
COMMISSION ON CARE

MEETING MINUTES FOR SEPTEMBER 21-22, 2015

The Commission on Care convened its meeting on September 21-22, 2015, at the ASAE Conference Center, 1575 Eye Street, NW, in Washington, DC.

Commissioners Present:

Nancy M. Schlichting – Chairperson
Delos M. Cosgrove – Vice Chairperson
Michael Blecker
David P. Blom
David W. Gorman
Thomas E. Harvey
Stewart M. Hickey
Joyce M. Johnson
Ikram U. Khan
Phillip Longman
Darin Selnick
Martin R. Steele
Marshall W. Webster

Commission on Care Staff Present:

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

Department of Veteran Affairs (VA) Presenters:

Robert McDonald – Secretary
Sloan Gibson – Deputy Secretary
David Shulkin – Under Secretary for Health
Patricia Vandenberg – Assistant Deputy Under Secretary for Health for Policy and Planning

Presentations on various topics were delivered by representatives from:

CMS Alliance to Modernize Healthcare
Grant Thornton LLP
McKinsey & Company
MITRE Corporation
Navigant
RAND Corporation

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Day 1 of the Commission on Care meeting opened at 8:30 a.m.

Welcome / Opening Remarks

Nancy Schlichting (Chairperson) opened the meeting and welcomed everyone to the first public meeting of the Commission on Care. Ms. Schlichting gave an overview of the agenda and explained the charge of the Commission.

Centers for Medicare & Medicaid Services (CMS) Alliance to Modernize Health (CAMH) Presentation Overview

CAMH gave an overview of the independent assessment (IA) of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs (VA). Section 201 of the Veterans Access, Choice and Accountability Act of 2014 (Choice Act) called for an IA of twelve areas. VA had engaged the Institute of Medicine of the National Academies to prepare the twelfth assessment on access standards. VA engaged CAMH for the other eleven assessments.

CAMH subcontracted with Grant Thornton LLP, McKinsey & Company and the RAND Corporation to conduct ten of the assessments, with MITRE conducting the eleventh. Over the course of the day and a half meeting, the CAMH team provided presentations on the eleven assessments, focusing on the findings and recommendations. They also highlighted their recommendation of an integrated systems approach being necessary for a future VA health care delivery system, which is addressed in the CAMH Integrated Report of the IA.

CAMH reviewed the methodologies and scope of the assessments, as well as the limitations and gaps posed by the legislation timeframe and requirements. The Integrated Report recommends four areas that serve as cornerstones for the systemic approach. The challenges identified are:

1. Governance – demand, resources, and authorities are misaligned.
2. Operations – VA operations and processes are bureaucratic and inconsistent.
3. Data and Tools – non-integrated variations in clinical and business data and tools hinder operations.
4. Leadership – leaders lack clear authority, priorities and goals to be empowered to act.

CAMH presented the recommended solutions to address these issues as follows:

1. Governance – align demand, resources, and authorities.
2. Operations – develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high quality health care.
3. Data and Tools – develop and deploy a standardized and common set of data tools for transparency and evidence-based decisions.
4. Leadership – stabilize, grow, and empower leaders with clear priorities, as well as build a healthy culture of collaboration, ownership, and accountability.

Overall, the IA found that point solutions to individual issues will not enable sustained change. A systemic approach to transformation is required that acknowledges the interdependence of the systemic issues identified throughout the IA.

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To help reinforce the integrated systems approach, the IA calls for the recommendations from the Commission on Care to fall into three categories:

- VHA should develop a comprehensive, integrated transformation plan with dedicated resources to ensure measureable improvement of care of Veterans.
- VHA should take credible steps towards implementing key recommendations from the Choice Act to build momentum for the transformation without interfering with the development of the transformation plan.
- VA should address the gaps in the assessment's approach to ensure even more complete coverage of the issues that plague VA.

The Commission discussed the findings and methodologies of the IA and posed questions to the presenters. Items discussed include:

- The use of non-health care industry practices being applied as best practices for health care delivery systems
- Why VHA would want to make the changes recommended
- The concept of a Governing Board for the Veterans Health Administration (VHA)
- How the IA aligns with current initiatives in VA and VHA
- VHA's other Congressionally-mandated missions (e.g., emergency preparedness)
- Why a survey of veterans' experiences with VHA was not conducted

Assessment A: Demographics and Health Care Needs Presentation

RAND Corporation provided an overview of Assessment A. The team was tasked with making an assessment of the current and projected demographics and unique health care needs of the patient population served by VA. The assessment found, among other things, that:

- The veteran population will decrease by 19 percent by 2024; however, the patient population using VA has been increasing. This increase will begin to level off.
- Veterans are older and have a higher prevalence of many conditions than non-veterans; those veterans who use VA are even sicker than the overall veteran population.
- The prevalence of many chronic conditions will increase by 10-20 percent among VA patients over the next ten years.
- The size and geographic distribution of the veteran population will change over the next ten years.
- VA patients rely on VA for only some of their health care needs.

The assessment recommended that VHA plan for a changing veteran landscape, anticipate shifts in the geographic distribution of veterans, improve data collection on veterans and on health care utilization and reliance, monitor health care use among younger veterans, and develop an analytic framework to perform scenario testing.

The Commission discussed the methods and findings of the assessment. One of the challenges of understanding the demographics of the veteran population is the diversity among veterans, and the variety of health issues facing them. Furthermore, the variability in veterans' reliance on VA for only a portion of their health care needs made comprehensive data collection difficult. Concerns were raised that the Commission is charged to look out 20 years and this assessment only assessed a 10-year period of time.

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Assessment B: Health Care Capabilities Presentation

The RAND Corporation provided an overview of Assessment B. The team was tasked with conducting an assessment of the current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans. The assessment found, among other things, that:

- VA has broad and deep health care resources and capabilities.
- Access to VA health care is good for many, but not all, veterans.
- VA enrollees who live more than 40 miles from a VA facility also have poor access to non-VA specialty care providers near their home.
- Most VA patients get appointments within two weeks of the preferred date, although some facilities have much longer waits for appointments.
- Compared to other health systems, most of VA quality measures are good, although VA does not perform well in measures of patient centeredness.
- VA will need to take steps to meet demand projected through 2019.

The assessment recommended that VHA use a systemic, continuous performance improvement process to improve access to care; systematically identify opportunities to improve access to high-quality care through use of purchased care; consider alternative standards of timely access to care; develop and implement more sensitive standards of geographic access to care; and take substantial steps to improve access to VA care such as clinicians working at the top of their license, increasing virtual care, and hiring more physicians.

The Commission discussed the methods and findings of the assessment. The point was made that looking at access without taking into consideration the provider model does not allow one to fully evaluate what is needed to address access. The Commission further discussed the importance of relying on patient preference for scheduling appointments and what is necessary to reform the VHA approach to scheduling.

VA Leadership Presentation

Secretary McDonald welcomed all the Commissioners and thanked them for joining in the Department's efforts to refocus VA on providing veterans with high quality care. VA looks forward to the dialogue and insights that the Commission will provide.

Secretary McDonald provided context to the Commission on their work. Beyond serving veterans, the VA is a vital part of the larger American health care system, and provides unique capabilities in research, education, and clinical care. Another factor that will influence the Commission's work is the recent access crisis. Contributing to the fiscal difficulties of the Department, and as an impediment to accessible, state-of-the art care, the Secretary noted the aged physical plant infrastructure that includes more than 70 percent of VA buildings greater than 30 years old with 40 percent greater than 70 years of age. The MyVA program is a new initiative within the Department to help shift the focus toward veterans and those who directly help them. The program comes as part of the recommitment of the VA to its core mission, and plans to improve the experience of veterans and employees, improve internal support services, establish a culture of continuous improvement, and enhance strategic partnerships. The transformation of the Department to realign with its mission and core values is underway, and VA is looking to the Commission for input on how to prepare for the future.

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Deputy Secretary Gibson highlighted some of the challenges the VA faces moving forward. While VA cares for hundreds of thousands of veterans daily, a lack of rigor in its systems and processes means the Department is unable to ensure the efficient replication of desired outcomes. Furthermore, demand for care and benefits exceed VA's ability to meet these demands, and as a result veterans often wait too long for care. Insufficient funding and minimal financial flexibility, construction challenges, and a culture that stymies innovation, further compound the problems facing the Department. In order to face these challenges, VA senior leadership has begun the process of remodeling the organization. These steps include overhauling the senior leadership, identifying unused capacity, optimizing scheduling, and dramatically expanding virtual care. An increased focus on issues such as timely access and hospital-acquired infections further demonstrates VA's vision for improving care for veterans.

Under Secretary for Health Shulkin provided an overview of his perspective of the current state and future of VHA. Coming from the private sector, one of the first steps the Under Secretary took was an extensive listening tour of VA facilities around the country. The Under Secretary found that resource allocation is not clearly aligned with VHA's essential core functions; permanent leaders are not consistently in place; there is reluctance to publicly articulate strengths and differentiators; too many performance measures and priorities make it impossible to align work, and a complex organizational structure and a divide between central office and the field has slowed down decision making. He also noted that the data capabilities of the Department are great, but ability to use the data for decision making doesn't match the potential. There exists a consistent and deep passion within staff who work for VHA, and the recent crisis has resulted in a willingness and readiness to change. With tools such as the IA and the Commission on Care to help, the Department is ready to tackle the issues that it faces and move veteran health into the future.

The Commission asked the VA senior leadership panel about specific VA programs, as well as general approaches to revamping the VHA system. Topics discussed include:

- Concerns within VHA about the transformation process and resistance of VA leadership/staff to the Commission's work
- The successes of the Kizer tenure and current issues around resolving the tension between cultivating innovation within the system and enforcing quality metrics
- Impact of areas not in VA's control such as the media and Congress and how reacting to these takes a substantial amount of the staff's time that would otherwise be devoted to the mission of the organization
- What role VA sees for the Commission in addressing the issues that face VA and how the Commission's report can help
- The need for a "base realignment and closure (BRAC)" for VA to address the aging VHA infrastructure and misalignment of physical plan resources with the veteran population

The Commissioners introduced themselves and Secretary McDonald made closing remarks.

Assessment C: Care Authorities Presentation

The RAND Corporation provided an overview of Assessment C. The team was tasked with conducting an assessment of the authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities,

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including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care. The assessment found, among other things, that:

- While the role of purchased care within VHA has grown recently, VA has multiple authorities for purchased care.
- These authorities contain inconsistent requirements, leading to confusion among veterans, VHA staff, and providers.
- The authorization rules can interrupt an episode of care.
- There is no clear make-or-buy strategy for delivering care.

The assessment recommended that VHA define a strategy for purchased care; simplify the purchase care program and establish clear goals and objective benchmarks for success; address cost and quality control more explicitly and systematically; develop a stronger management structure for purchased care; collect better data to accurately estimate demand for and measure quality, access, and costs of purchased care; and evaluate third-party contractors administering PC3 and Choice. The assessment stopped short of advising a specific approach to reforming purchased care authority, noting that the solution depends on the goals and objectives the Department intends to achieve through purchased care and how this fits with the overall strategy to deliver accessible, high quality care to veterans.

The Commission discussed the methods and findings of the assessment. Although not discussed in the presentation, the Commission thought that VHA should revamp its contracting system in order to more closely reflect the innovations of the broader health care system, prevent regional monopolies for implementing programs, and fix other inherent issues.

Assessment I: Business Processes Presentation

Grant Thornton LLP and Navigant provided an overview of Assessment I. The team was tasked with conducting an assessment of the business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third-party revenue collection, and vendor reimbursement. Concerning revenue, the assessment found that:

- Insurance information of patients is not captured in a timely manner, resulting in costly, retroactive patient accounting processes and outside contractors.
- About 55 percent of denials are related to patient intake processes in the revenue cycle.
- The patient accounting system requires extensive manual intervention, causing errors and delays.

Concerning non-VA care, the assessment found that:

- There is inconsistent use of the available purchased care options (non-VA care, PC3, and the Choice Card program).
- Only 29 percent of non-VA claims are submitted to VHA via electronic data interchange (EDI) (the commercial standard is 94 percent).
- No claims are automatically adjudicated (the commercial standard is 79 percent).
- VHA is not paying non-VA care claims timely and accurately.

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- Interest penalties are low compared to industry benchmarks. However, VHA risks increased penalties pending an Office of General Counsel review.

The assessment recommends that VHA develop a long-term comprehensive plan for provision and payment for non-VA health care services; establish a formal governance model that facilitates central office and VISN leadership alignment of interests and accountability; align performance measures to those used by industry; and, simplify the rules, policies, and regulations governing revenue. The assessment noted that the complexity of the rules governing what care could be billed contributed to the high level of manual adjudication.

The Commission discussed the methods and findings of the assessment noting that the organizational and information technology infrastructure are essential for changing processes. The Commission also discussed the challenges around the billing and payment for purchased care and the importance of collecting insurance information from veterans upon intake while visiting a medical facility (the Department of Defense had this issue and resolved it).

Assessment E: Scheduling Workflow Presentation

McKinsey and Company provided an overview of Assessment E. The team was tasked with conducting an assessment of the workflow process for scheduling appointments for veterans to receive hospital care, medical services, or other health care at medical facilities within VA. The assessment found, among other things, that:

- System limitations prevent accurate knowledge of the available appointment supply.
- There is inconsistent use of standard industry practices related to schedule setup, standard appointment lengths, reminders, etc.
- Policies such as patient desired date and electronic wait lists add administrative burden with unclear benefit.
- More than 90 percent of schedulers noted gaps in training and a need for additional training.
- Call centers that handle scheduling are subscale and variably managed.

The assessment recommended that VHA address system limitations to provide visibility into appointment supply; codify proven scheduling practices and empower clinics to use them; streamline scheduling policy implementation with tools and technology; ensure that clinic manager training programs are well scoped and resourced to manage provider availability; design larger scheduling call centers that offer expanded, consistent services; and improve scheduler training overall.

The Commission discussed the methods and findings of the assessment. The Commission further discussed the difficulties inherent in scheduling processes and the balance between patient desires and physician realities.

Assessment F: Workflow – Clinical Presentation

McKinsey & Company provided an overview of Assessment F. The team was tasked with conducting an assessment of the organizational workflow processes and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services. The assessment found, among other things, that:

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- Ineffective data and collection management has led to a lack of transparency.
- There is mismatch between VHA resources and veteran needs.
- There exist within the VHA network isolated pockets of best practices.

The assessment recommended that VHA should ensure resources such as staff and facilities are used to better serve patients at the appropriate level of care and at the appropriate times; improve hiring time of clinicians; scale existing best practices and support further innovation at the local and national levels; and improve clinical management through clear operational metrics, streamlined data collection, monitoring, and performance management.

The Commission discussed reasons for hiring delays and the difficulties of bed management, especially with the political challenge of closing hospitals.

Assessment G: Staffing/Productivity/Time Allocation Presentation

Grant Thornton LLP provided an overview of Assessment G. The team was tasked with conducting an assessment of the staffing level at the Department's medical facilities and the productivity of VA providers compared with health care industry performance metrics. The assessment found, among other things, that:

- The staffing mix reflects VHA's care model and the needs of veterans.
- There is a productivity gap between VHA and the private sector, with VHA specialists being less productive, although there are some exceptions.
- There are several reasons for this gap, such as fewer exam rooms per providers, fewer clinical support staff per provider, and few mechanisms to cover staff absences.
- Provider clinical time allocation is comparable to the private sector.

The assessment recommended that VHA improve staffing models and measurement; create a role of clinic manager to drive coordination and integration among providers and support staff; implement strategies for improving management of daily staff absences; and implement local best practices that mitigate space shortages within specialty clinics.

The Commission discussed the degree of latitude that local leaders have over space management, the inherent limitations within VA medical facilities, and the differences between the models of care for VA and other health care systems.

Assessment J: Supplies Presentation

McKinsey & Company provided an overview of Assessment J. The team was tasked with conducting an assessment of the purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care-related services by the Department.

The assessment found that:

- For pharmaceuticals:
 - VA pays relatively low prices for drugs, with some potential to improve.
 - VA has a robust and efficient pharmaceutical distribution network that achieves high satisfaction scores.
 - There are mechanisms in place to ensure appropriate utilization of medications.

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- For medical and surgical supplies, medical devices, and related services:
 - VA's contracting processes are bureaucratic and slow.
 - Purchasing workarounds to meet patient care needs leads to inefficiencies.
 - Utilization is difficult to measure and manage given poor data and systems.

The assessment recommended, for pharmaceuticals, that VA establish mechanisms to ensure a reliable supply of pharmaceuticals, with more consistent access to the lowest possible pricing. For medical supplies and devices, the assessment recommended that VA transform and consolidate the entire medical supply chain organization and improve key aids required to support the organizational transformation, including information technology systems, data standardization, and talent management.

The Commission discussed the methods and findings of the assessment including the use of cost effectiveness metrics in purchasing, whether legislation is necessary to implement recommendations, and why pharmaceutical and supply purchasing are so different.

Assessment K: Facilities Presentation

McKinsey & Company provided an overview of Assessment K. The team was tasked with conducting an assessment of the process of the Department for carrying out construction and maintenance projects at the medical facilities and the medical facility leading program. The assessment found, among other things, that:

- The capital required to maintain VHA facilities and meet projected needs over the next decade is likely to be two- to three-times higher than funding projections.
- Capital management, design and construction, leasing, and facilities management performance is on a par with public-sector performance in most cases, yet well below private-sector performance.
- The cost per square foot to deliver major construction projects is approximately twice the private industry best practice.
- VA's ability to deliver needed projects consistently on time and on budget is hindered by various factors, such as shortfalls in accountability, inconsistent capital allocation, and frequent changes to scope and design criteria for major projects.

The assessment recommended that VA improve the project selection process and refine the project portfolio. The Department should streamline project delivery across all construction types, ensure proposed projects make the most of existing infrastructure, and look to alternatives to building new infrastructure to meet the expected short-term surge in demand.

The Commission discussed the methods and findings of the assessment and concerns about the average age of facilities in VHA, what role the VA should play in construction, and how funding needs to adapt based on the evolving health care environment.

Day 1 closing remarks were provided by Ms. Schlichting. The meeting was adjourned at 5:05 p.m.

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Day 2 of the Commission on Care meeting opened at 8:30 a.m.

VHA Leadership Presentation

Ms. Schlichting opened the meeting and introduced Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning. Ms. Vandenberg provided an overview of her path prior to joining the VHA, and expressed how she welcomes the opportunities the IA and the work of the Commission will provide to move VHA into the future.

Ms. Vandenberg gave the Commission an outline of how VHA is preparing for the future. VA has a critical mission to provide care for veterans and some of the influences on VHA are different than those that shape other health care providers. The main strategic drivers that influence VHA are the Affordable Care Act, the Veterans Choice Act, and evolving veteran enrollment, utilization, and demographics. The Affordable Care Act has led to an increase of 33,000 veteran enrollees, a small but impactful increase. It is also driving new delivery models and structures through payment reform in the private sector that reward quality of care over quantity of care. The Veterans Choice Act increases access for veterans through the Choice Program and allows approximately 900,000 veterans to see practitioners in their community. Finally, evolving veteran enrollment, utilization, and demographics drive VHA planning. Two dynamic demographic trends impact the future cost of VA health care: the aging of the Vietnam era enrollee populations; and an increasing number of enrollees with service-connected disabilities, particularly in top-priority groups. There are also more women veterans and more veterans who identify as Hispanic, Latino, or Spanish. Finally the demographic distribution of veterans is changing with movement toward the southeast and southwest.

To meet these changing needs, VHA must be agile and flexible, taking advantage of community partnerships and alternative models of care to adapt to changing demographics, utilization patterns, and veteran expectations. The landscape of American health care is changing, and VHA must change or risk failing in this competitive environment.

The Commission discussed how the health care landscape is changing and how VHA must assess its position and adapt to provide services for veterans in the future.

Assessment L: Leadership Presentation

McKinsey & Company provided an overview of Assessment L. The team was tasked with conducting an assessment of the competency of VHA leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management. The assessment found, among other things, that:

- An expanding scope of VHA activities has led to confusion around priorities and strategic direction.
- The organization is intensely, unnecessarily complex due to lack of a clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.
- The broader VHA culture is characterized by risk-aversion and distrust, resulting in an inability to consistently improve performance across the system.
- Leadership faces a workforce that appears to be steadily losing its motivation.

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- The performance of a particular VAMC hinges, to a large degree, on the capability of its director and the executive leadership team, yet these leaders are often “on their own” without effective support services such as HR, contracting, and IT.
- Leadership attention is frequently consumed by addressing crises, at the expense of preparing for tomorrow’s opportunities.
- The leadership pipeline is not robust enough to meet VHA’s current and future needs.

The assessment recommended that VHA galvanize leaders around a clear strategic direction; stabilize, grow, and empower leaders; redesign the operating model; focus and simplify performance management; rebuild a high-performing, healthy culture; and redesign the human resource function as a more responsive, customer service-focused entity. Addressing these challenges will require a fundamental shift that can be achieved through a bold, integrated, multi-year transformation sequenced in a thoughtful manner.

The Commission discussed the current number of vacant key VHA leadership positions, how VHA salaries and benefits compare to the private sector, the situation of overall morale in VA, and the readiness of VHA for reform.

Assessment H: Health Information Technology Presentation

MITRE Corporation provided an overview of Assessment H. The team was tasked with conducting an assessment of the information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by the Department. In particular, the team was tasked with evaluating strategies related to clinical documentation of episodes of hospital care, medical services, and other forms of care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities. The assessment found that:

- There is ineffective implementation of strategic plans and health IT management.
- Organization and processes are not tuned to the scale and complexity of the VA’s information technology challenges.
- Complex information technology infrastructure and inconsistent clinical documentation processes are causing VA to lag behind the private sector in utilizing information technology to improve health care and patient satisfaction.

The assessment recommended that VHA designate a dedicated CIO to manage and advocate for VHA’s information technology needs; perform a comprehensive cost-versus-benefit analysis between a commercial, off-the-shelf electronic health record (EHR) or the continued in-house custom development of the Veterans Health Information Systems and Technology Architecture (VistA); implement a broad process, inclusive of clinicians, to pursue requirements that support clinical documentation best practices and improved functionality; and convert project-focused information technology approaches to information technology service management models focused on customers.

The Commission discussed reasons for replacing or maintaining VistA and the difficulties associated with changing or replacing VistA, as it is more than just VA’s EHR.

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CAMH Closing Presentation

CAMH summarized the findings and recommendations of the IA and discussed the larger ecosystem within which VHA operates. The ecosystem surrounding VHA can be broken down into social, political, technological, and economic sectors. All of these sectors operate on different scales, from within VHA itself, expanding outwards to VA, the larger U.S. health care system, and finally the external world. All of the findings and recommendations of the IA connect VHA with this ecosystem, and demonstrate the world in which an integrated systems approach to change must occur.

The Commission discussed VHA's role within this larger ecosystem and the external influences that operate upon VHA. The Commission further discussed the roles that VISNs play within the VHA system, what is necessary to implement evidence-based changes and its relationship with innovation, as well as the methods and recommendations of the IA.

Closing remarks/comments were made and the DFO adjourned the meeting of the Commission on Care at 11:53 a.m.