DEPARTMENT OF VETERANS AFFAIRS

MISSION ACT:
PUBLIC MEETING REGARDING HEALTH CARE STANDARDS FOR QUALITY

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P R O C E E D I N G S

(10:11 a.m.)

DR. FRANCIS: Okay. Good morning. It's -- good morning. It's 10 after the hour and we've had a few people show up from the weather delay, so we'll get started so we can get you all back to your homes or offices in time.

I'm Dr. Joe Francis. I'm the MC for today's event. I'm a physician. I'm the deputy chief officer in what's called the Office of Reporting, Analytics, and Performance Improvement Deployment. Basically, we're the measurement people in VA that do the internal as well as our public reporting. And I'm delighted to be hosting this event, where we hope to learn from you, our stakeholders, members of the public, members of federal and non-federal entities, something about what we should be doing for quality standards to implement Public Law 114-315, which we love to call the MISSION Act. One of the great acronyms of our time.

I want to introduce for some opening remarks Dr. Carolyn Clancy. Dr. Carolyn Clancy is currently the Deputy Under Secretary for Health for Discovery Education and affiliate networks, and I'll have her explain what that means. She was previously our executive in charge for a number of years, and she's also been a leader in

the world of performance measurement, having come to VA from the directorship of the Agency for Health Research and Quality.

I won't go any further than that, but, Carolyn, if this is good?

DR. CLANCY: Great. Yes.

Well, good morning, everyone. Anyone who shows up in this kind of weather you know is deeply interested. So we're very, very happy to have you here. And what my new job means is I'm effectively -- if you were really astute, you'd notice that the name of this group spells DEAN. So I have been -- or the, you know, initials. I have been telling people I am VA's dean.

And the whole intent is really to elevate our academic mission, both because I think our work in education and in research is sometimes a better kept secret than we mean it to be, but also because I think those are assets that we can use strategically as we strive to not only provide veterans the best care possible right now, but also be thinking about what are those veterans going to need in the future; how can we continue to push forward. So the MISSION Act will fundamentally transform elements of our health care system.

Those of you who have been following this will

have known that we had a Choice program, and that was superimposed on five to six other pathways to buy veterans care in the community. It's very, very important to know that buying care in the community for veterans goes back at least 70-plus years to the time when General Omar Bradley actually established the partnerships that we've had for, I think, 72 or 73 years -- who's counting -- with all of the academic medical centers in the country. A longstanding partnership and network of affiliates that has, I believe, been a huge asset to our efforts.

Many of our physicians have dual appointments, both as an academic physician as well as a staff physician at VA, which, I think, gives the veterans the best possible chance for success.

So, buying care in the community is nothing new, but this law does give us some very, very big advantages. One is it consolidates those seven pathways into one, which will sound a little bit funny, but, in administrative terms, we think this is going to be far, far more efficient. The terms of the Choice Act were interesting based on administrative criteria if a veteran had to wait more than 30 days for an appointment, or if the veteran lived more than 40 miles from the nearest point of care.

Now, the second criterion stirred up lots and lots of interesting conversations. And I want you to know I have received personally thousands of emails about how my 40 miles -- or my 38 miles is usually how it's framed, is actually at least equivalent to 200 because of construction, a bridge out, and so on and so forth.

The nice thing about administrative criteria is they're really easy to understand. The less good news is that they're not necessarily mapped, or don't correspond very directly to an individual veteran's clinical needs. So this law also gives us the opportunity to be far more thoughtful about how we assess the quality of the care from the community providers with whom we will be asking to take part in veterans' care.

So, what we want to get to is a place where our transformed health care system, right, which is no longer just what does VHA do internally, but it's a high-performing network comprised of both our own internal systems as well as care provided by our community partners. So we want that care to be easy and reliable in terms of access when veterans need it, and to provide exceptional care to veterans anytime, anywhere.

Now, this sounds like, of course, what else would we want for veterans, right? Except if you know anything about how we do in quality of care in this

country, you can learn pretty quickly that actually where you live matters.

You've probably heard lots of jokes about Minnesota being above average in all things if you were a fan of *A Prairie Home Companion*. It turns out Minnesota is reliably one of the highest quality states by just about every metric that we have, kind of neck-and-neck with Wisconsin. This is a little bit sensitive, so you do not want to get into a debate. That and the Packers, you know, it just doesn't go well necessarily.

And other states are pretty much consistently at the other end of that spectrum. And yet, our commitment to veterans is wherever you seek our assistance, we're going to make sure that you're providing us terrific care. So this law, what we also want is that this -- we will serve as a trusted, caring partner, helping the veterans and families be healthy and well, right?

Most people do not live to have an exuberantly positive health care experience. Nice when it happens, but much like taking an airline trip, right, the point is where you want to get to; what do you want to do; what do you want to be healthy for in terms of the everyday activities that you -- that give meaning to your life, whether that's work, hobbies, relationship with family

and friends, and so forth. That's what most veterans want as part of their new mission once they become veterans and leave active service.

It's also very, very important to know, and I will tell you that I actually joined and attended the confirmation hearing for our secretary where the word privatization came up, oh, I would guess about every 60 seconds. Are you planning to privatize this system? And the answer was no, because as I said, the reality is we've been providing care for veterans in the community for about 80 years. We can't possibly do it alone.

While the programs to deliver that care have changed over time, our objective remains to make sure that veterans can get care closer to home. This is a big, big challenge for us because one third of the veterans enrolled in our system live in rural areas. Now, some of those rural areas have lots of community options, others not so much. So the law requires us to establish standards for access and quality and to consult with public and private entities as well as stakeholders such as veterans in developing those standards.

So we are gathered here today to listen to you, to your ideas about quality standards. And with that, I would be happy to take questions or hand it back to our phenomenal host, Dr. Francis.

I don't think I've shocked anyone here with what I had to say.

DR. FRANCIS: We like no shock.

DR. CLANCY: Okay. Thank you.

DR. FRANCIS: Thank you, Carolyn.

All right. And I'm going to get everybody back on track and on the schedule here; just brief preliminaries. We thought about some ground rules for today's session, largely to make sure that all voices were heard and understood and respected. And this is really about us listening to you rather than us telling you. So a few things I think important to note.

First, is that we have a deadline to midnight tonight for the submission of public comments. But we also have an extended deadline to October 16th for responses to the things that were discussed today. And by the way, that comment line is also open to those who may not have been able to attend today for weather or other reasons. So we have that. And everything that we receive will be analyzed, summarized, and made part of our report to Congress when we issue our statement around quality standards for the MISSION Act.

The second ground rule is, when you do come to speak or to comment on another presenter's talk, please use the microphone, state your name, your title, and the

organization you are representing if you're representing somebody other than yourself.

Third ground rule; our focus today is on implementation of the legislation as written in Public Law 114-315. There are many spectrums of opinion on this legislation, folks that fear it went too far, folks that felt it didn't go far enough. There will be other forums to discuss that with your legislators. We're about implementing the law as written, and that's what we're asking your help for.

And then lastly, out of respect for all the voices we hope to hear from today, we ask that you keep your oral comments to 20 minutes. Again, additional materials may be submitted online. And then we'll provide 15 minutes for a discussion, for questions and clarifications and the like. We hope to have a little bit of dialog, particularly amongst our stakeholders, on the variety and spectrum of feelings on what should be important when we address the quality standards for our care in the community.

Any questions on that?

(No response.)

Okay. Well, our first speaker -- and we're back, I think, on time -- is Rachel Fleischer, Federal Relations Specialist from The Joint Commission. And is

Rachel in the audience?

Right there. And you can use the podium up here or you can use the microphone, whichever you're more comfortable with.

MS. FLEISCHER: Good morning. I am Rachel Fleischer, Federal Relations Specialist with The Joint Commission. Thank you for the opportunity to share the following remarks on behalf of The Joint Commission.

As a not-for-profit accrediting organization, The Joint Commission seeks to continuously improve health care for the public by evaluating health care organizations and inspiring them to provide safe and effective care at the highest quality and value.

The Joint Commission has had a long relationship with the Department of Veterans Affairs and the VA has called on The Joint Commission to accredit VA health facilities across the health care spectrum. The Joint Commission currently accredits VA hospitals, clinical laboratories, ambulatory care, behavioral health care and opioid treatment programs, and home care. We use the same set of standards for all of the facilities that we accredit within a specific program, whether military or civilian.

The Joint Commission appreciates the VA's commitment to ensuring that veterans receive the best

possible health care and we recognize the VA's efforts to provide an effective integrated system of service delivery for veterans. As the VA works to expand access to care for veterans in the communities where they live through purchase care or other delivery arrangements, the VA must continue to oversee the quality of the health care services that veterans receive.

The VA can achieve its oversight goals by creating the right vision and metrics for its quality framework through working closely with accrediting organization partners on its vision and execution.

As a first step, The Joint Commission recommends that the VA encourage veterans seeking care outside of the VA health care system to obtain their care from a facility that has achieved accreditation by an accrediting organization. Accrediting organizations use standards that meet or exceed the Medicare conditions of participation for health care providers and the conditions for coverage for health care suppliers. If veterans must receive care outside of a VA medical treatment facility and there is no available accredited health care facility, at minimum, the VA should require that the entity is Medicare certified.

Adherence to the Medicare conditions of participation ensures that facilities comply with

baseline federal quality requirements. For care provided in a primary care home, the VA should ensure that the primary care home has achieved accreditation. The Joint Commission works closely with health care facilities to drive their quality improvement efforts on the journey toward high reliability.

Our standards and national patient safety goals for hospitals far exceed Medicare's fundamental quality and safety requirements, and these private sector requirements are regularly updated to reflect the latest evidence-based advances in health care. In addition, The Joint Commission has firsthand knowledge of issues involving service and clinical integration that may be useful to the VA in developing requirements for quality oversight.

Furthermore, The Joint Commission has long been a leader in performance measurement. We developed the first national database of standardized hospital performance measures that were made publicly available. Because of this unique expertise, we offer our assistance in working with the VA to develop a quality framework that uses data-driven metric -- or excuse me, data-driven performance measures to evaluate and compare care settings.

The Joint Commission offers a public website,

QualityCheck, that allows patients to view Joint Commission accredited facilities, including VA-operated facilities. We would willingly collaborate with the VA on the development of additional tools to help veterans understand the quality and safety of facilities where they receive care.

Thank you for your time and consideration. The Joint Commission has also submitted formal comments in response to the VA's request for information. And we look forward to continuing to strengthen our partnership with the VA to improve veterans' access to quality health care services. Thank you.

DR. FRANCIS: You want to stay up in case there are any questions?

Are there any questions or discussion for Rachel?

Sir?

MR. CAREY: Bob Carey from The Independence Fund.

DR. FRANCIS: It would help if you could use the microphone. Thank you.

MR. CAREY: Hi, Bob Carey from The Independence Fund. Do you happen to know, like, what percentage of non-VA care -- no? There it is. Now it is.

So, Bob Carey from The Independence Fund. Do

you happen to know what percentage of non-VA care is currently delivered from non-accredited organizations or facilities?

MS. FLEISCHER: Thank you for your question. I don't have that number with me at the moment, but I'm happy to take your contact information and follow up with you.

MR. CAREY: Great. Thanks. And then you talked about the difference between your accreditation and Medicare certification. Do you have specific differences that you think are useful for consideration in that discussion, and then why is the Medicare certification inadequate?

MS. FLEISCHER: Thank you for your question. I'm happy to take your questions back to The Joint Commission leadership and follow up with you.

MR. CAREY: Thanks.

DR. FRANCIS: And, Rachel, I have a question for you, and maybe it's already answered in the material submitted. But in terms -- there's a lot of discussion around high-reliability organization and it's sort of a holy grail, but I hope that the materials will include what Joint Commission views as its definition of high reliability. Or maybe you have that at a moment's notice and you can share that with the group.

MS. FLEISCHER: I'm happy to follow up with you about that, as well --

DR. FRANCIS: Okay. Excellent. All right.

And, Bob, I'll just say, from the standpoint of hospital care, I do know that currently under the Choice program, for hospital care, Medicare conditions of participation generally have to be met, and for the hospital, it's Joint Commission has dean status. So I'm unaware that we're using any non-accredited facilities for hospital care. Outpatient is a very different animal, as you know.

Anybody else from the audience, any further discussion or dialog?

MS. PARK: I have some comments. Is this the time?

DR. FRANCIS: Those would be great and, in fact, right at the -- just please come to the microphone.

MS. PARK: The mic? Okay. Sure.

DR. FRANCIS: Yes. And your name, title, and organization, please?

MS. PARK: My name is Marilyn Park. I am a legislative representative with the American Federation of Government Employees, which represents the vast majority of people in VA health care system on -- in non-management positions, including many who use the system

themselves, as a third of our members are veterans.

So, my concerns -- and we have obviously been very concerned about the MISSION Act from the beginning and the -- what we consider a overly accelerated and overly large push towards privatization. So I will say that up front.

As far as quality measures, I have a couple of big concerns. First of all, I'm very concerned about the capacity of the private providers to collect the data we need to compare quality. We're talking about a lot of people have had no connection to the VA system, that are very small providers, and I think they're -- we're simply not ready to compare quality in the private sector and the VA before we make decisions about sending individuals out for better care, and even more significant decisions about what parts of the VA, for example, service lines, we can close. So I'm very concerned about that, the lack of capacity in the private sector.

I'm also concerned about the fact that current quality measures that may be relied on are not adequate, especially for something like PTSD; that the measures out there now are flawed and don't always measure what is most important for delivering care and may, for example, measure customer service, but not necessarily measure the right care for the particular veteran. And I think PTSD

is one of those weakest areas.

I think, finally -- let me just try to sum this up better. I think that, actually, this is a concern we've heard a great deal. When you compare quality in the non-VA population and the VA population, it's an apples-and-oranges problem. Veterans have unique medical needs, they have conditions that are more complicated, more complex, and multiple conditions, and I fear that any attempts to measure quality will not adequately measure what this non-VA provider can do for the veteran based on data that is really based on different populations.

So, I think that sums up my concerns, and I'll be putting those in writing, as well. Thank you for the opportunity.

DR. FRANCIS: Excellent. Thank you, Marilyn.

Any more?

All right. Well, then we'll move now to the next presenter, Mr. Carey from The Independence Fund.

MR. CAREY: Good day. I'm Bob Carey, Chief Advocacy Officer for The Independence Fund, a retired Navy disabled veteran enrolled in VA health care, but not currently a user.

The Independence Fund is a relatively new player in this arena. We just opened up our Washington,

D.C. offices in January this year. We've been around for about 10 years. Provide support services for catastrophically disabled veterans, primarily mobility equipment. You've probably seen our cross-country track wheelchairs, the motorized wheelchairs with tank treads. We've provided about 2300 of those. As well as support for caregivers and their families; supported about 1700 catastrophically disabled veterans' families. As well as other adaptive mobility equipment, mostly around adaptive sports. And then, in the Washington, D.C. office, we do a lot of work now in the advocacy arena.

We have six main recommendations that we will elaborate on in our written comments, but I'd like to go through those in a bit of a higher level here.

First, we believe the implementing regulations should prescribe mandatory access to non-VA care where quality standards are not met. So the MISSION Act amended Section -- at 38 U.S.C. Section 1703 for the -- where it states that the Secretary shall provide non-VA health care to covered veterans where the VA is not able to furnish such services in a manner that comply with the designated access standards. But, it only says that the Secretary may provide that non-VA care access where the quality of care standards are not met.

We think that such a distinction between

mandatory access to non-VA care where access standards are not met and optional access to non-VA care where quality standards are not met are illogical and place the veterans' health care at risk. To argue VA facilities not meeting department quality of care standards can be held to a lesser standard of accountability than those facilities not meeting department access standards simply means the VA will ensure veterans receive quicker access to potentially inadequate care.

Bottom line, a VA facility not meeting quality of care standards is probably placing the veteran's care more at risk than if it does not meet the access standards, although that's -- that can be highly debated. I understand.

Therefore, we recommend that the Secretary use the full authority granted by the MISSION Act and regulatorily change that may to a shall and that the -- direct that the regulations provide the same mandatory access to non-VA care where quality standards are not met as will be drafted when the access standards are not met. In fact, we recommend that the exact same language for access to non-VA care where quality of care standards are not met be used where the access standards are not met.

Second, we recommend that the MISSION Act implementing regulations should provide separate access

and quality standards for catastrophically disabled veterans. As I said before, we service primarily catastrophically disabled veterans. Originally, we were doing a lot with the post 9/11 catastrophically wounded, but with the Vietnam and Desert Storm era veterans increasingly aging and their immune systems being compromised, we are now seeing a lot more service-connected ALS and MS that we're now servicing, as well, for those generations of veterans.

In August of this year, I wrote an op-ed some of you may have read in the *Houston Chronicle*. I can provide a copy for you. It will also be with my comments that we submit today. That the current VA access and quality of care standards are inadequate to address the specific and urgent needs of catastrophically disabled veterans. In fact, given the considerable variance in the disabilities and needs of veterans served by VA health care, single system-wide access and quality standards fail to capture the unique and urgent conditions of catastrophically disabled veterans, as they probably do a number of other different types of veterans.

Therefore, separate, unique access and quality of care standards, both for VA and non-VA care, we believe should be promulgated with the MISSION Act

implementing regulations so catastrophically disabled veterans are not subjected to life-threatening delays in care and services, nor to inadequate care.

Further, we recommend that the MISSION Act implementing regulations should provide for separate and unique formularies for catastrophically disabled veterans, providing, especially in things like prosthetics and wheelchairs, providing them far greater access to non-formulary devices and pharmaceuticals, as well as greater quantities and quicker replacements.

Third, we recommend that TRICARE Prime and DoD military treatment facility quality of care standards should be the model for VA health care quality of care standards, as well as, fourth, that the Department should tie access and quality of care standards together.

Repeatedly, we find our clients, most of whom are medically retired due to their catastrophic wounds, choose DoD over VA care, especially with regards to prosthetics, mobility devices, and burn treatment, all of which we think would be hallmark care areas of the VA. When we talk about core areas that the VA should be operating in, we would think that prosthetics, wheelchairs, and burn treatment would be core areas for the VA to engage.

Is there a problem -- we're good? Okay. I

just wanted to make sure I wasn't doing something wrong.

The primary reason these veterans give us for choosing DoD care is that DoD provides greater varieties and quantities of care, provides care at a lower threshold levels than with the VA, and provides a more seamless and integrative care experience. Oh, and also provides the care quicker than the VA can.

We especially see this in prosthetics with Walter Reed. In fact, our executive director's husband, catastrophically wounded in Afghanistan, is recovering at Walter Reed right now from his 119th surgery, where they had to remove more of his left leg, in large part because they grew frustrated with the VA care.

To go to my fourth point about tying the quality and access standards together, this is also indicative of why we believe access standards cannot be divorced or considered separately from quality of care standards. Quality of care standards are directly tied to the timeliness of receiving that care in the first place. In fact, the quality of care standards probably will not accelerate but become greater the longer you have to wait, especially for the catastrophically disabled.

While the MISSION Act separates the access standard development from the quality of care standard

development, there is nothing preventing the Department from presenting the final report and any proposed rules as an integrated set of access and quality of care standards and overcoming that sort of arbitrary division. To try to separate them is in fact, in our opinion, to force an arbitrary and capricious standard on what should be an integrated medical care standard.

Fifth and sixth; fifth, we believe that we should be allowing for much greater stakeholder input than appears currently envisioned within this MISSION Act implementation regulation process and, sixth, we believe that the Department should submit final access and quality of care standards as proposed rules and not simply as VHA directives or policy notes.

While the Administrative Procedures Act places clear limits on what a federal agency can discuss with nongovernmental agencies once the proposed rule is issued, the APA provides considerable freedom of engagement by federal agencies prior to such issuance. In fact, the APA specifically allows federal agencies to accept specialists' input on the drafting of actual rule language from stakeholders and to engage in a give-and-take on that. To that end, while The Independence Fund deeply appreciates the opportunity to participate in today's activities, we recommend the Department engage us

and other stakeholders much more intimately in the rules-drafting process, including informal workshops and even rule-drafting roundtables where we review proposed draft language -- draft proposed rule language.

Similarly, we know access and quality standards are usually not issued by proposed rule but, instead, by VHA directive or policy document. Given the importance of these standards, however, to the implementation of the MISSION Act and access to non-VA care, and the fact that they are actually specifically built into the MISSION Act legislative requirements for the policies that are going to come out of that with regards to access to VA and non-VA care and the quality of care standards for VA and non-VA care, we recommend that the actual access and quality standards be issued through a notice of proposed rule-making process. In fact, we believe that the way the legislation is written, that these access and quality of care standards now reach the threshold of significant policy decision that mandates an Administrative Procedures Act proposed rule-making process.

Now, some will argue that, you know, that the MPRM process will be too cumbersome for a health care system to use for such dynamic standards. However, the law's the law, and we believe that these standards have been elevated to a degree of significance because of that

law that mandates that.

Now, if emergent health care practices or technologies require immediate adoption of new standards, the APA provides for such urgent action and allows for the issuance of final rules without issuing a first proposed rule. It still is cumbersome, but given the importance of these, to do these through VHA directive or policy memoranda alone is, in our opinion, not meeting the requirements of the APA.

I will be happy to provide any of these documents to anyone else. I'll be submitting them, as well, online later on today. And I'm open for any questions.

DR. KELLY: Good morning. Dr. Heather Kelly; I'm director of military and veterans health policy for the American Psychological Association, so a different APA from the one Bob was just talking about.

(Laughter.)

So, a couple things. As a good psychologist comments more than questions, of course, Bob, we definitely from APA agree with your final statement about the need to have this as a rule, a proposed rule for a comment. We agree that these are quite significant.

The two things that I might not take exception with you on but maybe use to point out again how

different some of the different kinds of care, mental health care in particular, may be different from catastrophic and prosthetic care, two points that you made that I'll take a different take on because of mental health.

One is I also cover Department of Defense and TRICARE and I've been working very hard on TRICARE issues. We would not want to see the mental health care standards be tied to at least the existing TRICARE standards because they really don't exist, and they certainly don't measure not -- and I've met often with the TRICARE office, oversight office about this. I think they would like to, but they don't, and they're two current mental health care vendors, Humana and Health Net, do not measure outcomes in mental health. And so, I do not want to take the VA backwards and tie them to a TRICARE standard that doesn't exist, frankly.

And then the other issue is just in terms of the it's not just access versus quality of care, and you made reference of this. It does matter to us both the access and the speed of access, but also the quality of care. And this is why we advocated pretty strongly against the MISSION Act, which is currently -- and I'm going to read some recommendations that we have. The outside providers are not held to any of the same

standards for mental health care that VA psychologists in particular are in terms of measurement. And so, it does matter to us, and I talked a lot with the variety of VSOs on this issue. It's not just getting someone quickly into a door; it matters very much who is sitting in that chair and what his or her training standards and professional development standards and use of evidence-based psychotherapies is.

So I will stop here unless -- I do have some recommendations overall that aren't tied to Bob's remarks. Would you like me to save those for later? They really echo Marilyn's remarks in terms of --

DR. FRANCIS: We have time.

MR. CAREY: But --

DR. KELLY: Respond please, yes.

MR. CAREY: I think you raised really good points. This goes to my fifth, my fifth --

DR. KELLY: Did I cut you off before you got there?

MR. CAREY: Well, you said would not want, you had the mental health care, TRICARE standards, and you believe that outside mental health care providers are not held to the same standard as --

DR. KELLY: Correct.

MR. CAREY: -- as what VA is, VA health care --

mental health care providers.

DR. KELLY: Correct.

MR. CAREY: And this comes to my fifth recommendation, that I don't think that a more formal proposed rule-making process is going to be able to collect that type of nuanced data that you're discussing, and how different that is from the catastrophically disabled.

DR. KELLY: Right.

MR. CAREY: And that's why we need to take a nontraditional regulatory approach on this, a much more intimate approach, I think, between the stakeholders and VA, long before the MPRM process is public.

DR. KELLY: I'd be happy to do that. So, in terms of the recommendations, again, I'll cut them shorter because they do echo Marilyn's remarks to a large extent. But these are also -- they were submitted to you by another organization, the Veterans Healthcare Policy Institute, and I just want on record that APA, my APA echoes and agrees with and endorses these same recommendations in terms of you all moving forward with professional standards.

So, right in there -- the -- in the document you have from the Policy Institute, you certainly have the rationale behind these recommendations, so I won't go

into those, but in terms of reading into the record for today the recommended solutions include:

One, before full implementation of the MISSION Act and before any further expansion of VCCP -- that's the community providers -- the VA should establish meaningful quality metrics on what matters most, comparative patient symptom improvements, which are outcome metrics; patient functional improvements, also outcome metrics; and then provider use of standard of care evidence-based therapies, and that's a process metric, of course.

A second recommendation; require there to be listings by diagnosis and condition on the quality website so that veterans can easily and readily search according to their disorder. And we share the same concern about PTSD in particular and there not being comparative data on the outside.

Third, require that the metrics used for determining VA and non-VA provider performance are identical. I cannot say this strongly enough and often enough.

Fourth, before their final determination of underperforming 36 clinics and issuance of vouchers for non-VA care, require that the quality metrics be obtained at the service-line level and be compared to regional

clinics and compare apples to apples, or else you are not doing a meaningful comparison, and that is not in the service of veterans.

Fifth, I believe, require the VCAs -- these are the outside organizations -- keep separate track of the data on veterans referred through the VCCP so that the quality of care to veterans in the community and the VA can be correctly and directly compared.

Seventh [sic], require all VCCP providers to perform needed screenings and be subject to the same continuing education and follow-up training as VA providers. And that was to my earlier point.

I hold my own psychologists to this standard because I represent, and APA represents all psychologists, not just those within the VA. We have the luxury of getting after all of them. So we don't have any financial interest or concern in terms of where veterans get their care, or their mental health care in particular. We get to look at the data and say who are performing better for veterans in terms of provision of mental health care. And if it's at the VA, that's the VA. But we need the outside providers to be trained to the same standards, to be collecting data to the same standards, and providing outcome measures to the same standards.

And finally, ensure that patient satisfaction with care scores are not used as a substitute for quality of care. I think all of us in health care realize that's an interesting metric and interesting for other reasons; it does not reflect outcome measures. So thank you very much.

DR. FRANCIS: Sir?

MR. TURNER: I've got a question for you.

DR. FRANCIS: Yes, sir.

MR. TURNER: Aaron Turner, Vice President of Government Relations at URAC. We're a national accreditor. We accredit several of the vendors that the VA currently uses to provide and implement the Community Choice Program. Just a question, and I think this kind of dovetails a couple of the comments. Can you -- have you given any thought to how the regional variation in practices in different communities may impact some of the work the VA's doing around quality metrics?

Now, I know Paul Cotton back here from NCQA. I don't know if you're going to testify.

But he might be able to comment on a national standard set that reflects on, you know, the variation that's allowed for in the private sector.

So, have you thought about how, you know, a national benchmark at the VA level might impact those

providers who are willing to see veterans, but there has to be some kind of allowance for what they're doing in their commercial contracts and Medicare and Medicaid contracts? Just a -- an open-ended question, just a thought.

MR. CAREY: No, I guess I'm not tracking it specifically what you -- what I -- what we're proposing would impact that.

MR. TURNER: Yeah, I guess it's -- so there are -- so Medicare, Medicaid, NCQA, which is their HEDIS (ph.) measure set is largely used in the commercial side. But there are metrics that are used and metrics that aren't used that are -- that vary by the medical community, the populations that are served in a different community segmented by things that are important to that demographic. So, if you're in a county that has a high diabetes rate, maybe that metric --

MR. CAREY: I understand.

MR. TURNER: -- is more important than something else.

MR. CAREY: I gotcha.

MR. TURNER: So, when, at least from our perspective, when we're evaluating or setting benchmarks at a national level, there has to be some consideration given to the things that are unique to a given community.

So, while broadly speaking, you can talk about vets holistically. You know, when you get down to where the rubber meets the road, you know, different segments of that population in different communities have different needs. So I'm just -- an open-ended question of how do you --

MR. CAREY: No, I mean, it seems --

MR. TURNER: -- how do you -- yeah.

MR. CAREY: This -- I think this argues to what we were trying to argue -- and I'm sorry that I didn't present that clearly enough -- about the catastrophically disabled access and quality of care standards. Or what Ms. Park, Dr. Park? I'm sorry, Ms. Park was talking about with regards to PTSD standards, there seems to be substantial difference in standards of care needs across these demographics.

Now, so I don't know if it -- the question becomes does that mean that we need to have different metrics or different standards or -- I mean, there's -- I guess there's a lot of different ways to skin that cat and I'm not necessarily, you know, opposed or shooting for one way or the other. Let's just get the cat skinned. And I'm a dog guy.

(Laughter.)

And so, yeah, but again, a more iterative,

give-and-take, intimate regulatory development process between VA and stakeholders and what I think is currently envisioned, and I -- hopefully I'm wrong, I think would provide a lot more opportunity for that. Thank you very much.

DR. FRANCIS: Thank you, Bob.

Any more comments or questions? This is exactly the kind of rich dialog we had envisioned, so we hope you're not bashful.

(No response.)

Okay. I'm going to take the liberty. We're actually ahead of time, but is Joanne Frederick from WellPoint Military Care here?

MS. FREDERICK: I am.

DR. FRANCIS: You can have the podium.

MS. FREDERICK: Thank you. My written comments say good afternoon, but that's clearly not true, so --

(Laughter.)

Hopefully I can edit on the fly here. So, good morning. My name is Joanne Frederick. I am vice president for strategy and innovation of WellPoint Military Care, an Anthem company. I am honored to be here this morning, and I appreciate the enormity and complexity of the task facing each of us as we work to develop the operational and procedural requirements to

implement the MISSION Act. And the morning has just begun.

I am here on behalf of WellPoint Military Care and the entire Anthem organization just to provide our perspective and input. So I'm going to use my time this morning to talk, just some general thoughts regarding the standards for health care quality and how companies like us can function as a collaborative and supportive partner to the high-quality care delivered to veterans across the VA system today. We will provide additional written input by the deadline.

So, with my comments today I don't mean to imply that VA is not already doing some of these things. I believe, and I tell our internal team all the time, we're always better when we sit down and work together. I think that's what Bob is talking about, as well. So I'm pleased to be working with VA and everyone here to continue to improve the health care services delivered to the nation's veterans.

I'm going to share three foundational tenets that I believe are important drivers of future success for the implementation of these health care quality standards throughout VA: Consistency, evolution, and education.

So, I think consistency is something we've been

talking about a little bit here already, not directly perhaps. But it's important to say over and over again that the only way to effectively measure quality is to make sure that what we measure from a VA delivered-care perspective is the same way we measure care that's delivered in a community. Whatever those metrics are, they need to be consistent.

To the gentleman from URAC, I didn't catch your name, Aaron?

MR. TURNER: Yes.

MS. FREDERICK: To your point, you're right. There is absolutely regional variation in how care -- health care quality is measured, and I think that's a very important point that we need to consider as well. Thank you for that.

So it's complicated to decide what those measures are and how they are consistently applied across communities and across the national program and for both VA-delivered care and community-delivered care. Complicated, not impossible.

We're talking about the consistent application of measures across both parts of the ecosystem, from the very beginning. Across the Anthem lines of business, we use NCQA, HEDIS, and CAP surveys just as a few examples of the ways we measure quality in the care delivered

through our provider networks.

I contend that starting with a smaller number of identical measures for both VA-based care and community-based care is the best strategy, and then as the processes and systems are developed to support the analysis of those measures, let's layer on additional measures to the initial set. If we try to take on too much at once, compromises might have to be made.

I think one of the challenges VA faces today is the data is in disparate systems, and now we have the new EHR implementation coming on top of it. So, veteran medical data in now Vista, soon a new HR (ph.), is not easily combined and compared with the results of the health care claims that are processed when a veteran seeks care in the community, and we have to figure that out. I think that's going to be a challenge. To be able to combine and normalize both parts of the data so we actually are looking at the entire ecosystem at one time, I think that's important.

So, from an evolution perspective, the layering-on concept is critical. I absolutely agree that a comprehensive set of quality measures is certainly what veterans across the nation deserve. But again, taking on too many measures too soon could have the unintended consequence of compromising the quality of -- the results

of the quality measures.

Consider the implementation timeline of the new EHR and the data that will come available as that gets rolled out across the country and what's possible once that migration is done. I understand that's a 9- to 10-year migration for that EHR.

Lastly, and I -- I'm not sure it's been mentioned directly, but I think the concept of providing quality data so health care consumers can, as a whole, not just veterans, but all health care consumers are able to make informed decisions about their health care is certainly a worthy and noble goal. But providing that data and information is often the easiest part of those kinds of initiatives. Developing the education and outreach programs that then teach those consumers how best to use that data is hard, is difficult.

Without the education component, the data can go unused or even misunderstood, and that can also result in unintended consequences. So I encourage VA to consider how we will educate veterans and caregivers and both parts of the ecosystem on the health care quality standards while the standards are being finalized. If we think about the education while we're going through it, I think that'll help ease the implementation and, ultimately, the better use of that data once it's

released.

I end my comments there today and welcome any questions.

DR. FRANCIS: Questions and discussion, please come up.

DR. KELLY: Thank you.

MS. FREDERICK: Good morning.

DR. KELLY: Good morning. Heather Kelly again from APA. I appreciate the planned strategy for huge health care system use of the data. From a professional association standpoint, however, I would and will and do demand that our psychologists, wherever they sit, be using these high-quality standards immediately. And they should be already, and they should have been for the last 4 years.

We have really clear measures for lots and lots of things that they're working with outside and inside the VA, and they should be doing measurement-based care as it is. So, from the professional standpoint, our demands of our own providers probably will be higher to begin with. I understand for entire systems how you want to layer. I want to tell all my psychologists you should be doing the following kinds of evidence-based care right now.

So, I guess our -- we would see more expediency

in what we demand of our providers than, perhaps, the system demands can meet. But we won't be talking about layering. We want our psychologists out there to be doing the same kind of data collection that VA psychologists are doing now.

MS. FREDERICK: So let me clarify.

DR. KELLY: Yes.

MS. FREDERICK: That's not what I meant exactly.

DR. KELLY: Oh, good.

MS. FREDERICK: I think that their -- that the application and the standards to which people must perform are easily set and established at the beginning. It's the reporting on and then the using of that data that I think needs to be layered on.

DR. KELLY: Right. And again, I would say that's for the system -- to standardize that within a system I understand is a huge task for psychologists. That's why professional organizations exist, is to -- that we can absolutely, and already do, train psychologists in how to use the data that they get from their own quality assessments and tools that they should be using already for evidence-based care.

So those, at discipline levels, it's different from a system level. But from a discipline level,

psychologists can and should already be getting training on how to use assessment within evidence-based care. So I would say that's just the difference between a system level and what they should be doing. So they should be collecting that data now. How that eventually gets pulled into data that's shared across the system, it is, again, a different, a much more long-term goal.

MS. FREDERICK: Yes, again, that's --

DR. KELLY: But I want them collecting that data now.

MS. FREDERICK: Right. Well, I'm not suggesting --

DR. KELLY: And using it in their care. Yeah.

MS. FREDERICK: -- that in an individual provider's office, they're not doing all the things they need to do.

DR. KELLY: Well, they're not, and that's what we know from some of the RAND studies is they're not using that in mental health care. Again, everything is -- in my world is in the mental health care system. So we know that they're not, so we can demand that, and should, and do demand that at this point, before any of the system-level stuff gets set.

But just again, it matters sometimes when we're talking about a system level versus what providers, even

huge numbers of outside providers should be held to as a stance. Because you go to a VA provider for mental health care, there are absolutely already a bunch of metrics that they use, and not just process, but in their actual delivery of care to veterans. I want that same sophistication in the outside care to veterans. So we'll be demanding that faster than the system will be demanding it, I guess is the --

MS. FREDERICK: So are those standards part of what would come with a URAC or an NCQA accreditation?

DR. KELLY: So I don't speak the acronym level or the accreditation level. I don't know. I don't know. But, certainly, the -- all the metrics that VA psychologists have to track we would demand that outside providers track before they're getting VA money to do that.

MS. FREDERICK: We're absolutely aligned. It's the reporting of that publicly and how the data gets compared --

DR. KELLY: Right.

MS. FREDERICK: -- is the tricky part of this.

DR. KELLY: Right. But before we send money to those outside organizations, I would expect that to be in place.

MS. FREDERICK: That was easy.

DR. FRANCIS: Stick around. We may actually have time for a omnibus discussion, too.

(Laughter.)

DR. FRANCIS: All right. Okay, Paul Cotton from National Committee for Quality Assurance, NCQA.

MR. COTTON: Thank you, Dr. Francis.

And thank you all for being here. It's a very rich discussion. I'm learning a lot and almost got writer's cramp taking so many notes.

My name's Paul Cotton. I'm the director of federal affairs at the National Committee for Quality Assurance. NCQA is a nonprofit. We were established in 1990 to improve health care quality by measuring that quality, being transparent about it, and holding people accountable for improving it.

We work to build consensus among stakeholders from government, private industry, consumers, and academia on ways to improve quality. As a result, our programs are market leaders that enjoy broad stakeholder support in both the public and private sectors. Our programs also closely align with many MISSION Act requirements and we hope we can help the VA meet the law's intent and very real challenges.

Now about our programs. We have the largest patient center and medical home program in the nation.

It includes nearly 20 percent of all primary care physicians now, at this point, at over 14,000 sites. We also have related medical neighborhood programs for specialists, retail, and other clinics. Over 100 public and private payers support our patient-centered care programs. Congress recognized the value of patient-centered medical homes and specialty practices by legislating automatic credit for them in Medicare's merit-based incentive payment system.

Our patient-centered specialty practice program in particular aligns with MISSION Act provisions for ensuring quality and access for non-Department clinicians. Our specialty program features agreements for two-way exchange of critical data between specialists and the primary clinicians who refer patients to them.

We also have the nation's largest health plan accreditation program with over 181 million Americans in NCQA-accredited plans. We accredit plans by rating their actual performance and make the results publicly available to help the VA and many others set benchmarks. And we steward the HEDIS measures, health care effectiveness data and information set.

HEDIS tracks prevention, management of chronic conditions, misuse and patients' experience of care, and it's the most widely used set of clinical quality

performance measures. Medicare, most states, and many private purchasers require HEDIS and insurers covering 57 percent of Americans now report HEDIS. We are fortunate to have a liaison from the VA, along with other private and public entities on our HEDIS performance measurement committee.

We've had encouraging discussions with the VA staff, as well as the House and Senate Veterans Affairs Committees about the potential for helping the VA implement the MISSION Act. We believe we can add real value and are eager to help in any way we can, and that includes tailoring our programs to meet the VA's unique needs if that would be useful.

I thank you for the opportunity to talk today and I'm happy to try and answer any questions.

MR. TURNER: I can't let you go without a question, Paul. Aaron Turner, Vice President of URAC. Could you just, I don't know, just talk a little bit about setting benchmarks at, like, a national level for a VA system and what that might look like? And there are a whole bunch of HEDIS measures, but maybe starting with a select few that we know are collected in the commercial space but also apply to the VA. Like, what that process would look like and how that might be beneficial.

MR. COTTON: As far as HEDIS goes, we have

specific sets for product lines. There is a commercial set that includes the employee population, who tends to be healthier. We have a separate set for Medicaid, which is the sicker population, that have more challenges. We have another set for Medicare, which is older Americans. And we have a different set that they use for the Affordable Care Act Marketplace changes. They're tailored to meet the needs of the population.

The VA obviously has very unique needs and we would take some of the measures from HEDIS that would apply there. We would probably need to look to some of the other measures. The American Psychological Association have some measure I'm sure that we don't have. And we would work to find what is the best measure set for the VA. And that's obviously something that they need to decide on themselves. Thank you.

It's not picking up on the phone. I don't project very well.

Any other question, Aaron?

MR. TURNER: No, I think that's it. I mean, I think that's it.

DR. FRANCIS: Any other questions for Paul?

(No response.)

Well, this went faster than we expected. Well, I have some questions for you all. And again, we're here

to listen and to learn. I'm hoping that you'll step up and at least share your thoughts on these. And these are three questions that we've been wrestling with. And they're kind of intertwined, so I'm going to present to you all three at once.

How do we take into account provider burden, particularly when some of our most challenging areas for access are in rural areas of the country where the practices are small and may not have the infrastructure to afford collecting a large number of measures?

Related to that, how closely should VA follow Medicare's lead in measurement? Currently, Medicare has -- if you're not joining an ACO or an alternate payment mechanism, you have a pick six process of over 200 measures. Providers can choose any six to report. And if you're lucky, those six will measure -- will line up with the ones that are doing star ratings for. But I just learned last week from the Physician Compare Help Desk that only 3 percent of practices have lined up around core measures. The rest are reporting what they want.

And I had the frustration of trying to find something for my parents from Physician Compare and I could learn that the invasive cardiologist in my dad's community used an electronic health record and monitored

cholesterol, but I couldn't find any publicly available data of what their outcomes were for PCI because of that flexibility.

And so, that kind of gets us into the third related piece, and maybe a great topic for some of that engagement that we would use in the rule-making process: How do we balance mandatory versus optional metrics that might be tailored for local needs or local practices versus what we want to do as a system.

So, anyway, three questions: Burden, how closely we follow Medicare, and should we mandate versus allow measure sets to be optional. We're very interested in what your thoughts are on this one. And this is a completely open forum, so those of you that would like to speak, just come to the mic.

Paul, if you'd like to come to the mic.

MR. COTTON: I swear we didn't send you those questions in advance. How do you address burden; that's a huge issue and we're very aware of it at NCQA; that clinicians are spending far too much time staring at the computers, not dealing with their patients, doing measurement reporting.

We have a very aggressive initiative underway to move to an automated electronic reporting system. Right now, most measures are reported by a claim.

There's very limited data in claims, but when measurements started, that was the only place where we had to be able to get that data. Now we've got all these electronic health records of varying quality. We also have a great deal of registries out there, many run by very good specialty societies. Quality varies there as well.

But, we also think if we can get to a system where clinicians, all they have to do is enter data in their EHR as they would normally for providing regular patient care, we can develop a system through data aggregators that would then extract that data from the EHRs, from the registries, other electronic data sources, apply the specifications up in the cloud so that there is not this burden on the clinicians to do anything for measurement beyond what they would simply enter into their electronic health record in the normal, routine pace of care.

This is a very aggressive project. The reason it's never been done before is it's kind of hard. And we've got all these data geeks that are working very -- they're proud of that term data geeks. They're working very hard to make this happen. They've demonstrated that it's feasible and we are on a very aggressive timeline to move it forward. So I wanted to let that out. It's not

going to fix your problem tomorrow, but it's something that we're very aggressively working on.

As far as how closely you should follow Medicare, Medicare's doing very challenging work getting this MIPPS program up off the ground, the Merit Based Incentive Payment Program. The challenge we see there is in letting people pick their own measures. People have a tendency to choose the measures that make them look good. And if you look in the Medicare MACRA rule that was proposed for this year and last year, a discussion about how a large percentage of those measures appear to be topped out, where everybody's doing really well. Dr. Clancy spoke this morning about everybody above average. That's what those measures are starting to look like.

So, the challenge with getting to a better system there is that there are not the right measures for every single specialty. Some specialties have lots of really good measures, some have very few, if any. We can't really mandate core sets for each specialty until we have a really reliable set for each specialty, but we need to get away from letting clinicians choose their own measures because that's creating the impression that quality is better than it actually is.

And your last question was?

UNIDENTIFIED FEMALE SPEAKER: Balance mandatory --

MR. COTTON: Mandatory versus optional metrics. Thank you.

UNIDENTIFIED FEMALE SPEAKER: You're welcome.

MR. COTTON: You're very helpful.

Mandatory is -- what we'd like to see is there's a core set of reporting for each one, and then if clinicians would like to choose on others because that's an area they think is important for their own practice, where they want to improve or show that they're doing well, then there could be a core set and the option of reporting additional measures if that's what is useful to that practice. Hope that helps.

DR. FRANCIS: Very good.

Marilyn, would you like to come up?

MS. PARK: Yes. First, I want to say that your question has raised again the concerns that we're moving too fast and too big. And while I know less about Medicare measurements than others, my sense is Medicare, the Medicare system is the leader in developing quality measures and driving quality and VA's not ready. And if Medicare is still developing things and not sure which measures are the best ones, I don't think VA should be moving this fast.

And as far as provider burden, there's no question that rural small providers are not going to be able to collect the data that we need. And I want to bring up the point from the speaker from WellPoint, which is if this is moving forward, which it is, then I think what we're not doing enough of is in the education piece, which is, again, from the beginning, how to use these measures. Because like you said, whether it's our own family members or not, every day there's a veteran just trying to make a quality decision, especially if they're going on the outside, as all of us are.

What we need to be educating our veterans about is this fact: The measures are not out there. When you go outside versus the VA itself, you are going into two very different worlds, with less transparency and less measuring of quality, and they need to know more about the differences in training, among other things.

And obviously, by pushing the MISSION Act, we have not -- those pushing the MISSION Act, and other expansions of privatization, have not elaborated on the fact that the VA is subject to a tremendous amount of transparency and accountability in its quality of care relative to the private sector. So I hope and pray that when veterans are sent out to the private sector and there are education efforts to this greater extent, that

there is more clarification on the choices they're making when they go out there, and the lack of information. Thank you.

DR. FRANCIS: Okay. Thank you, Marilyn.

Please, Aaron.

MR. TURNER: Because I haven't spoken enough this morning, I think I would just echo some of the comments. There are things that may be available to the VA that are happening on the commercial side. NCQA is doing a bit of this, Paul mentioned, to -- if a physician's reporting, for example, to Medicare via a vendor or a specialty service, is there an opportunity for the VA to allow that provider's information to also flow to the VA that's also going to CMS.

That's a way that you can leverage what already exists without having to create a new pathway that may limit the burden on providers. But, you know, I think we all hear that in the benchmarking world that, you know, less is more. And I think that is what NCQA is working through now, as well, that Paul mentioned.

How closely to follow Medicare's lead. You know, as the SGR was getting repealed and replaced, I think there was a bit of the devil you know. And I think the physician community is working through the MIPPS world now. And so, closely aligning with that outside

of, you know, leveraging what exists to reduce burden is probably, you know, not URAC's official position, just my thoughts.

Probably not the best to emulate until Medicare gets farther down the road. But there are probably opportunities that have already been mentioned to select for the VA to establish the things that are most important to the VA and to the veterans to know about. And that process, once you know what the veteran needs to know and what the VA would like to know in terms of quality and access, you can look on the commercial and Medicare space to see what's already happening and leverage that opportunity.

You know, mandatory versus optional, I think folks are right on. There are certain things that you know that you want to know, you can make those mandatory. But, you know, everything else to a certain degree, with burden in mind, can be optional.

DR. FRANCIS: Thank you.

Please.

MR. CAREY: So let me just go back to the issue real quick of how we should structure this. I'd rather us all be sitting around in a circle and have your poor scribe sitting in the middle so he could hear all of us.

DR. FRANCIS: The chairs are on wheels, by the

way. We can do that if you want.

(Laughter.)

MR. CAREY: And have a bunch of butcher block paper around and some white boards, and maybe even we've got a smart TV, and you could have someone who's taking notes up there. And what, we've got 20 people here? We've put together a pretty good working group. And that's the sort of --

DR. FRANCIS: We actually have flipcharts in reserve.

MR. CAREY: There you go. And we work in the White House office at 14th and G and we've got free coffee and, if we do this after 4 p.m., we've got free beer.

(Laughter.)

We'll host. But I think that -- I'm serious about, you know, when I talk about how I think this should move forward. Just how this is set up, we've set aside 4½ hours for this. We're not going to use that. We could be putting -- I think we could be doing a lot more good for you and taking advantage of that in a much more productive manner than -- this sort of feels like, you know, an in-person version of an MPRM process. And I think we can -- I think the APA provides enough flexibility to be able to align from that. No horse is

so dead that you can't beat it more, but I beat that one pretty well.

So, I would like to take this up to a higher level. As a veteran service organization, what we're hearing, especially from our catastrophically disabled veterans, is they are not pleased with the quality. They don't believe they're getting adequate care. Yes, there are examples where they do get great care. And sort of the meme that we've developed is the VA is fully capable of doing the extraordinary, but oftentimes has to do that because it doesn't seem capable of doing the ordinary. And that is sort of a philosophy, a feeling that our veterans have; that people have to move heaven and earth because the regular system can't move, you know, can't move a tablespoon worth of earth.

And that is what I think is in large part behind the MISSION Act. You know, some folks would believe that the MISSION Act goes too far, goes too fast. We don't believe it goes far enough and we believe that we're going too slow and we're trying to achieve too little. That debate's been done and had.

But from our veterans' perspective, they -- many of them are also eligible for Medicare. Since they're catastrophically disabled, they're on SSDI, so they're eligible for Medicare. And they're also

medically retired, so they're eligible for TRICARE. And they don't understand why they have to go through a PCP every single time they're going to go see their specialist, or why they have to go through an 800 triage line. DoD, the doctor that they're talking with, you know, calls up the next person for them immediately or schedules themselves immediately.

And a lot of the process that we have in place seems to be built more around, philosophically built around containing costs and preventing supposed fraud than in optimizing care for veterans. And this is the perception, right or wrong, that our veterans have about the health care process.

And I think, in general, we're going to look at these, you know, whatever regulations come out in terms of are we providing more choice to the veteran to be able to be involved in their health care process, because right now they don't feel like they are. Thank you.

DR. FRANCIS: So I have another question to provoke the audience, and this is something that came up with our planning group prior to holding this public hearing. The legislative language uses the term quality standards. We often equate that with quality metrics, but the standards can go beyond simply the metrics. We alluded a bit to it in the discussions around

accreditation. Marilyn mentioned transparency, public reporting, which is one of our standards. We also have standards on disclosure, which we know are often unique in our system and not followed by private providers, which sometimes put us at a disadvantage in the public sphere.

What are your thoughts about some of the non-directly measurable standards, the things that you don't[have numerators and denominators for but might be something that's directly observed, assessed through an accreditation or a certification process? Secret shoppers are things that come to mind, or other types of tools and what you think might be important.

MR. CAREY: Well, a quick question. The way you phrase that -- maybe we should just hand this thing around. The way you've phrased that question, are you saying the quality standards as required by the MISSION Act are simply post care metrics of the quality of care given, or do the standards of care and formularies that are developed within the VA system by their very nature imply a level of quality that also needs to be addressed by what we're doing here with the MISSION Act implementation regulations.

DR. FRANCIS: I wasn't going in that direction, but I think the discussion that we've had and the tension

that we've felt is that there are some things that we think are very important to have in a health system that's accountable but are not necessarily easy to measure.

So I would say things like our ethical climate, our responsiveness. Yes, you can gain some grasp of that through patient experience surveys, but, you know, should we, for instance, require of our partnering community providers standard for public disclosure in the event of exposures. Because that's not commonly done in private hospitals, you know, to do mass disclosure. That's something -- you know, we may not have sterilized all the operative equipment. Many states have talked about that. Some individual states have mandatory reporting for adverse events.

MS. FREDERICK: This is Joanne Frederick. So I think, from an industry perspective, we are able and willing to do just about any requirements that VA can derive. The challenge becomes when those standards are something that isn't done as part of the current practice or business. Is that perfect? No, but the reality is back to your provider burden question.

As soon as there are, let's call them extraordinary, whether they're important or not, let's just say extra, additional requirements placed on any

system, it doesn't matter if it's health care of anything else, the people that don't want to meet those standards won't deliver the service. So, particularly in areas where there's a shortage of providers, that could create access challenges. And there's no perfect answer, and I understand that, but what we have to do collectively, to Bob's point, is balance access with the standards with all the things we can report on and find the sweet spot that enables the delivery of high-quality care by the people that are in the community to deliver that care.

And back to my point about the evolution, I think we need to decide collectively where to start, and then what to add as we get better as we go along. It's not to say that we're -- we want to accept substandard care at any point in time, no, but there are always additional things we can measure. And let's start with the question of why are we measuring this, what's the point, what's the objective. And with that in mind, then decide what are the right things to measure, how often, what numbers, what are our goals. Does that help?

DR. FRANCIS: Mm-hmm.

Please use the microphone. I realize it gets very aerobic, but it's good for you.

(Laughter.)

MS. PARK: The roundtable is actually starting

to sound like a good thing. I support broader measures, while recognizing that there are these clinical outcome measures that are very critical and have very far to go. But I am proud that VA has these broader measures and I would -- I think that veterans deserve that wherever they get care.

I want to bring up another measure. You've mentioned some states are model states when it comes to, I think what you said was adverse events. Some states require transparency in staffing levels. And we, in the VA, the staffing policy, minimal staffing policies are pretty fluid and they are constantly bent. But in California, for example, they are public and they are mandatory.

And there is legislation that's been pending for a very long time from Jan Schakowsky to make nursing standards -- minimum nursing patient ratios mandatory in all systems, and there's a provision in there that we've worked hard on for the VA, as well, that would actually protect people, nurses who speak up when there's short staffing.

So, what I'm saying is, if we're going to consider broader standards, staffing is very important. And, you know, this Department itself just published under the MISSION Act something we supported and fought

for, which is the number of vacancies that are in all the -- facilities. So I think staffing is about as key to access and quality as you can get. And if that's not considered a core quality measure now, it absolutely seems to be something the VA already recognizes but I think should have more teeth to it. Thank you.

DR. FRANCIS: Okay.

MR. COTTON: Paul Cotton again from NCQA. There is an important balance between what you require in an accreditation standard and what's optional. Your point about the balance, if you have too much, you're going to have people just not come forward.

And in our patient-centered specialty practice program, for example, there are a range of standards. Some of them, however, are must-pass. And if you cannot demonstrate you meet these things, we will not give you status as a patient-centered specialty practice. For example, to be a PCSP provider, you must have agreements with the primary care clinicians who make referrals to you on how are you going to exchange data back and forth. That's critical.

When we see quality problems crop up, it's often because a referral was made and the exchange of information was not going back. As you're moving with the MISSION Act to provide care outside of the VA in a

wider sense, that exchange of data is essential. So that is an accreditation standard. You would not want to make that optional.

Similarly, we have a criteria that you must have an ability to provide a same-day appointment for when somebody needs it. We find a lot of specialists, they have booked up for months in advance. If you need specialty care right away, you can't wait 3 or 4 months for that appointment. So, in order to get our PCPS recognition, you must demonstrate to us that you have a system in place to provide same-day access when necessary. That's a critical piece in the MISSION Act, as well.

So you need to balance. There are some things that are must-pass, and there are other things that would be nice to do and you can give people credit for the more of those they do, but the must-pass is essential and you should not be able to let anybody in if they don't meet those critical must-pass elements.

DR. KELLY: Heather Kelly, APA. I echo and agree exactly with Paul on that. And to do an even deeper dive related to TRICARE providers and what we're seeing and what we're demanding on the TRICARE side, and I would hope VA would circumvent ahead of time, is what a lot of outside providers consider network adequacy in

mental health we certainly would not. And we can provide you from APA what we think the criteria should be for what an adequate network looks like.

For example -- and we've pushed VA on this, too. So, when the metric was can you get a first appointment in mental health within a certain amount of time clinically indicated, and VA got really good all of a sudden, much better at making those first appointments. And then what we said was check and see how far it is from the first appointment to the second appointment. That's a really key gap in mental health care. So now VA's getting better at that second appointment. Nobody's measuring that on the outside. And if they are, it's proprietary and they're not sharing it.

So we would want to see those very deep dives on not just same-day appointments, very important obviously in mental health, but also first appointment, second appointment. What we saw with a lot of the former Choice providers was their networks filled up. They had a lot of openings in the beginning, filled up very quickly, and now they are often sending them back to VA instead of being able to see them in mental health.

So we also want to make sure that when you measure a network for mental health, it's not just measuring bodies in the network. Measuring the

difference between a neuropsychologist and a psychologist is light years in terms of veterans care. This won't be as relevant for VA, but the difference between asking if someone is a child and adolescent psychologist, so -- and in the rural areas in particular those two specialties are gaps. So we have a lot richer list of things that look like adequate networks than I think the outside would suggest.

DR. FRANCIS: Right. And then you mentioned you were going to be submitting those standards?

DR. KELLY: I'm happy to, yes.

DR. FRANCIS: That would be delightful. Thank you.

Please, Bob.

MR. CAREY: If I could go back to my question, because what Heather just brought up is sort of -- comes back to what I was asking. I get the impression that Heather and I are thinking of quality standards as the quality that goes into a standard of care. And what I heard you saying earlier is the quality of that care.

DR. KELLY: Well, I care about both.

MR. CAREY: Oh, of course, of course. But in terms of what VA is going to develop in response to MISSION Act, do you believe that these quality standards are what goes into the standard of care or the measure of

the care provided? Or is that an item up for debate?

DR. FRANCIS: I can tell you that we have lots of internal debates, which is why we're really interested in what all of you have to say on this issue. So, you're right; is this an input? So we're not going to work with you if you don't have a certain threshold of quality? And then what is the output or the outcome? What are we getting out of this, and how to we actually measure it?

Our other conundrum is, do we measure either your input of quality or your output of quality by what you do in general for the population you are seeing, or do you -- do we measure it for the actual veterans that we have sent to you?

Because if the population you are seeing is, let's just say, you know, comes from a high socioeconomic standard. You know, ZIP code typically dictates health outcomes. You may be doing very well with that population, but how good are you going to be with homeless veterans with disruptive behaviors and no family networks?

But if we're only measuring on the veteran side, we have very small numbers. And in fact, you may be doing the best job you can. You took two challenging veterans, one didn't succeed in your care, does that mean you're only batting 50 percent? Is that statistical

noise or is it the inherent challenge of that population? And I do this for a living, trying to do risk adjustment and case mix adjustment, and they don't level the playing field. You know, you can get a little bit of a difference in comparison, but there's always going to be some unmeasured and unadjustable covariance.

I would love anybody to come up with an answer to this conundrum.

DR. KELLY: I was going to say, may I pop back? Heather Kelly, for the record. So, certainly we want all of the above. In an ideal world, we want to measure the system into which we're sending someone and we can do things like hold outside psychologists at the same training standards, professional development standards, use of evidence-based therapies.

In terms of then the very important question of whether -- about the provision of care and the provision of care to veterans versus provision of care to other kinds of clients you maybe see in the community, we have some data on things like that from RAND and other groups.

But one of the things industry is getting very good at and smart at is aligning with professional organizations like us and other training groups to add in training in military and veteran culture at a minimum, but also stepping it way up, training in combat PTSD, not

just, you know, the regular PTSD, and training in very specific mechanisms of working with veteran and military patients.

So we started 15 years ago the Center for Deployment Psychology, handed it off to DoD 10 years ago. They run it. It's beautiful. So we put tons and tons of civilian, not working for DoD and VA, civilian psychologists through the Center for Deployment Psychology to get a much better -- and they can get continuing education credits. So there are incentives and they're incentives for, you know, TriWest or United to be able to say our psychologists, these 2,000 psychologists have gone through advanced training in working not only as psychologists, and we should all hold us to those standards, but to additional standards of working with military and veteran patients. And so, they can sort of sell to their clients, to their patients these 2,000 have an additional gold star for being able to work with military patients.

And so, there are important ways to build all of those things into the measurement of the system, I would say.

DR. FRANCIS: Aaron?

MR. TURNER: Sure. Aaron Turner, URAC. I'm going to frame this comment by saying I think it's

important to start. I think one of the things that the accreditors have experienced and that certainly the commercial health insurance industry has experienced is getting better with this over time.

One of the things I would be reluctant [sic] if I didn't mention was the variable exists here is the choice aspect for the veterans. So, if you've identified those things that are the most important from a veteran's perspective and from the system's perspective to measure and display, to a certain degree, my understanding of this from what I'm following is that this is meant to provide the veteran with choice when choice exists or when it doesn't exist.

So some of this consideration -- and if you haven't had these conversations, hopefully you will start to have. And certainly, I think all of the accreditors could help facilitate this. But to what degree do you allow the veterans' experience in the commercial sector to play a role?

They're going to know from that first visit if the type of care they're getting and the interaction they're getting is of value to them. And if they have to drive and wait in traffic an extra 2 hours to go to a VA facility because they had a poor experience or they didn't feel like the provider that they visited with was

acutely aware of their unique needs, then certainly that provides -- that alone right there is feedback.

And one of the things that the accreditors require and that the commercial health plans have gotten very good at is a dynamic process to evaluate the networks that they've put together and the providers they've put together. That experience only happens over time. So, again, as I think has already been mentioned, it's important to start. And if you start small, you can start to -- not only are you going to get better at the management of this, but you're going to have more concrete data from those who are actually going through and getting the care received.

So I want to highlight that. It's important to start, and I think starting small is the right frame, but not to discount the role that the veteran will have in terms of choosing who they want to see and receive care from.

DR. FRANCIS: Your comment, Aaron, provokes a follow on from me, which is related to the measurement issue, which is the unit of analysis. It's very hard to come up with meaningful, quality metrics when the unit of analysis is an individual provider. Even if I put aside how many veterans that individual's seeing, I may only see a couple hundred diabetics. I may see no patients

with amputation. I may have only a handful with serious mental illness.

But you raised the issue of using -- making the unit of analysis the network so that we're not expecting every individual provider to collect or even hit targets for all the core measures but, more in aggregate, the network has what we feel is needed, and then we have a feedback mechanism to find out when we're not getting something that the veteran needed.

And we struggle, because in the legislative language, they ask us to measure the quality at a very fine level of granularity, and they define a medical service line as a specific clinic in a specific community. That may mean, you know, a two-doctor or a one-doctor practice, or it may be a 500-doctor practice if the community is Rochester, Minnesota.

MS. FREDERICK: Let's talk globally again, not necessarily VA. So Joanne Frederick. It's a triangle, right? Some would refer to it as the iron triangle: Access, quality or cost. And I would contend, with almost every health care appointment that happens across the entire system, somewhere along that triangle there is a tradeoff or a compromise.

So to Aaron's point, the measurement is absolutely perfect. If the requirements for measurement

make the cost too high or the access too low, is that a good thing? And that's, I think that's the challenge.

DR. FRANCIS: Paul?

MR. COTTON: The small numbers is a very legitimate problem when you get down to a one- or two-clinician practice. One or two patients can make a big difference on a measure and it's not statistically valid. When I get back to the shop, I can look up what the minimum number is for reporting certain things.

But there is a provision in the MACRA law that tries to address this. And what the law does, it allows physicians to voluntarily join together in what they call a virtual group, and they agree to be measured as a group so that they have sufficient numbers to achieve statistical significance on the measures. They're just now opening this up in the program. They didn't launch it the first years.

But we're very encouraged because it does allow avenue for the small clinicians to get measured accurately if they're willing to join into a virtual group. We also think that by joining into a virtual group, they can compare notes with their peers and learn from each other and share the best practices for how to improve on this metric or the other. So that might want to be something you want to consider, as well.

DR. FRANCIS: Great idea.

It was so great that you all took less than the allotted time because all my questions get to be posed to you. And Paul's comment brought to mind something else, and it's a little bit around sort of the psychology of why we measure and it's less about understanding what our number is today, because we know that that changes and there's a lot of noise to the number. But it's more about the behaviors you incentivize, and the most important behavior we incentivize is improvement.

And so, in thinking about quality standards, we talked, we already talked about inputs and outputs, we talked about the measurable and other things can be observed but not easily measured. How much should we factor in, or how would you envision we could factor in improvement as opposed to any static performance or an indicator at a specific point in time? How would that work?

MR. COTTON: Paul Cotton again. Going back to Medicare Advantage, which is the part of Medicare where they allow private plans, they do have an improvement measure in the Medicare Advantage star rating system. So the idea is if you just measure everybody on the measures themselves, some people come in at the top of the class year after year, and that's the way it's been for a

while.

But by providing this improvement measure, you give some credit for the improvement in their total score. That gives a health plan that's working hard to improve a little bit of extra oomph when they get their ratings and maybe a little bit of extra money, because the ratings are tied to the way the plans get paid. So having that improvement measure in there is a way to recognize that you want to reward achievement, but also gives the folks that are trying to come up the scale a little credit for working hard to make those changes.

DR. FRANCIS: Yeah. Other means that people can think about?

(No response.)

We've tossed around the idea, and I'll put this out there for your comment, that we create some partnership around improvement so it's not just, you know, VA committees trying to improve VA care and practice committees and outside group improving their own care but more mechanisms of shared governance in discussions around key issues. Particularly, I think, worries that we have, which is the safety in handoffs.

We held a focus group with veterans recently just to help get their input, just a population representative set, what matters most to them. And one

of the themes that came out of that discussion was really around continuity and coordination. And we have a problem inside VA, but there's a similar problem outside, and sometimes a little easier to solve internally because we at least have a shared electronic health record. On the outside, it's very, very challenging.

So I would appreciate any of your thoughts on that. We're getting everybody on this side of the room, too. I want to encourage this side to also speak.

MS. PARK: I have a question, but go ahead.

DR. FRANCIS: Oh, go ahead, Marilyn.

MS. PARK: Can you elaborate some more? You said the veterans concerns about safety in handoff. I would just like a little bit more detail.

DR. FRANCIS: Yeah. I'll give you some context.

MS. PARK: Sure.

DR. FRANCIS: We held a focus group to focus on two topics, access and quality. We did feel like Bob has suggested, that you cannot divorce the two, they have to be talked about as a unity. And we were a little surprised. In one of the focus groups, you know, access we tend to think about in terms of temporal metrics. What the veterans were telling us -- and we're still waiting on the final report from our contractor that

summarizes this, and this will be part of the public record when we, you know, send out a report to Congress. But it was more the theme of accessibility.

Like when I have a problem, I can long onto my Healthy Vet and my provider will get back to me, or I can call the office and they know how to reach me and something can happen. And when I get there and I see the provider, you know, I don't have to be sent to five different places to get the lab tests or the specialty follow up.

You know, I think of an example which was given was oncology care, where, you know, a standard in the community now and in many VAs is to have everything under one roof. You know, you're not driving one place for your radiation therapy, another for your chemotherapy, yet a third for your surgery. And it's there and we know that folks are talking to one another.

I never would have thought of that as an access standard, but that's how they were articulating it.

MS. PARK: When is that report out, may I ask? You said there's a contractor completing this report? Is this tied to a specific statutory deadline?

DR. FRANCIS: This is actually something that we did internally.

MS. PARK: I see.

DR. FRANCIS: It was our own decision and not part of the legislation, but we thought it would be appropriate to use a mechanism -- there's some language, actually, in Section 104 of the MISSION Act that says we'll do a survey of veterans, but we felt that actually a focus group would allow for deeper input than just the standard survey.

MS. PARK: You said there's a report to be completed in the near future.

DR. FRANCIS: Correct.

MS. PARK: And that it will be accessible to the public on this?

DR. FRANCIS: It will be part of our report to Congress.

MS. PARK: I see. Okay. I appreciate that.

DR. FRANCIS: We have a report due to Congress. The exact date is not in my memory, but it is in the spring.

MS. PARK: Thank you.

MS. FREDERICK: So, Dr. Francis, if you can -- I mean, I've taken feverish notes here. Can we respond to these additional questions within the 2-week expanded deadline?

DR. FRANCIS: You have until October 16th.

MS. FREDERICK: Okay. I'd like to think about

it.

DR. FRANCIS: -- information. I hope you all took these questions down.

MS. FREDERICK: I did. But if you wanted to take the opportunity to email to those of us who registered an are here, then that might help.

DR. FRANCIS: Yep, we can. We will send that out. It'll be great to hear.

I hate to put anybody on notice, but we do have some experts from the Hill and from some of our oversight bodies here. I don't know if you wanted to comment on that from your committee's perspective, your office's perspective?

(No response.)

No? And let me check, we have, I know we have as of last count over 20 people that had dialed in onto the toll free number to listen in. Do we have the opportunity for that group to ask any questions?

UNIDENTIFIED MALE SPEAKER: No.

DR. FRANCIS: And the answer is no.

UNIDENTIFIED MALE SPEAKER: It's listen only.

DR. FRANCIS: Listen only. But if you do have comments or things to add, either to the discussion that's taken place so far or to some of the open-ended questions that I just laid out to you, again, please take

advantage of the website in the federal register through October 16th for comments.

Aaron?

MR. TURNER: Just a question. Are you also considering the role that the pharmacy component plays in this? So if you go to a community physician and you walk out the door with a prescription and you then have to go back to a VA facility to pick up your prescription or you can use the mail order service the VA has contracted, is there -- are you considering the metrics around that, the med adherence rate and drug-and-drug interaction that may occur, you know, part on the community side but partially in the VA side as well?

DR. FRANCIS: We have not teed that up but that sounds like a fantastic suggestion. And I would be interested in hearing -- you know, Bob made a comment earlier about formulary latitude and, I guess, some frustration with VA restrictions as compared to TRICARE. I don't know if you want to elaborate on your thoughts?

MR. CAREY: Okay. Did you have more to answer before I did?

DR. FRANCIS: No, I'm just provoking more discussion here.

MS. FREDERICK: And doing a fine job.

MR. CAREY: Bob Carey, Independence Fund, for

the record. So a couple of examples that we've had is in formularies for some of our catastrophically disabled veterans is we had one amputee whose surgeon prescribed eight times a specific non-formulary prosthetic sleeve, and also at a much greater quantity because the veteran still had a lot of skin infections associated with the IAD explosion.

And so, the standard was two prosthetic sleeves every 6 months. This doctor was saying this veteran probably needed two prosthetic sleeves a month, and he needed a very specific prosthetic sleeve that was not in current formulary. And eight times that surgeon prescribed that and eight times medical administrators denied it without explanation, nor without contacting the veteran or the surgeon.

Another example is --

DR. FRANCIS: Let me just be clear, was that a surgeon within VA or --

MR. CAREY: Yes.

DR. FRANCIS: Okay.

MR. CAREY: It was a VA surgeon. And then another example being catheters. And we have a veteran who's quadriplegic, or -- quadriplegic, shot in the neck, has some use of his arms, but his hands, back and feet are to the point where he really can't do much with them.

And the standard is two catheters a day. The formulary is two catheters a day. Well, he has a spastic bladder so he has a bunch of false positives and he'll go through his 60 in a week. And again, no ability to shift from the formulary, and so they just buy them in the market personally.

But in a previous life, I also worked some of the Medicare Part D versus TRICARE pharmacy access. And that is an area where I have personal knowledge where the TRICARE standard is, in my estimation, far better than the Medicare Part D standard, especially in determining what is a rural versus suburban versus urban area and the standard for that, and what definition you use for rural. Because the veteran population is disproportionately rural. Especially the disabled veteran population is disproportionately rural.

And so, what I found in that is the -- and what effectively happened is that Medicare Part D providers were able to provide a compliance program for a Medicare Part D region that basically went from Colorado up to Montana and up over to the Dakotas where because the percentage of the population in the rural area that needed to be covered within 25 miles of a participating pharmacy was such that they could be compliant with that and have no providers in North Dakota or South Dakota.

And so, I think that is -- you know, granted, that's more of an access standard, but to the extent that you do start to address those pharmacy issues, from my experience, the TRICARE standard and the definitions that TRICARE uses for what a rural area is versus what Medicare uses as a -- Medicare Part D uses as a rural area are substantial.

DR. FRANCIS: Okay. So we'll take that as a recommendation to look more closely at TRICARE than Medicare practice.

MR. CAREY: At the pharmacy.

DR. FRANCIS: The pharmacy, mm-hmm.

MR. CAREY: I know there's concerns about the TRICARE standard for mental health care, and I don't have the knowledge to be able to speak to that.

DR. FRANCIS: Right. Yeah. I'll get back to elaborate on Aaron's comment about getting drugs from multiple sources, multiple formularies. I'll just say, it poses a measurement challenge. So, we have situations where sometimes veterans can get their medications for a lower cost from TRICARE or sometimes even from Walmart, and it's a challenge for measurement.

Fully 25 percent of the veterans that we track with elevated cholesterols get their lipid-lowering drugs from outside a VA pharmacy. And for us, that's a

measurement gap. And so, we may actually -- we may be reporting lower rates of compliance with lipid management for our own doctors when in fact, you know, they're saying these veterans are getting those medications, just you can't pick it up electronically. And so, we struggle with that.

One solution is to make sure that the VA provider, the doctor or the nurse can input that into Vista. But now, you're basically asking our scarcest and most highly paid providers to be doing more clicks and keystrokes. My wife recently retired from VA and she used to come home joking about death by a thousand clicks. Just the sheer amount of data entry that happens in the course of a day for measurement and for other purposes is an issue.

But one day we'll have a completely interoperable health record and these problems will melt away.

MR. TURNER: So shameless plug. URAC's the leading accreditor of all pharmacy quality services in the country, so we accredit all of the major PVNs, including the VA's contracted pharmacies and pharmacy networks. So we'd be happy to talk offline about -- we also collect measures across populations for our quality -- or for our pharmacy folks, so we'd be happy to

sit down and chat and just share some of the information that we have.

DR. FRANCIS: Great. And we would be very happy if you would submit before October 16th some of that information.

MR. TURNER: Yes, we will. We will.

DR. FRANCIS: Okay. Good. It's something we need to look at.

Marilyn?

MS. PARK: Your comment about the death by keystrokes and quality gaps, I just wanted to point out the incredible burden that -- I mean, the incredible workload before the MISSION Act and Choice became so big for all the providers, the doctors, the nurse practitioners, the physician assistants, because of all the computer alerts and other responsibilities that you mentioned on top of the patient duties, which are already quite heavy. And yet, at the same time, collecting the data is critical.

So, I want to point out not only was there not really adequate staffing for all these additional, I wouldn't call them non-appointment duties because they're still patient duties, but there has been really no measure of the additional staffing burdens for in-house VA staff to make sure you have a good coordination of

care and quality of measures for all the consults. A tremendous amount of work that not only goes to sending the care out but helping patients navigate the many snafus that have occurred.

And I don't -- and there's a very brief reference to staffing needs in the MISSION Act in terms of adequacy, but I want to point out that we have never -- we already started with the short staffing and way too much burden, like you say, on highly-skilled people having to do these duties, and it's going to get much worse. So thank you for that opportunity.

DR. FRANCIS: I want to respect everybody's need for lunch. And I love the idea that we could get together around a table and a flipchart and start drafting some of these regs. I'm a little bit worried that we didn't advertise that, and if we did, we probably would have had a more robust, a larger, more participative audience.

MR. CAREY: We can do that 31 days from now. You have time to get it in the federal register tomorrow.

DR. FRANCIS: I'm actually going to take that back as a recommendation and see what we can do. I am not the person that understands all the ins and outs of the Administrative Procedures Act, but I think that's a great follow-on recommendation for us to propose.

So, we will take a break for lunch. And I'll say that afterwards, you may have to go back to your offices or other lives, but we'll still be here, and if anybody's back, we can continue the discussion. And we can even put the tables around in a circle if that's going to be viewed as useful. So thank you.

There are lots of places in the area, if you're not familiar with Crystal City, to get good lunch. Cosi's is right around the corner here, and then across the way are many options right on Crystal Drive.

MR. CAREY: Hey, how many people are looking to come back?

UNIDENTIFIED FEMALE SPEAKER: I'm coming back.

MR. CAREY: Okay.

UNIDENTIFIED FEMALE SPEAKER: Is that it, it's just us?

MR. CAREY: -- I'll come back if others are going to come back. But if no one's going to come back --

UNIDENTIFIED FEMALE SPEAKER: All right, I'll come back if others are coming back. Do you have to go --

UNIDENTIFIED MALE SPEAKER: I'm coming back.

MS. FREDERICK: I mean, we could just close now, Dr. Francis, if that's -- if you don't have

additional questions.

DR. FRANCIS: I don't have any additional questions.

MR. CAREY: Well, we know how to get in touch with you.

DR. FRANCIS: You know how to get in touch with us.

MR. CAREY: Call Jacob.

MS. FREDERICK: I'm happy to come back as well, but if we're just going to come back and then leave, I would just as soon --

DR. FRANCIS: I think what we're going to end up doing is looking into the option of having a little bit of a different engagement, a follow on to this.

MR. CAREY: Today or later?

DR. FRANCIS: I'm thinking maybe later because, well, number one, the weather, number two, I think we only have two people so far that raised their hands -- I'd like it to be a little bit bigger. And if we put on another engagement, we might be able to actually -- those groups, probably multiple groups. Okay? I'm thinking aloud on my feet, which is --

MR. CAREY: Yeah.

DR. FRANCIS: -- thing to do, but --

MS. FREDERICK: No, I think that's --

MR. CAREY: Yeah.

MS. FREDERICK: So I think we should reconvene at some point. Is that okay with --

MS. PARK: That's what we're getting to.

MS. FREDERICK: Okay.

MS. PARK: No point in going for lunch and coming back and --

MS. FREDERICK: Yes.

MS. PARK: I could be home by then --

MS. FREDERICK: I understand.

MS. PARK: I love hanging out in Crystal City.

(Many people speaking at once.)

(Whereupon, at 12:03 p.m., the meeting in the above-entitled matter was concluded.)

C E R T I F I C A T E

This is to certify that the attached proceedings

In the matter of:	MISSION Act: Public Meeting Regarding Health Care Standards for Quality
Place:	Crystal City, Virginia
Date:	September 24, 2018

were held as therein appears, and that this is the original transcript thereof for the files of the Veterans Administration.

By _____

TIMOTHY J. ATKINSON, JR.
(Official Reporter)