and potential solutions

Closing remarks/comments were provided by Commission members.

The meeting was adjourned at 3:22 p.m.