

COMMISSION ON CARE

MEETING MINUTES FOR MAY 9–11, 2016

The Commission on Care convened its meeting on May 9–11, 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
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
Robert E. Burke – Program Analyst
Stephen Dillard – Program Analyst
Susan Edgerton – Program Analyst
Beth Engiles – Program Analyst
Wilmya Goldsberry – Program Analyst
Sherrie Hans – Program Analyst
Dan Huck – Program Analyst
Ralph Ibson – Program Analyst
Gideon Lukens – Staff Economist
Osita Osagbue – Program Analyst
Jamie Taber – Staff Economist

Department of Veterans Affairs (VA) Presenters:

Leigh Bradley – General Counsel
Jessica Tanner – Staff Attorney, Office of General Counsel

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The Commission on Care meeting opened at 11:00 a.m.

Opening Remarks

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

VA Office of General Counsel (OGC)

Leigh Bradley (VA General Counsel) and Jessica Tanner (OGC) answered Commission questions about the legal and regulatory aspects of preparing the final report. While the role of the Commission is to provide analysis and recommendations to VA, the VA and OGC are tasked with putting the meaning of the recommendations into practical and successful operation. Most of OGC's work is trying to interpret laws and provide legal advice to VA, including on recommendations of federal advisory committees. Ms. Bradley provided advice on how the Commission could make its recommendations clear and understandable. The Commission discussed the OGC's role in implementing the final report's recommendations and posed questions. Items discussed included:

- The Commission balance between a concise report with clear recommendations and a detailed, reasoned explanation for those recommendations
- Specific ways for the final report to make the Commission's reasoning clear
- The role of the Commission once the final report is released
- The rules the Federal Advisory Committee Act (FACA) places on the Commission's deliberations
- The procedures mandated by the Federal Acquisition Regulation (FAR) and the VA Acquisition Regulation (VAAR)
- The relationship between VA policies and federal regulations
- The impact of the Commission's recommendations after the publication of the final report
- The current legal standing of various VA programs and anticipated changes
- The effect of certain language in the Commission's recommendations
- That OGC does not offer to draft legislation, but must be asked to assist.
- Process from final report submission to recommendation implementation.

OGC requested that the Commission be specific about what it wants VA to do with supporting rationale.

Governance and Leadership Recommendations Discussion

Chairperson Schlichting led the Commission in a facilitated discussion about its draft report. The discussion focused on reviewing draft recommendations, which were broken into five areas: Governance and Leadership, Administrative Infrastructure and Capital Assets, Access/Choice/Integration, Eligibility, and Contracting. The discussion began with several Governance and Leadership Recommendations:

- Establish a board of directors to provide overall governance to the VHA, set long-term strategy, and direct and oversee the transformation process.
- Develop a leadership succession system based on a benchmarked health care competency model for recruitment, development, and advancement within the leadership pipeline.
- Transform organizational structures and management processes to maintain consistency with national policy and standards, promote decision making at the lowest

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level of the organization, eliminate waste and redundancy, promote innovation, and foster the spread of best practices.

- Streamline and focus performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a workforce performance management system for health care leaders in VHA that is distinct from an operational performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

Specific items discussed regarding a potential governing board for VHA included what form it might take and its responsibilities, relationship with VHA leadership, and interactions with VHA leadership and Congress in managing VA health care. Discussion also involved what fiduciary role a potential VA governing board would have and the legality associated with having the board hire the USH as CEO. The Commission also discussed how the members of the potential governing board would be selected, what qualifications they should have, including the number/percent to be veterans, and expected diversity, as well as the role of the SECVA on the board. Further, the Commission gave attention to the reporting requirements for the board and the frequency of board meetings. The role of other Veteran Advisory Boards was also raised.

The continuing discussion included:

- The meaning behind specific words and phrases in the final report and how they are intended to be understood outside of the Commission
- How to increase input from veterans in governing VHA
- Examples of governance and best practices from the private sector
- How to ensure sustainable board leadership while still leaving room for external ideas
- Whether board members be compensated for their work
- How the USH should be selected and evaluated under the proposed board governance structure
- The need for continuity and overlapping terms for board members due to challenges in implementing institutional change in an organization with political appointments and frequent changes in leadership
- The importance of creating a new governance structure for VA to ensure future improvement
- The importance of having multiple experts with different expertise making decisions for VHA rather than one person
- That board members meet conflict of interest requirements and have high ethical standards

Access/Choice/Integration Recommendations Discussion

The Commission continued its discussion with two recommendations related to access and choice:

- Develop fully integrated care networks of VHA and community care providers through which veterans receive coordinated medical care.
- Identify emerging problems with access and continue to develop clinically meaningful benchmarks and standards that reflect the many dimensions of access.

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Specific items discussed included:

- The size and nature of the community networks, the network entry criteria, level of veteran choice, constraints on choice and the impact of open access/choice
- How local capacity will drive the extent of choice in each network
- How to ensure an integrated health care network maximizes choice for patients
- What criteria should community providers meet to partner with VA health care – providers should meet pre-established criteria, standards and requirements defined by VA
- Reorganization necessary to maximize the effectiveness of VA community partner networks – should they align with major medical network areas and existing medical service areas? Should they leverage established Medicare networks? VA should standardize the approach for building the local networks.
- The necessary costs of ensuring veterans have choices for their health care options. Should veterans be allowed to go outside of the VA networks with significant cost share?
- The unintended consequences of broad choice
- The differences between partnering with national and regional providers
- The effect of community partnerships on VHA internal health care
- The logistical challenges facing greater VA integration with community partners
- What the balance of community and VHA care that ensures the best results for veterans should be
- How much choice patients have in modern private and public health care
- The political environment surrounding VA transformation, and what role it should play in the Commission's recommendations
- How broad the VA's community partnerships should be
- The differences between access and choice
- What immediate changes are necessary to improve veterans' access to health care
- The differences between using community partners for veterans' primary care and secondary care
- Economic factors that influence veterans' choice and access
- Setting standards to ensure minimum requirements for access
- The value of reorganizing VHA health care from a strategic viewpoint, rather than short-term fixes
- The extent to which community care will be managed and coordinated by VA via primary care team, veteran's medical home, etc.
- Evaluating the effectiveness of community network providers – transparency is key
- Choice should not trump care quality
- Current choice eligibility requirements (i.e., time and distance) be removed
- Service-connected veterans should receive the most choice and not pay for care
- Crossing VISN lines should not be a barrier to receiving care
- The requirements for IT systems to support community care
- Same day primary care access should be a goal
- Role of patient navigators vs. medical home/primary care coordination
- Ultimate goal of expanded choice is better health outcomes for veterans

Day 1 closing remarks were provided by Chairperson Schlichting and the meeting was adjourned at 5:03 p.m.

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Day 2 of the Commission on Care meeting opened at 8:34 a.m.

Commission Economists Presentation

Jamie Taber and Gideon Lukens provided an update on their work estimating future costs for VHA. The team ran two scenarios through the projection model: one where VHA moves certain specialty care into the community and another where VHA moves certain specialty care into the community without referrals.

In the first scenario, all care currently provided by the VHA 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 (medical practitioners including physicians, mid-level practitioners, therapists, hospitals and clinics) who are vetted and credentialed by VHA. CDS would be focused on tertiary and quaternary care, but would not provide primary care, special emphasis care, and some types of specialty care. This network of providers would be coordinated and vetted by the VHA, and additional nurse navigators would help guide veterans to the appropriate providers inside and outside of VHA.

The team presented the results of the first CDS scenario and explained their findings. The scenario came with a series of assumptions:

- 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 induce more reliance of veterans' health care needs on the VHA system and increase enrollment

It also came with several caveats:

- Estimates did not include savings or costs of reducing or repurposing 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
- Other than equipment and national overhead, the costs of care shifting to CDS networks would be phased out of VHA facilities concurrently with other effects in the model
- Hiring nurse navigators would be the only additional administrative cost.
- New enrollees have same costs as existing enrollees
- Reliance increases occur only for services shifting to CDS network; no spillovers
- For care priced at historic community rates, national average rates are representative of future rates
- Unit costs for services remaining in VA facilities effectively increase by assuming equipment and national overhead costs are fully retained
- Unit costs of moving some care out of the VA does not impact the cost of care remaining in the VA

The team then presented the results of the second scenario. The only major differences from the first were that veterans receiving care in the community do not require a referral, and thus the assumptions the team used were more tenuous and therefore were more uncertain. The

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Commission discussed the projection model scenarios 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
- The effect of current health care market trends on VHA's operational costs
- The current balance between care provided within the VHA and the community, and how it would change based upon the Commission's recommendations
- How facilities and IT improvement costs will affect VHA's budget
- The impact of VHA's teaching and research missions on the health care budget
- How utilization is projected to change based on the Commission's recommendations
- The correlation between market concentration and health care prices
- Other potential scenarios that would factor in cost shares, enrollment fees, etc.

Access/Choice/Integration Recommendations Discussion (continued from previous day)

The Commission continued its discussion from the previous day on recommendations related to access and choice. Specific items discussed included:

- Community network, access, and choice principles
- What form future VA community partnerships should take, and whether there is a model to base them upon
- Scenarios in which third-party administrators should be considered
- The administrative costs associated with coordinating an integrated health care network
- What criteria should community providers meet to partner with VA health care? What the clinical quality and access standards should be? Whether VHA can legally reject providers who do not meet VA's criteria
- The demographic makeup of the veteran population and the challenges this presents for VHA health care
- How a national health care network operates on a local level
- How VHA will pay for increased choice for veterans' health care; whether non-service connected veterans should have a cost share; whether this should be determined by the board.
- How VHA will coordinate care in an expanded care in the community program
- The role of Department of Defense (DoD) facilities, academic affiliates, and current partners in VA care in the community
- The timeline for VA's transition to increase community care, including planning

Information Technology Recommendation Discussion

The Commission continued its discussion with a recommendation related to administrative infrastructure:

- Modernize VA's IT infrastructure to improve veterans' health and well-being, and provide the foundation needed to support VHA's key business processes.

Specific items discussed included:

- Interoperability between VA's Health IT system and those in the private and public sectors

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- The benefits of increasing VHA's IT interoperability with the Veterans Benefits Administration (VBA)
- Lower cost solutions to improve VA IT functionality
- The increased importance of system interoperability in American health care
- How to avoid typical IT overhaul pitfalls, and lessons learned from past examples
- Administrative changes that would improve VHA IT
- The need for a health IT leader in VHA
- EHR requirements
- Streamlining the IT procurement process
- Veterans opting out of sharing their medical information with VHA community providers
- Need for long term IT strategic plan and budget
- Need for predictive analytics and big data management

Capital Assets Recommendation Discussion

The Commission continued its discussion with a recommendation related to capital assets:

- Provide VHA the tools required to meet and manage its capital needs.

Specific items discussed included:

- The role of the proposed board of directors in managing VHA facilities and assets
- How a proposed commission, similar to a Base Realignment and Closure (BRAC) Commission, can help VA navigate difficult facilities decisions
- Current VA procedures for closing down underutilized facilities, and potential improvements to these procedures
- Industry best practices for closing facilities
- Political considerations and statutes that affect asset management
- How VA and communities can make use of closed and vacant facilities
- What metrics should be used to determine the usefulness of a facility
- Current facilities issues facing VA, and how the Secretary should handle them
- How changing veteran demographics affect BRAC decisions
- How to navigate difficult decisions concerning the closure of hospitals
- The challenges that historic building designations create for VA in managing its capital assets

Leadership and Transformation Recommendation Discussion

The Commission continued its discussion with a recommendation related to leadership:

- Develop a focused, clear, benchmarked plan to transform VHA culture with full leadership engagement.

Specific items discussed included:

- The role of leaders and employees at all levels of an organization to transform culture
- The impact of a change in administration in transforming VA's institutional culture
- Examples of past VA efforts to transform institutional culture
- The components and infrastructure that drive a healthy organizational culture, including open communication, diversity, and engaging in recognition

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- Culture and organizational vision should be kept consistent across different administrations/secretaries

Human Resources Transformation Recommendation Discussion

The Commission continued its discussion with a recommendation related to leadership:

- Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve a high performing health care system.

Specific items discussed included:

- How to align VA human resources with best practices from the private sector
- Historic problems that have plagued VA human resources
- The structure of human resources throughout VA, and inherent challenges it creates
- Training practices within VA and how to improve them
- Importance of developing consistent HR standards, policies, processes and their implementation

Human Capital Management Recommendation Discussion

The Commission continued its discussion with a recommendation related to administrative infrastructure:

- Create a simple-to-administer alternative personnel system, in law and regulation, that governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

Specific items discussed included:

- The challenges that hinder VA's ability to compete for talent with the private sector
- Changes in VA's policies and procedures that will ease up hiring schedules and authorities, specifically Title 5 vs Title 38 authorities
- Specific requirements of hospital employees that pose challenges when hiring by federal regulations
- Similar hiring challenges faced by DoD's TRICARE
- The scale of the Commission's hiring recommendations, and what parts of VA they affect
- The legality of this recommendation and obtaining OGC's input
- Applying a systems approach to personnel management

Health Equity and Cultural Competency Recommendation Discussion

The Commission continued its discussion with two recommendations related to leadership:

- Establish health equity as a VHA priority.
- Identify and address health inequities in subpopulations treated by VHA.

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Specific items discussed included:

- The history of VA's efforts in addressing health inequities
- How to create a diverse workforce, reflective of the patients they serve, and promote inclusion
- Best practices from the private sector
- Combining these into one recommendation that encompasses a broad range of diversity (e.g., racial, ethnic, women, mental health, religious, LGBT, etc.)

Staff Productivity Recommendation Discussion

The Commission continued its discussion with a recommendation related to administrative infrastructure:

- Enhance health care value and staff productivity by ensuring staff have adequate resources and training, utilizing staff to their fullest potential, and expanding use of patient-centered care practices to improve access and quality.

Specific items discussed included:

- How staffing shortages have affected VA providers' ability to provide care for patients
- How improvements in Health IT help increase provider productivity
- Examples of methods used in the private sector to improve staff efficiency
- How to develop best practices within the VHA network, and then introduce them system-wide
- Models to help identify and encourage best practices
- Number of exam rooms per provider at VA vs private sector
- Standardization of approaches to delivering clinical care across VHA

Clinical Workflow Recommendation Discussion

The Commission continued its discussion with a recommendation related to administrative infrastructure:

- Improve clinical workflow by implementing appropriate staffing practices, creating a culture of continuous improvement, ensuring bed levels correspond with demand, and tracking resource distribution in real-time

Specific items discussed included:

- Examples of workflow best practices developed within VHA
- The role of the Veterans Engineering Resource Center (VERC) in using systems engineering to make VA care more efficient, effective, and reliable
- The role of capacity in maintaining efficiency and even resource distribution – all resources should align with demand
- Establishing a process to diffuse evidence-based best practices across VHA
- Ability to track resource utilization in real time
- Role of Community Health Needs Assessment (CHNA)

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Supply Chain Recommendation Discussion

The Commission continued its discussion with a recommendation related to administrative infrastructure:

- Transform the management of the medical and surgical supply chain in VHA.

Specific items discussed included:

- How involved physicians and nurses should be in supply chain decisions; what level of clinical collaboration should occur
- How lessons learned from the VA pharmaceutical supply chain system can be applied to all of VHA
- How to address the resistance to changes in VA supply chain practices from vendors
- The impact of contracting on VA's supply chain and the challenges it presents
- How clinical effectiveness should drive purchasing decisions
- Centralization of supply chain functions
- Timing of supply chain transformation

Performance Standards Recommendation Discussion

The Commission continued its discussion with a recommendation related to access:

- Identify emerging problems with access and continue to develop clinically meaningful benchmarks and standards that reflect the many dimensions of access

Specific items discussed included:

- How the private industry measures access and sets benchmarks
- The importance of VA measuring quality through the same metrics as private sector, ensuring that comparisons between VA and the private sector are possible
- How VA currently measures quality and surveys veterans about their experiences
- The importance of striving for top performance in access, especially for mental health

Outreach and Education Recommendation Discussion

The Commission continued its discussion with a recommendation related to access:

- Develop a program to ensure veterans know how to access VHA health care.

Specific items discussed included:

- How Veterans Service Organizations (VSOs) can serve in educating veterans about their benefits
- Why VA offices should place an increased focus on reaching out to veterans
- Examples of how veterans stay informed and best practices used in VA facilities

Day 2 closing remarks were provided by Chairperson Schlichting and the meeting was adjourned at 4:41 p.m.

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Day 3 of the Commission on Care meeting opened at 8:34 a.m.

Final Report Process Discussion

The Commission reviewed the processes and timeline for finishing the final report.

Recommendations Recap

The Commission reviewed the decisions made over the previous two days' recommendation discussions and considered potential changes. Specific items discussed included:

- The meaning behind specific words and phrases in the final report and how they are intended to be understood outside of the Commission
- How to balance governance at national and local levels, and whether contracting community networks should be done on a regional or national level
- The challenges of contracting care from an already highly integrated national network
- Changes to physician payment models in the private industry and how VA should pay its community providers (e.g., fee-for-service; Clinical outcomes; DRG)
Note: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is expected to drive care delivery and payment reform across the U.S. health care system for the foreseeable future. Congress intended MACRA to be a transformative law that constructs a new, fast-speed highway to transport the health care system from its traditional fee-for-service payment model to new risk-bearing, coordinated care models.
- How VA and community providers demonstrate military cultural competency
- How VA will integrate care with community providers and avoid duplication of efforts
- How to transform VHA into a modern, integrated care network
- Differences in health care needs between veterans and the general public
- Managing the risks associated with increased utilization and costs – includes policy safeguards for VA medical facilities
- Assisting veterans with the clinical appeals process
- Structure of each recommendation (e.g., problem statement, solution, approach, actions, etc.)

Commission Economists Presentation

Jamie Taber and Gideon Lukens provided an update on their work estimating future costs for VHA. Since the previous day's discussion, the team ran another scenario through the projection model. With the same assumptions and caveats as the previous two scenarios, the third one differed in that CDS will include primary and standard specialty care, and not special emphasis care. This is a broader array of services eligible for the CDS network than in the previous two scenarios. The team presented their results. 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
- The effect of current health care market trends on VHA's operational costs
- How increased reliance on the VHA system by veterans will affect operating costs
- How changing eligibility requirements will affect VHA's costs
- The benefits and pitfalls of increased choice in community health care
- Need to front load costs of critical changes to infrastructure so that the transformation can occur

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Contracting Recommendation Discussion

The Commission engaged in a discussion about a recommendation related to contracting:

- Transform contracting support and culture to create a more flexible and responsive approach to business functions across VHA

Specific items discussed included:

- The far-reaching effects of VA's contracting issues, and specific examples of these problems
- Precedents of novel solutions to overcoming contracting logjams in the federal government
- Differences between contracting the federal government and the private sector
- Contracting issues require special focus for transformation to occur

Eligibility Recommendations Discussion

The Commission continued its discussion with three recommendations related to eligibility:

- Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service
- Establish an expert body to develop recommendations for VA care eligibility and benefit design
- Develop pilot programs to test the feasibility of enabling veterans' spouses and higher-income veterans to obtain VA care through their health plans.

Specific items discussed included:

- The relationship of these recommendations to other parts of the final report
- How societal changes affect expectation of veteran eligibility for health care
- The impact of changing eligibility on costs within VHA
- How questions about eligibility requirements fit within the Commission's tasking
- The eligibility requirements for accessing VHA care, and how other-than-honorable discharges should be addressed from an eligibility viewpoint

Closing remarks/comments were provided by Commission members.

The meeting was adjourned at 12:14 p.m.