October | FY12

VHA T21 Implementation Guidance

Office of Healthcare Transformation

Department of Veterans Affairs

The following guidance will help Networks develop implementation plans to bring about the transformational changes associated with VHA's major initiatives. These transformational changes are the highest priorities of the Secretary and Under Secretary for Health. Although the Program Offices are managing many aspects of these initiatives, Networks must have a clear vision of how they will effect the major changes needed to bring about visible improvements for our Veterans and their families. In FY12, we will continue to fund specific pilots (such as the Patient Centered Long-term Care pilots), Kiosk acquisition, Homelessness and Rural Health efforts separately. Like last year, we have pooled resources intended to support the field implementation of other sub-initiatives in to the T21Y account. These pooled funds may be used to support the T21 efforts in any way that supports the accomplishment of the goals outlined in this document, but they can only be spent on these transformation efforts.

Once Network plans for FY12 are finalized, they should be entered into the planning template provided. A work group composed of Network and VACO representatives are currently developing the tool. The final tool will be available in September and will be an Excel based product. We will focus on implementation milestones and spend plans. Quarterly updates will be due prior to each Networks quarterly performance review. Once again, each Network is expected to develop a disciplined project management approach to ensuring the specific goals outlined here are accomplished. Each Network will be expected to complete a specific virtual care expansion plan that will assure that 50% of Network patients are receiving some of their care through telehealth, secure messaging, telephone care and other non-face to face means as appropriate. Further details about this goal and a template will be forth coming.

General questions about these requirements can be directed to the Office of Healthcare Transformation (James Tuchschmidt at (503) 880-7177). Contact information is provided at the end of each section for a subject matter expert who can answer specific questions about the sub-initiative goals.

Patient Aligned Care Teams

The Veterans Health Administration (VHA) began implementation of the patient centered medical home model now known as PACT (Patient Aligned Care Team) in the beginning of FY10. The overall goal of the initiative is to transform our health care delivery system to provide more patient centric care. As primary care is the foundation of VHA healthcare, the transformation begins with Primary Care and permeates other areas of the healthcare delivery system to include specialty care, women's health care, geriatrics, and academic training programs. Long term goals of the initiative are to 1) provide superb access (including alternatives to face-to-face care) to Primary Care; 2) provide seamless coordination of care within VA and with non-VA providers; and 3) redesign primary care practices and team roles to facilitate a patient centered culture. In part, this will be evidenced by:

- Widespread use of daily huddles and regular team meetings
- Increased use of secure messaging to communicate with patients
- Increased number of telephone visits
- Increased number of group visits
- Increased use of telehealth modalities to improve access to primary care
- Use of virtual or telephone consults or telemedicine specialty care
- Score at least 75% on Primary Care provider continuity measure
- Increased visits (face to face OR non-face to face) with non-provider team members
- Decreased number of Emergency Room visits by Primary Care (PACT) patients
- Maintain or improve quality and prevention measures
- Use of protocols and SOPs to define and specify non-provider role in care
- Overall care plan for each patient maintained by PACT Team
- Certification as a PACT practice through whatever mechanism is identified for VA by the Primary Care Program Office will be required at some future time. Networks will have time to review and prepare for this requirement.

Funding to support this initiative has been provided in the pooled T21 funds (T21Y) distributed to each Network. In FY12, the Networks will:

1. Ensure that PACT implementation includes all Primary Care providers and teams. There are to be no "pilot teams." PACT includes primary care delivered in any setting, such as HBPC, Spinal Cord Injury, Post-Deployment Care, Geriatric Primary Care, specialty care clinics (i.e. ID, Renal/Dialysis), academic trainee clinics, and Comprehensive Women's Health Centers.
2. Ensure that primary care clinics have a staffing ratio of at least a 3:1 support staff to Primary Care provider by the end of FY12. These teams are typically composed of a clerk, a LPN, Medical Assistant, or Health Technician, with a RN and principle provider make a teamlet. Additional staff, such as a clinical pharmacist, social worker, etc may support the teamlet. Staffing for HBPC, Spinal Cord Injury, Post-

Deployment Care, Geriatric Primary Care, Infectious Disease and other "special population" primary care clinics may vary but should conform to specialty staffing guidelines.

3. Develop an implementation plan to hire, realign, and train staff so that every Primary Care practice conforms to the PACT model of care. Any special population clinics that provide primary care should be included in the plan. The implementation plan must include at a minimum:

   3.1. Full utilization of the PACT Collaborative Teams in the teaching and training process.

   3.2. A tentative schedule to send all PACTs (excluding the collaborative team) for Learning Center training by September 2013. Although less in depth than Collaborative Training, Learning Center attendance provides necessary background to accrue benefit from subsequent on-site teaching and training. Learning Center training is team-based; VISN and Facility Leadership must ensure that complete teamlets attend Learning Center training sessions together. A complete teamlet includes the primary care provider, the clerical associate, clinical associate, and a RN Care Manager. Additional attendees from one or more key disciplines are strongly recommended, such as Pharmacy, Social Work, Nutrition, Mental Health, Health Promotion/Disease Prevention and Geriatrics.

   3.3. A timeline for implementation of critical components of PACT, including: i) ratio of 3 or more support staff per primary care provider, ii) presence of same day access, iii) utilization of high risk patient registries for all PACTs (NB: A risk stratification and patient tracking tool is being developed nationally and should be available in FY12), iv) high degree of reliance on telephone, secure messaging, telehealth, or other non-face to face visit modalities, and iv) systems in place to ensure patient contact by their PACT within 2 days following hospital discharges. These elements must be in place by end of FY12.

   3.4. Continuous monitoring of PACT metrics (found in the PACT Compass) to motivate and guide performance improvement.

   3.5. A systematic plan to reinforce education and training, identify and spread strong practices, and recognize high performers. Facility site visits conducted by VISN leadership to inspect progress of PACT implementation is highly recommended.

   3.6. Use of a specific model to encourage organizational change, such as regional or facility collaboratives, Rapid Process Improvement Workshops (RPIW), or other models. The plan must include the implementation of the chosen change modality to be completed no later than March 31 2012.

4. Mirror the VISN implementation plan at the facility level, with formal concurrence by each facility's Chief of Staff, Nurse Executive, Associate Director and Director along

with Primary Care Leadership. An approach to ensure the communication of the VISN and facility plans to all PACTs must be included.

5. Develop a "medical home culture" primary care leadership, systems redesign coordinator, health behavior coordinator, health promotion disease prevention program manager, health education coordinator, woman's health program manager, educators or designated learning officers, and MyHealtheVet Coordinators.
6. Submit quarterly implementation status reports outlining progress (e.g. staff hired, staff lost, net gain, funds obligated) and identifying deviations from initial implementation plan through a VSSC website tool.
7. Update VSSC Primary Care Staffing and Room Utilization Data website monthly (*http://reports2.vssc.med.va.gov/ReportServer/Pages/Reportviewer.aspx?%2fPC%2fPCMM%2fStaffingRoomsData%2fStaffingMenu&rs%3aCommand=Render*). This *is the ONLY source for data that determines staffing ratios.* This website automatically records the date and author of the last PCMM update.
8. Measure clinic demand and balance with supply to improve continuity and access. Eliminate "carve outs" as a strategy to ensure patients have same day access. Rather, favor the use of open access for clinical needs through face-to-face visits, telephone visits or secure messaging with their assigned Team.
9. Every Network will participate in the PACT Recognition process.
    - 9.1. Reconfigure PCMM for each PACT such that each provider represents an individual team and all team members (teamlet, etc.) are identified. Ensure that special population primary care teams are included and correctly designated in PCMM.
    - 9.2. Ensure that continuity with the Primary Care provider and teamlet remains at or above 75% for each PACT.
    - 9.3. Demonstrate increase in the ratio of primary care telephone encounters to all primary care encounters.
    - 9.4. Ensure that the measure of same day appointments with primary care provider on the Compass remains at or above 70%.
    - 9.5. Ensure that all patients discharged from VHA inpatient care, and as many from non-VA facilities as possible, should be contacted either by telephone or face to face by a member of their PACT within 2 business days.
10. Integrate telehealth modalities into the daily operations of all PACTs.
    - 10.1. Ensure that Community Based Outpatient Clinics (CBOCs) without on-site services have at least 3 of the following services available via clinical video Telehealth (CVT) as clinically appropriate:
        - 10.1.1. Diabetes Consultation or case management or group classes
        - 10.1.2. Pain Consultation or case management or group classes
        - 10.1.3. Dermatology (CVT and/or Store and Forward)

10.1.4. Cardiology Consultation
10.1.5. Geriatric and/or palliative Consultation
10.1.6. GI consultation or Pre-colonoscopy group visit
10.1.7. Other Medical Specialty consultation
10.1.8. Respiratory follow-up or group visits (example: COPD, sleep apnea, home oxygen)
10.1.9. Neurology Consultation or follow-up for chronic neurologic conditions (Parkinson's, seizures, MS)
10.1.10. Nutrition Consult or group classes
10.1.11. Clinical Pharmacist visits
10.1.12. Social Services visits, telephone visits
10.1.13. Mental Health Consult
10.1.14. Pre-op Visit or evaluation
10.1.15. Post-op Visit
10.1.16. Wound Care

10.2. Ensure that CBOCs have at least 2 CVT specialty care sessions and 2 CVT group education sessions weekly, with the capability of having those sessions occurring at the same time. CBOC's with fewer than 800 patients enrolled should schedule as many sessions as possible.

10.3. Enroll at least 1.5% of each PACT's assigned panel in a Home Telehealth program

11. Ensure all PACTs will participate in Secure Messaging.

POC: Richard Stark; (202) 461-6968; richard.stark@va.gov

Prevention

The Veteran will experience health promotion and disease prevention (HPDP) clinical interventions that are seamlessly integrated within care received from PACT and across the continuum of their health care. This care should be delivered in a variety of modalities matched to the Veteran's needs and preferences. VHA clinicians and clinical support staff will value and participate in the delivery of HPDP interventions for patients as appropriate to each Veteran's priorities and overall plan of care.

Evidence-based health promotion and disease prevention services focusing on the following core prevention messages are integrated into clinical care delivery throughout medical centers and all affiliated CBOCs: Be Tobacco Free, Be Physically Active, Eat Wisely, Strive for a Healthy Weight, Be Safe, Manage Stress, Limit Alcohol, Get Recommended Screening and Immunizations and Get Involved in Your Health Care.

Funding to support this initiative has been provided in the pooled T21 funds (T21Y) distributed to each Network. In FY12, the Networks and Facilities will:

12. Maintain Facility HPDP Program committee or sub-committee structure with identified leaders. The HPDP Program committee or sub-committee structure includes broad staff representation, including at minimum, representatives from MOVE! Weight Management Program, Veterans Health Education, Smoking Cessation Lead Clinician, Patient Aligned Care Teams (PACT) and others.
13. Maintain the Facility Health Promotion and Disease Prevention (HPDP) Program Manager position. This individual must have completed VACO (10P4N)-directed HPDP Program Manager orientation within sixty (60) days of hire or appointment. This individual must attend eight (8) of twelve (12) monthly national calls designed specifically for HPDP Program Managers.
14. Maintain the Facility Health Behavior Coordinator position. This individual must have completed VACO (10P4N)-directed Health Behavior Coordinator orientation within sixty (60) days of hire or appointment. This individual must attend eight (8) of twelve (12) monthly national calls designed specifically for Health Behavior Coordinators.
15. Establish robust training capacity at the Facility to ensure that the PACT training goals for "Patient Education: TEACH for Success" and Motivational Interviewing can be met and sustained. At each facility a minimum, at least two (2) facility personnel have completed "Patient Education: TEACH for Success" Facilitator Training and are conducting local TEACH training courses. At least one (1) facility personnel has completed Motivational Interviewing Training and is conducting local Motivational Interviewing training. *Note: Two (2) opportunities for TEACH Facilitator Training and Motivational Interviewing Leader Training will be provided by VACO (10P4N) in FY12, in addition to the five (5) training opportunities that were already provided in FY10 and FY11. The numbers of required facilitators listed here is a minimum. Larger facilities may need more than this number to ensure a robust training capacity. The Facility Veterans Health Education Coordinator and the Facility Health Behavior Coordinator are the preferred staff to initially complete TEACH Facilitator Training and will be funded by VACO (10P4N) to attend training in FY12 if not already trained. The Facility Health Behavior Coordinator is the preferred staff to initially complete MI Training and will be funded by VACO (10P4N) to attend training in FY12 if not already trained.*
16. One (1) or more TEACH for Success Facilitators and one (1) or more Motivational Interviewing Facilitators at each facility have completed VACO (10P4N)-sponsored Communication Skills Implementation and Coaching Course. *Note: Five (5) opportunities for participation in this Communication Skills Implementation and Coaching course will be provided in FY12 and participant travel will be funded by VACO (10P4N). Facility Health Behavior Coordinators, Veterans Health Education Coordinators, and Health Promotion and Disease Prevention Program Managers will be prioritized to attend this course. Others may attend on a space-available basis using locally provided funds.*

17. Each facility shall complete an annual review and update of the local environmental scan of internal and external HPDP resources that was developed in FY11. The facility must submit a copy of the environmental scan to the responsible VACO Program Office (10P4N).

18. Disseminate messages and tools related to the nine (9) Healthy Living Messages. Each facility must accomplish at least four (4) of the following seven (7) tactics for disseminating Healthy Living Messages:

    18.1. Healthy Living Messages are included in the facility's new patient orientation program. *Note: Minimally, patients should be introduced to the Healthy Living Messages and the My Health Choices tool. A new patient orientation toolkit is available at: http://vaww.prevention.va.gov/VHEI/NPO_Toolkit.asp. Healthy Living Message Tools and Handouts and The My Health Choices Tool* (IB 10-367 P96438) *and a single page handout summarizing all nine of the Healthy Living Messages (IB 10-402 P96472) is available for order from the VA Forms Depot* or download:\\vhaprvmul5.vha.med.va.gov\Reports\Communication_Products

    18.2. Healthy Living Messages are included in the orientation of new PACT team employees (PACT teamlets and extended PACT team members). *Note: At a minimum, employees should be introduced to the concepts of the Healthy Living Messages including the My Health Choices Tool (IB 10-367 P96438), a single page handout summarizing all nine of the Healthy Living Messages (IB 10-402 P96472), and the Clinical Staff Guide to Healthy Living Messages. (10-366 P96437), which can be ordered from the VA Forms Depot.*

    18.3. The VACO-developed Healthy Living Goal Setting and Tracking CPRS tool is installed and training has been provided to PACT staff. *Note: This tool, which uses clinical reminder technology, will be available for installation in 1Q FY12. Pre-requisites for installation and use include an adequate PACT teamlet ratio (3:1), PACT teamlet completion of "Patient Education: TEACH for Success" training, and an identified CAC to support installation. Please contact Kathy Pittman (Kathleen.pittman@va.gov) for more information if your facility is interested in pursuing this tactic*

    18.4. Specific PACT staff in-service training sessions are delivered to PACT teamlets on at least two (2) or more Healthy Living Messages.

    18.5. Healthy Living Messages are included in at least three (3) Veteran outreach events during FY12.

    18.6. Evidence of Healthy Living Messages campaign in at least three (3) different "formats" or modalities at the facility (e.g., posters, screen savers, banners, electronic bulletin boards, patient phone hold messages, patient appointment reminders, closed circuit videos, etc) *Note: Healthy Living Message Videos for use by facilities are in development by VACO (10P4N) and will be made available towards the end of FY12.*

18.7. Evidence of articles and stories about Healthy Living Messages in facility or local publications/media.

19. Each Facility will provide "Patient Education: TEACH for Success" training to Patient Aligned Care Team (PACT) clinical teamlet staff (i.e., Clinical Associate; Provider; RN Care Manager). The FY12 target is 50% of all PACT staff completing the full seven (7) hours of TEACH modules.

20. Each Facility will provide TEACH for Success (full seven (7) hours of TEACH modules) training to 50% of clinical staff providing MOVE! Weight Management Care.

21. Each Facility will provide VACO (10P4N)-approved Motivational Interviewing training (at least four (4) hours over at least two (2) sessions) to PACT teamlet RN Care Managers. The FY12 target is 50% of all PACT RN Care Managers.

22. Each facility will ensure that Clinical Reminders for Clinical Preventive Services (screening, immunizations, brief behavior counseling, preventive medication) are aligned with VHA Clinical Guidance Statements for Preventive Services as found at: http://vaww.prevention.va.gov/Guidance_on_Clinical_Preventive_Services.asp

    Note: For end of year reporting, facilities should ensure that their clinical reminders reflect guidance statements posted at this site through 8/31/2012. VACO does NOT intend that new reminders be created nor that there must necessarily be a clinical reminder for every guidance statement, only that IF a site already has a reminder on one of the topics that it be consistent with the posted guidance. Additionally, some of the guidance statements specify that a service is NOT recommended (for example using Aspirin or NSAIDs to prevent colorectal cancer). The appropriate action for services that are NOT recommended would be to NOT have a reminder. If potential discrepancies are identified, clinical leadership should be consulted to determine if the discrepancies are, or are not intentional and to determine whether a modification to the reminder is needed.

23. At each Facility, System redesign or quality improvement teams are engaged within PACT to evaluate inappropriate utilization (e.g., overuse) of at least one of the following three clinical preventive services. If inappropriate utilization is found, changes are implemented.

    23.1.1. Prostate cancer screening with PSA in men >= 75 years

    23.1.2. Cervical cancer screening with PAP smears:

        23.1.2.1. Women older than age 65 if they have had adequate recent screening with normal Pap smears, are not otherwise at high risk for cervical cancer, and have no compelling medical indication to continue screening.

        23.1.2.2. Women of any age who have had a total hysterectomy for benign disease.

23.1.3. Inappropriate colorectal cancer screening:
- 23.1.3.1. Screening in adults >= 85 years
- 23.1.3.2. Redundant screening such as ordering periodic FOBT cards on patients with evidence of normal colonoscopy in the last 10 years.
- 23.1.3.3. Screening colonoscopy exams at intervals less than 10 years

Note: The three services selected for this goal have relatively strong evidence and support for appropriate screening intervals and criteria for discontinuing screening. (see: http://vaww.prevention.va.gov/Guidance_on_Clinical_Preventive_Services.asp and http://www.uspreventiveservicestaskforce.org/uspstopics.htm). Inappropriate utilization is inherently a clinical judgment, thus these guidelines should be used as a starting point to identify inappropriate utilization and may not be able to be applied to 100% of all patients..

24. Facilities should increase the number of patients treated with MOVE! (in person, by phone through MOVE! TLC (Telephone Lifestyle Coaching), or through TeleMOVE, the MOVE! Home Telehealth program). This will be measured using the current EPRP 'mov6' mnemonic, which measures the percent of eligible patients that have evidence of at least one (1) participation visit/contact related to MOVE! in the last twelve (12) months. Facilities with FY11 performance less than 9% should target a 30 % relative increase. Facilities with FY11 performance >=9% should target a 15% relative increase.

    Note: 9% is the median for this measure as of 2QFY11. The 'mov6' measure is influenced by the degree to which patients have access to various options for MOVE! services as well as the degree to which PACT staff use motivational counseling techniques to discuss weight-related issues with patients, offer treatment, and provide seamless and efficient referrals or transitions in care.

25. Facilities should increase the proportion of patients that receive intense and sustained treatment with MOVE! Weight Management Program For Veterans. Intense and sustained treatment is defined as at least eight (8) in person or telephone visits provided over a span of four (4) months.

    Note: this threshold was empirically derived from MOVE! Program data that this threshold correlates with better weight loss outcomes. The national estimate for this measure is 13% of all patients treated with MOVE! receive intense and sustained treatment. In 1Q FY12, Facilities will be provided with FY10 and FY11 data to understand their baseline. Sites should target a 15% relative increase for FY12.

POC: Leila Kahwati, MD MPH; (919) 383-7874, Ext 251; leila.kahwati@va.gov

Virtual Medicine Non-Telehealth

The incremental national rollout of Secure Messaging (SM) through My HealtheVet will culminate with the use of SM offered to every Primary Care clinician by the end of FY11. Expanded iterative use of SM will continue in FY12 as SM will be used by all Primary Care Clinicians, and offered to clinical subspecialty and non-clinical users. SM will also provide a virtual technology alternative to patient face-to-face encounters with their PACT and Specialty Care teams. Actions focusing on providing online access to portable health records are in progress and continue to expand. During FY12-13, a Pilot will be implemented to provide advanced information access and communication tools (e.g., mobile devices, social networks, websites, chat) to enhance patient self-management and will be integrated into chronic care management. An e-Health QUERI Center has been established to evaluate implementation and clinical impact of Secure Messaging and other My HealtheVet applications, and a report of preliminary findings from implementation and evaluation projects will be submitted during FY13. In FY12, the Networks will:

26. Complete, by January 1st, 2012, a 3-year plan to ensure that 50% of uniques are receiving some care through virtual care on or before October 2014. The plan will include telehealth and telephone care. The Network plan related to secure messaging will ensure that clinical and nonclinical staff are using SM to communicate with patients and that patients are authenticated and able to use SM.
27. Expand SM involvement among Primary Care (PACT, Women's Health, and special needs PACT clinics) providers; 100% of Primary Care providers will be associated with teams and the teams will have evidence of active messaging with patients by 3/30/12.
28. Expand use and increase adoption of SM through My HealtheVet, within specialty care, by creating SM triage groups to allow all patients the ability to communicate with their specialty teams by 9/30/12. All specialty team members, including Fee-basis physicians with CPRS access, shall be trained and able to communicate with patients using SM. VISNs/VAMCs will submit quarterly updates on the percentage of Specialty Care clinicians who have received SM training.
29. Increase the number of VA patients who have upgraded their My HealtheVet accounts by accomplishing a one-time process of In-Person Authentication (IPA) and opt in for secure messaging (SM);
    - 29.1. IPA VISN-level rate of 25% by EOFY (number of unique VISN patients who are authenticated for MHV over the number of unique VISN patients treated within the performance period).
    - 29.2. "Opted-In" VISN-level rate of 15% (number of unique VISN patients who have 'opted-in' for SM over the number of unique VISN patients treated within the performance period).

30. Ensure that SMs receive a timely response (within 3 business days) by establishing processes/strategies to reduce the volume of escalated messages and monitoring the number of escalated messages.
31. Each VAMC will establish and implement a process for handling and completing all SMs received by another clinical area that requires a response from a Specialty Care clinician, by 9/30/12. In addition, each Specialty Care area will, by 9/30/12, document the processes/protocols it is using (or will use) to receive and respond to SMs within the SM application when that specialty implements SM.

POC: Alex N. Hersh; (410) 360-9508; alex.hersh@va.gov

Virtual Medicine Telehealth

The Telehealth transformation initiative continues to increase the size and scope of telehealth usage in VA in order to expand access to care and offer more timely care to Veteran patients while improving quality.

The expected growth target for FY2012 is a 100% increase from their FY2010 baseline. Fifty percent of that increase should have been realized in FY11 and the remainder of the growth is expected in FY12. In order to give Networks the flexibility to match telehealth services to the needs of their Veteran population, the methodology in which the growth target for FY2012 is being assessed has changed. Instead of the individual growth targets for each area of telehealth (Home Telehealth (HT), Clinical Video Telehealth (CVT) and Store and Forward Telehealth (SFT)) that were employed in FY2011 there is a now the composite growth target for all three areas. As long as Networks meet their expected goal of total consultation numbers, the relative proportions of HT, CVT and SFT are being left to an individual Network's discretion (Networks must however ensure that they comply with any other organizationally required targets that might apply to telehealth (e.g. non-institutional care). The targets for each VISN will be distributed prior to FY12, through 10N and the Office of Telehealth Services. Furthermore, the overall goal will be the % of uniques receiving telehealth services in the Network.

Dedicated funding is being provided to meet these targets, but Networks are expected to leverage assets from other transformation initiatives to work synergistically in supporting telehealth development. The majority of funds for telehealth expansion will be distributed as T21Y pooled funds. These funds can be used to cover the costs of existing staff performing the functions described below. Networks that received funds in FY11 for interactive voice response, teleMOVE staffing, Tele-Spinal Cord injury coordinators, tele-intensive care unit model development, and/or the designated pilots for teleretinal imaging, teleaudiology and telepathology will continue to receive funding in FY2012.

In May 2011, the Secretary of Veterans Affairs authorized a telehealth expansion initiative that follows the recommendations of the Telehealth Expansion Task Force Report. In FY11, this expansion initiative provided funding to acquire equipment for CVT and ensure that VISNs throughout VHA have one (1) VISN Level Telehealth Program Manager/Lead and one (1) dedicated facility telehealth coordinator (FTC) at each VAMC. In FY12, sustainment funding will be available to Networks for these positions. Based on best practices in VHA, the Task Force recommended standardizing additional infrastructure across VHA. Consequently, in FY12 Networks are required to have one (1) telehealth clinical technician at every CBOC and two (2) TCT's at each VA Medical Center. The TCT's in small CBOC's can share other non-telehealth duties, but the facility must ensure that there is sufficient support to meet the CVT program needs.

Additionally, Networks are required to have adequate support for the VISN Telehealth Lead. Three support positions are suggested at the VISN level. These are a program support person, data analyst, and management analyst. The responsibilities are outlined elsewhere by the Program Office. Funding has been provided to support these three positions and Networks must ensure that 2 of the 3 positions are filled, either by reassigning duties or hiring staff. However the Network decides to staff this program, the VISN must ensure that the full spectrum of function that would be provided by these three positions is met.

In addition, the VA Office of Information Technology has undertaken the task to ensure that all sites of care have the telecommunications infrastructure to conduct two concurrent 384 Kbit/s clinical videoconferencing sessions. The FY12, the Telehealth Expansion Initiative is being incorporated within the Virtual Medicine's Telehealth operating plan. The Office of Telehealth Services is developing a contract for a clinical help desk. This tier 1 help desk is intended to provide direct support to clinicians and telehealth technicians in the event they experience telehealth technology issues and this will integrate with the associated OIT and Biomedical Engineering support. In FY 12, the Networks will:

32. Complete, by January 1st, 2012, a 3-year plan to ensure that 50% of uniques are receiving some care through virtual care on or before October 2014. The plan must meet VHA "conditions of participation" for telehealth, address necessary staffing, organizational alignment, training, needed equipment and space.
33. Meet a composite target for the total number of patients receiving care through telehealth services by the end of the FY12 as outlined in the ECF Technical Manual and ECF performance plan.
34. Recruit and retain the telehealth staff required under the FY2012 Telehealth Expansion Initiative.
35. Monitor the growth of telehealth and provide monthly updates as requested by the program office.

POC: Ellen Edmonson; (202) 461-5993; ellen.edmonson@va.gov

Non-Institutional Long Term Care

The *Patient–Centered Alternatives to Institutional Extended Care,* also known as *Patient-Centered Non-Institutional Long Term Care,* is a sub-initiative of New Models of Care. Through a competitive Request for Proposal (RFP) process, the Office of Geriatrics and Extended Care awarded funding totaling nearly $20 million dollars per year for three years to initiate 59 innovative pilots of patient centered non-institutional extended care and to augment the Veteran-Directed Home and Community-Based Care program. These pilots will enhance options for Veterans choosing to receive their extended care in the home and community rather than in an institution. These innovative models are part of the overall transformation of how we will provide care to Veterans in the future. The expectation is that these approaches to care will be sustained at the pilot sites, and successful models disseminated broadly throughout the VHA. Funding for the pilot(s) was sent directly to the facility and is in addition to any pooled T21 funds (T21Y) received by the Network. In FY12, Networks with pilot sites will:

36. By the end of Q1, at least 25% of the projected FY 2012 target for number of unique Veterans enrolled or served by the pilot
37. By the end of Q2, at least 50% of the projected FY 2012 target for number of unique Veterans enrolled or served by the pilot.
38. By the end of Q3, at least 75% of the projected FY 2012 target for number of unique Veterans enrolled or served by the pilot.
39. By the end of Q4, at least 100% of the projected FY 2012 target for number of unique Veterans enrolled or served by the pilot.

POC: Barbara Hyduke; (734) 222-4327; barbara.hyduke@va.gov

Specialty Care

Specialty care is a critical component of VHA's comprehensive package of medical services designed to meet the health care needs of Veterans. Unfortunately, Veterans can experience fragmented care and services, long wait times, and/or and unacceptable delays due to the scarcity of providers in some specialties and in certain geographic regions, especially rural areas. The vision of the Specialty Care Transformation Initiative is to transform specialty care to a Veteran-centric system where the Veteran is the driver of health care delivery. Specialty care will interface with the Patient Aligned Care Teams (PACTs) to provide coordinated, team-based care in which all disciplines (e.g., pharmacy, social work, nutrition, and chaplains) are valued partners. The focus will be on the Veteran experience and on shared decision-making. Specialty care will leverage the use of Telehealth and other technologies to deliver care without requiring a face-to-face visit (examples are SCAN-ECHO and Electronic and Phone Consults).

Broad implementation of evidence-based specialty care will reduce readmissions, unnecessary clinic appointments, and unscheduled visits to the emergency room. In FY12, Innovations in Consult Management (Electronic and Phone Consults) and SCAN-ECHO will be expanded to additional specialties and sites. Pilot projects will be initiated for Chronic Disease Management, Specialty Care Mini-Residencies and Enhancement of Specialty and Surgical Care Platforms. Curricula will be developed for specialty care through the TILC and use of SimLEARN.

In FY12, Networks selected for expansion of SCAN-ECHO, Innovations in Consult Management, and specialty care pilot projects (Chronic Disease Management, Mini-Residencies and Enhancement of Specialty Care and Surgical Platforms) will receive funding to support these projects. In FY12, these sites will be required to:

40. Identify and secure resources (personnel, space, equipment, etc) to expand SCAN-ECHO to additional specialties and/or sites.
41. Networks that already have SCAN or eConsult pilots will expand these pilots (Electronic and Phone Consults) to additional specialties and sites within the VISN.
42. Selected pilot sites will design a Mini-Residency program to train Primary Care Providers and mid-level practitioners to perform basic specialty care procedures.
43. Selected pilot sites will design a Chronic Disease Management program through the continuum of a specific disease/condition.
44. Selected pilot sites will develop Enhanced Specialty Care and/or Surgical Care Platforms and ensure PACT coordination.
45. Integrate telehealth modalities into the daily operations of Specialty and Surgical Care Clinics, including the use of Secure Messaging.

POC: Meredith Ambrose; (202) 683-2017; meredith.ambrose@va.gov

Women's Health

The long-term goal of the Women's Health Sub-Initiative is to achieve patient centered comprehensive health care for women Veterans. Redesign of comprehensive health care for women will support PACT initiatives, decrease fragmentation of care, systematize coordination and improve continuity of care to better meet the needs of women Veterans. These will also be addressed through the PACT sub-initiative, a national women's health assessment, national clinical inventory of women's healthcare delivery, and ongoing provider education. Improved care coordination will advance care provided to women Veterans and also improve health outcomes and patient satisfaction by focusing on emergency room care, breast cancer screening and treatment and managing teratogenic medications. Working with homeless services, a brief vulnerability screening tool has been developed that can be used wherever a woman Veteran accesses services. The tool will identify the Veteran's risk for homelessness in

an effort to prevent homelessness and to create a streamlined access to wrap around services that will assist veteran in housing and employment. Created in FY11, the Women Veterans Call Center is an outgoing call center that was developed to expand outreach efforts to women Veterans. The Women Veterans Call Center serves to increase women Veterans' knowledge of all VA services and benefits, and increase enrollment and utilization by women Veterans in VHA. Emphasis on privacy and environment of care has served to correct deficiencies outlined in the Environment of Care survey and improve the physical environment to accommodate women Veterans. Funding to support this initiative has been provided in the pooled T21 funds (T21Y pooled funds) distributed to each Network. In FY12, Networks will be required to:

46. Ensure that all Comprehensive Women's Health teamlets meet the same PACT standards as Primary Care teamlets, including the staffing levels and Telehealth and Secure Messaging Requirements.
47. Ensure that primary care clinics have a staffing ratio of 3:1 support staff to principal provider by the end of the FY12. These teams are typically composed of a Clerk, a LPN, Medical Assistant, or Health Technician, a RN, Clinical Pharmacist, etc.
48. Develop an implementation plan to hire, realign, and train Women's Health PACT staff.
49. Update VSSC Primary Care Staffing and Room Utilization Data website monthly (*http://reports2.vssc.med.va.gov/ReportServer/Pages/Reportviewer.aspx?%2fPC%2fPCMM%2fStaffingRoomsData%2fStaffingMenu&rs%3aCommand=Render*). This *is the ONLY source for data that determines staffing ratios.* This website automatically records the date and author of the last PCMM update.
50. Send appropriate staff for training at PACT Learning Centers.
51. Improve continuity and access to ensure patients have same day access for clinical needs to their assigned teamlet through face-to-face visit, telephone visit or secure messaging. Women's Health teamlets will be expected to meet the PACT Compass measures.
52. Ensure that all Women's Health Programs have teamlets and panels entered into PCMM.
53. Ensure that all sites have mechanisms in place to be accountable for all Prevention and Chronic Disease measures for Women Veterans as outlined in the ECF plan.
54. Ensure that at least 90% of bathroom and privacy deficiencies identified in the Privacy and Environment of Care survey are addressed and completed.
55. Ensure that each medical center, OPC, and CBOC has a minimum of one trained (in VHA's women's health mini-residency program or equivalent training) or an experienced designated women's health provider (suggested minimum of 3 years of 50% women's health primary care experience).

56. Ensure that a WH-Emergency Department (ED) champion, who is a provider in that ED (is the ED Director or can coordinate with him/her) has been identified at every facility.

57. Integrate telehealth modalities into the daily operations of all WH PACTs. All WH PACTs will participate in Secure Messaging.

POC: Stacy Garrett-Ray; (202) 461-1047; stacy.garrett-ray@va.gov

Patient Centered Care & Cultural Transformation

At the core of the **Patient Centered Care (PCC) Culture Transformation** Initiative is an entirely new approach to healthcare that is a radical shift from our current system. The medicine of tomorrow moves beyond problem based disease care to patient-centered health care. This approach requires a process that is proactive rather than reactive and engages the patient at the center of their care. There are three key components to this approach to healthcare: personalized health planning; whole person, integrative strategies; and behavior change and skill building. This radical departure requires a rational strategy for change that is aligned and integrated with the resources, capacities, and ongoing initiatives throughout VHA. This can be achieved by building partnerships with Veterans, family members, providers, and other staff/team members. The "Voice of the Veteran" is a key component which needs to be consistently elevated during all planning.

Five Centers of Innovation (COI) have been identified and include Greater LA, CA, Dallas, TX, Birmingham, AL, East Orange, NJ, and Washington, DC. There are also 4 evolving COIs which are new medical centers and include New Orleans, LA, Orlando, FL, Denver, CO, and Las Vegas, NV. These COIs will be utilized to pilot new models of care and to share innovations which exist throughout the VHA. There will not be any T21 pooled funding for FY12. Additionally, Field Based Implementation Teams designated by the program office will ensure Patient Centered Care Partners work with each VISN and their Medical Centers for plan implementation. Partners will be identified and Medical Centers notified as plans are rolled out. Specific Network Responsibilities for FY12 are:

58. Each facility will develop a PCC plan for implementation in FY12 and document it in the template that will be provided by the program office.

59. Develop local plans to distribute information regarding PCC to employees and Veterans using shared national communication strategies and marketing plans.

60. Participate in educational opportunities which will be offered throughout FY12

61. Contribute innovations to COIs and national program office for spread of excellent practices

62. Staff will complete approved training to improve competency at personalized health planning and integrative health coaching, to begin transformation of care delivery. Tools will be distributed in FY12.

63. Track and monitor PCC innovation program outcomes and collect Veteran stories to represent significant change to care delivery.

POC: Lauri Phillips; (432) 213-6453

Health Care Quality and Transparency

The Health Care Quality Transparency Initiative provides veterans and other stakeholders alike with the information necessary to evaluate care based on quality, safety, and reliability. The users of VHA's quality and safety data are Veterans, their families, caretakers, the public, VA staff and leadership, Congress and healthcare researchers. Each stakeholder will require a slightly different translation of available quality and safety data to address their needs. The Office of Quality and Safety is addressing the needs of many of these stakeholders with the goal of presenting VHA's quality and safety data to the Veteran, their families and the public in a useful and understandable format. In addition our goal is to leverage routine customer feedback about healthcare quality and safety data so information needs of veterans can be translated into pertinent and understandable context for informed customer decision-making. This transparency strategy will allow VHA to build awareness and create advocates for VA healthcare, increase trust among our enrollees and promote improved healthcare behaviors and decision-making. Networks have no action to take.

POC: Crystal Elliot; (202) 266-4557

Rural Health

The Rural Health major initiative for FY 2011-2013 is the implementation and operation of Section 403, Public Law 110-387, which is now being referred to as Project ARCH (Access Received Closer to Home). Project ARCH is a congressionally mandated pilot program, which requires the Department of Veterans Affairs (VA) to conduct a pilot program to provide non-VA health care services to eligible Veterans in at least five Veterans Integrated Service Networks (VISNs) over a three-year period. Based on the criteria outlined in the statute, VISNs 1, 6, 15, 18, and 19 are eligible to participate in the pilot programs. At this time, one pilot site will be selected within each of these VISNs. Funding for these pilots will be provided by the Office of Rural Health and are in addition to any pooled T21 funds your Network has received. If you do not have a pilot, no action plan is required. The long-term objectives of this program are to:

- Conduct a thorough evaluation on the effectiveness of the pilot programs, including the pilot program's cost, volume, quality of care, patient satisfaction, access to care, and benefits to Veterans

- Identify the strengths and challenges associated with implementing the pilot programs
- Provide recommendations regarding the continuation of the pilot programs, expansion to other or all VISNs, discontinuation, or making the program permanent
- Submit annual reports to Congress on the status of the pilot programs for each year in which the pilot is conducted

POC: Mary Beth Skupien; (202) 461-1884

Veteran Health Benefits Handbook

The Veterans Health Benefits Handbook program will provide a tailored benefit handbook for every Veteran enrolled in the VA health care system. The handbook will provide detailed description of how to access VA health care, the Veteran's preferred facility (parent VAMC), contact numbers, comprehensive health benefits, specialty care health benefits and the Veteran's responsibilities. After completion of the pilot and necessary improvements, the handbook will become available online to the Veteran through My HealtheVet or other web portal as a downloadable document. Later revisions will allow search capabilities for Veterans specific eligibility information contained within their handbook. We will also be developing a "what if" program to allow any Veteran to enter various eligibility criteria to generate an overview of available benefits. Over the next couple years the program will look to expand facility information down to local CBOC information to the Veteran. In addition, certain Clinical Inventory information will be included as part of the handbook or as a separate product detailing the specific services available locally to the Veteran as well as how to access other eligible health services. We will be working with VBA and NCA to incorporate additional Veteran specific benefit information into this handbook to create a recognized benefit source for the Veteran.

- Veterans at the Dayton VAMC are scheduled to receive their tailored handbook during September 2011 as part of a pilot implementation.
- National deployment to begin ~ January 2012 with an approximate 18 month roll out period to complete mailing to all Veterans.
- Facilities will be provided training materials on the handbook to provide to appropriate personnel.
- Selected facility personnel will be able to view Veteran specific handbooks online to allow them to address questions.
- Handbooks will be produced and distributed at the national level. Networks will not have any responsibilities for distribution

No network specific T21 funding will be needed in FY12. Specific Network Responsibilities for FY-12 are:

64. Facilities will continue to ensure that their facility information within the VA Site Tracking (VAST) program is correct with necessary contact numbers. – Each Veteran Handbook will contain their respective preferred facility contact information. The VAST application is currently being redesigned and processes are being developed to allow facilities to directly input their contact numbers into the application. Until that time the Health Eligibility Center's Member Service Division will periodically request verification via email of facility contact information.

    POC: James Mallard; (727) 697-5157

System Redesign

The primary purpose of this initiative is to pursue an agenda of continuous improvement. Now aligned under one philosophical improvement approach, VHA has increasing engagement by facility and network executive leaders and enjoys success from many specific projects. The greatest long-term benefit for patients does not result from these projects alone, however, but from a new culture where every employee continuously improves their day-to-day work.

The overarching goal of the Systems Redesign Sub-Initiative is to improve VHA's healthcare delivery systems operations to achieve our mission of providing exceptional healthcare. Implementation of continuous improvement is one of VA's top priorities. This goal requires each employee to engage in improving our work by creating increasingly reliable and timely systems responsive to patient needs. The FY 11 network deliverables include:

65. Engagement in Patient-Aligned Care Team (PACT) System Redesign and Primary Care leading collaboratives for successful spread of existing knowledge about PACT across 5 regions;
66. Support clinical and administrative staff in actively participating in Access Education offerings as access to care continues to be a salient issue within VHA. Curriculum is being developed to teach access principles across VHA facilities, targeting rural areas and CBOCs that may have not had prior opportunities to implement key change principles;
67. Support No-Show Reduction activities. No-shows are costly for the VHA system, wasting resources that could be used to take care of Veterans in need of medical care. The focus will be on reducing the no-show rate across VHA by at least 2% through end of FY 13;
68. Fully adopt and actively support use of a portfolio of Inpatient Informatics Tools in FY 11, including the Bed Management Solution (BMS) and the Emergency Department Integration Software (EDIS)

69. Support staff to fully engage in Rapid Process Improvement Workshop (RPIW) training and "train the trainer" roles as a way in which to spread RPIW as one of a portfolio of strategies to intensively work to improve local processes.

POC: Leigh Starr; (757 722-9961 (Ext 1699)

Enhancing Telephone Services (Fix-the-Phones)

Timely and responsive telephone system function is a key driver of patient access to and satisfaction from VHA health care services. Care delivery systems are gradually moving away from face-to-face venues toward use of telephone (and secure messaging) - making telephone services an even more vital tool in the delivery of high quality healthcare. In order to improve the overall reliability of telephone service, VHA has established the Fix-the-Phones Initiative to take a comprehensive look at our telephone infrastructure and operations.

It is clear VHA has many opportunities to improve telephone service by quickly answering the phone, standardizing business processes, providing reliable, predictable answers to questions and increasing first call resolution for Veteran requests. Much has been learned from facilities and networks who have already invested in this improvement journey. Currently a small group is working on piloting a uniform high level call tree opening message for eventual use by all facilities. In addition, plans are being made to pilot at least three VISN level call centers to support PACT, including the development of logical phone trees, scripts, tools for communication between the call centers and the facility clinics.

We recognize most facilities will not see significant service level improvements from the national efforts for a while. However, there are many changes that can be considered by local facility improvement teams for implementation now.

70. Track and trend your data to the extent your system is capable and use it to target areas for improvement. Enter your call center data on the VSSC website: http://vssc.med.va.gov/CallCenter/

71. Charter a systems redesign team to improve telephone access and first call resolution. Set stretch goals that will get your facility closer to meeting the URAC standards of answering calls within 30 seconds with an abandonment rate of <5%. The VHA Telephone Systems Improvement Guide provides change principles discovered during the Telephone Collaborative that can lead to sustained improvement. The guide is posted on the Systems Redesign Website at the following address: https://srd.vssc.med.va.gov/Pages/default.aspx

VA Point of Service (VPS)

The VA Point of Service program (VPS) shall develop, deploy and maintain small, stand-alone devices that will enable Veterans and patients to efficiently and easily perform a variety of administrative, financial and clinical tasks. These devices will introduce standardization of basic patient-facing activities at VA health care facilities. VPS will also improve VA's information collection without requiring significant expenditures in staff costs. VHA is planning to implement point of service kiosks in all VA health care facilities to help to improve its interactions with patients – providing Veterans convenient control of their own information.

The long-term goal of the VPS program is to improve interactions with patients by providing convenient control of their own information and standardizing basic patient-facing activities at VA health care facilities. The program will manage and execute program delivery by employing an iterative approach to developing and implementing administrative and clinical capabilities. The end result of the program is to ensure that VA provides a continuous, efficient means to Veterans and their families to complete activities they choose to complete when and where they want to complete them.

In FY12, each VISN is requested to participate in pre-planning initiatives that include completion of a site readiness assessment tool. The tool is designed to prepare the VISN for network deployment and implementation at designated sites. The expectation is that each Network will complete the following:

72. Designate a VISN Project Lead and establish a VISN Integrated Project Team
73. Complete a Site Readiness and Preparation Assessment, including ISO and privacy issues.
74. Identify and Manage Site specific Risks.
75. Determine Workflow Processes.
76. Finalize Task Orders and Cost Estimates.
    76.1. FY12 rollout will be the in the following order:
    76.2. Wave 2 production deployment: VISN 2, VISN 3, VISN 5, VISN 6, VISN 10.
    76.3. Wave 3 production deployment: VISN 19, VISN 21, VISN 22,
    76.4. Wave 4 production deployment: VISN 17, VISN 18, VISN 23,
    76.5. Wave 5 production deployment: VISN 8, VISN 9, VISN 11, VISN 12, VISN 15

POC: Lori Amos; (404) 828-5575

Veterans Transportation Service

Veterans Transportation Service (VTS) seeks to overcome barriers to VHA access for all Veterans, but especially for Veterans who are visually impaired, elderly, or immobilized due to disease or disability, and those living in rural and highly rural areas. VTS will increase transportation resources and options for all Veterans, but also focus on improving efficiency of existing transportation resources through use of 21st Century technology including ridesharing software and GPS units. To accomplish these goals VTS will establish a network of transportation service providers including Veteran Service Organizations (VSOs), community and commercial providers, nonprofits and federal state and local governments. Emphasizing convenience and customer service, VTS will create a transportation option that will assist Veterans to access the healthcare they have earned. Ultimately, VTS will facilitate a transportation model in which a Veteran can make one call to the VA and receive assistance with arranging public, commercial or VTS transportation.

Any funding needed to support this activity will be provided directly to the pilot site by the program office. The use of pooled T21 funds (T21Y) should not be needed to support this effort. FY12 VTS will rollout to 40 additional sites bring the total to 83 sites by the end of December 2012 these sites will be notified. Since not every network will have a VTS site to begin the year, the following applies only to those Networks that have VTS sites:

77. Evaluate the role of transportation in access to care and Veteran satisfaction.
78. Ensure that VTS sites are participating in required meetings and conference calls.
79. Ensure a cooperative approach to include VTS Board of Directors and key stakeholders at facility level.
80. Attend annually, a VTS site program review with facility key staff and VTS Program Office.
81. Support the structure and responsibility of Mobility Manager Position.
82. Create, define and support an integrated transportation service.
83. Develop a VTS marketing plan to increase ridership and utilization.
84. Provide annual recommendations regarding program, strengths, and lessons learned to VTS Program Office.
85. Serve on VTS National Program Board of Directors, if nominated.
86. Ensure required reports are sent to CBO.

POC: Paul E. Perry; (404) 828-5325

Improve Veterans Mental Health (IVMH)

The long-term goals for the IVMH Initiative are to: 1) Develop a mental health (MH) infrastructure that ensures full implementation and sustainment of the VHA Uniform MH Services Handbook (1160.01). This will be accomplished through the development of IT resources and quality improvement processes that provide surveillance, feedback, technical support, and evaluation for ongoing practice improvement. These activities will ensure that the quality of MH care is consistent with national policy and that workforce development adequately provides staffing and training to facilitate consistent availability of evidenced-based MH practice at all VHA facilities; 2) Develop mechanisms to support Veterans' MH in communities though outreach to families, employers, colleges, universities, community agencies and through the web-based resources; and 3) Implement the VA/DoD Integrated MH Strategy to improve practice consistency and collaboration between VA and DoD as appropriate. In FY12 each network must:

87. Maintain MH staffing levels.
    - 87.1.1. Benchmark: 98% of 9/2009 staffing levels at each facility, minus the new homeless positions added after FY2009.
    - 87.1.2. Data source: ARC Database.
88. Fully implement the Uniform MH Services Handbook in all facilities and CBOCs and partner with the Office of Mental Health Services (OMHS) and MH Operations in identifying and improving practice variations.
    - 88.1.1. Benchmark: 100% of facilities will achieve and maintain 95% implementation.
    - 88.1.2. Data source: http://reports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fMentalHealth%2fMHSurveyStruct_Summary&rs:Command=Render
89. Identify the Mental Health Treatment Coordinator (referred to as the Principal Mental Health Provider in the 2008 Uniform MH Services Handbook) in the electronic medical record for eligible Veterans seen in MH specialty care.
    - 89.1.1. Benchmark: 75% of eligible Veterans.
    - 89.1.2. Data source: Quarterly report from OQP.
90. Provide OEF/OIF Veterans with a primary diagnosis of PTSD a minimum of 8 psychotherapy sessions within a 14-week period.
    - 90.1.1. Benchmark: 20% of eligible Veterans.
    - 90.1.2. Data source: Monthly report through VSSC.
91. Conduct educational outreach to train community MH providers on Veteran and military culture, readjustment issues, and deployment-related MH conditions.
    - 91.1.1. Benchmark: At least one educational outreach event per month.
    - 91.1.2. Data source: Monthly report to OMHS per established protocol.
92. Assess all OEF/OIF Veterans in active treatment for PTSD with the PTSD checklist every 90 days.

92.1.1. Benchmark: 20% of eligible Veterans.
92.1.2. Data source: VSSC monthly report.

93. Establish and show clinical activity in telemental health capability to deliver psychotherapy for PTSD.
    93.1.1. Benchmark: Capability established and clinical activity in all Networks by end of FY12.
    93.1.2. Data source: Clinical activity is defined as individual or group psychotherapy paired with a Telehealth stop code.

94. Install and make available the MH Suite Treatment Planning software in the electronic medical record, train MH staff, and show use.
    94.1.1. Benchmark: Installed and functional in 100% of Networks; appropriate numbers of MH providers trained and using the software as defined in pending field guidance.
    94.1.2. Data source: Installation – OI&T implementation team report; site self-report for other parameters using FY12 data as baseline for future years.

POC: David Carroll; (414) 384-2000, x41652

Eliminate Veteran Homelessness (EVH)

The Department of Veterans Affairs is taking decisive action toward its goal of ending homelessness among our nation's Veterans. To achieve this goal, VA has developed the Eliminate Veteran Homelessness Major Initiative that will assist every eligible homeless and at risk for homeless Veteran. VA will help Veterans acquire safe housing; needed treatment services; opportunities to return to employment; and benefits assistance. Additionally, VA plans to end the cycle of homelessness by preventing Veterans and their families from entering homelessness and by assisting those who are homeless to exit as safely and as quickly as possible.

The initiative is built upon six strategies: Outreach/Education, Treatment, Prevention, Housing/Supportive Services, Income/Employment/Benefits and Community Partnerships. These six strategies encompass a wide continuum of interventions and services to prevent and end homelessness among Veterans. Homeless Veterans will benefit from the expansion of existing program capacity and treatment services, as well as the implementation of new programs focused on homelessness prevention and increased access to permanent housing with supportive services. Programming will include mental health stabilization; substance use disorder treatment services; enhancement of independent living skills; vocational and employment services; and assistance with permanent housing searches and placement. Funds, outside of the pooled T21 resources (T21Y), have been provided to each Network specifically for this initiative. Networks will:

95. Ensure VISN and VAMC leadership involvement in the development and monitoring of Five-Year Plan initiatives and efforts to end homelessness among Veterans.
96. Develop initiatives to identify and support Veterans at-risk for homelessness in VHA and community settings.
97. Develop and expand Federal, state, local and community partnerships to support VA efforts in ending homelessness among Veterans.
98. Promote the expansion and promotion of the National Call Center for Homeless Veteran outreach in all VHA, VBA and community partner settings.
99. Promote the development of 24-hour response and rapid re-housing approaches to support homeless Veterans and Veterans at-risk for homelessness.
100. Promote the development of a homeless Veteran continuum of care that ensures Veterans, within the VISN, have access to needed programs and services in support of a permanent housing goal.
101. Promote the development of programs and services to address the needs of Homeless Veteran special populations (i.e. women Veterans; Veterans with children; OEF/OIF Veterans; rural/remote Veterans; etc).
102. Decrease the estimated number of homeless Veterans by 25% from FY11 levels (Data Source: Veterans Supplemental Chapter to the Annual Homelessness Assessment Report).

POC: Keith Harris (510) 791-4014

Health Care Efficiency Initiative

The following is provided for informational purposes. No plan is required. This Major Initiative was developed to identify areas where variation should be minimized or potentially eliminated in order to reduce cost and improve organizational efficiency without compromising the quality of services provided. Most of the areas this initiative is focusing on are related to unwarranted variation that is causing inefficiencies in either business or clinical processes, which can translate to increased costs. By eliminating unwarranted variation we strive to improve the patient experience, bend the cost curve, and create organizational efficiencies. The six primary areas of focus are: 1) facility automation, 2)commodities standardization, 3) beneficiary travel, 4) the purchase of non-VA care, 5) organizational oversight and accreditation, and 6) specific purpose funding, which will be mainstreamed at the end of FY11. What does this mean to you and how can you prepare?

Commodities Standardization – A structure has been implemented for Network Commodity Standardization Committees (NCSCs) that will be utilized to standardize and align the process for commodity standardization (including planning, acquisition and lifecycle management) at the enterprise (VA), strategic (VHA), operational (VISN), and

tactical (medical center) levels. As a result, VISNs will be asked to report activity and status of consolidated contracting opportunities.

Beneficiary Travel – As we continue modifications in the Beneficiary Travel (BT) software program and begin to develop and implement a Vet Traveler Program, facilities should be considering issues such as: 1) How do you verify Veteran eligibility for the BT Program? 2) Do you use a standardized method for mileage calculation? 3) Do you have a process in place to consolidate clinic appointments?

Non-VA Care – The Chief Business Office will be completing a pilot of an updated non VA care health care claims adjudication and payment software in FY12 that leverages and maximizes health care payer best commercial practices. Additionally, a non-VA integrity program will be deployed that will proactively ensure accurate payments for non-VA health care services. On the clinical side there will be a continued focus on reducing variation in care management processes, measuring quality of non-VA care and patient satisfaction with that care. As these new processes are developed facilities should begin to review the following: 1) Do you have a local process for determining when non-VA Care is authorized? 2) How do you measure patient satisfaction with non-VA Care? 3) How do you case manage patients in non-VA Care?

Facility Automation – The FY12 goal is to award a national indefinite delivery/indefinite quantity (IDIQ) contract for the procurement of Real Time Locator Systems (RTLS) and to implement and install the solution for targeted applications in VHA, VBA and NCA. The goal is for VISNs 10 and 11 to have the technology installed across their VISNs. For VISNs 20, 21, 22 and 23 the goal is to have the technology purchased and begin the installations. Depending upon the deployment of the wireless infrastructure, some VISNs may be able to complete the VISN wide installation prior to the end of FY12. For FY12 Networks will be required to:

103. Ensure they have Commodity Standardization Committees established
104. Report activity on the status of their consolidated contracting opportunities
105. Targeted VISNs (such as VISN 10, 11, 20, 21, 22 and 23) will be required to procure and install Real Time Locator System (RTLS) technology
106. Implement the Beneficiary Travel Dashboard application

POC: Susan Kane; (724) 496-6779

Transforming Health Care Delivery through Health Informatics

The following is also being provided for informational purposes. The Department of Veterans Affairs has had a rich history in clinical software development. The creation of the Health Informatics Initiative was driven in large part by three realizations: 1) many of the Secretary's transformational initiatives depend on enhanced clinical information systems; 2) delivery of clinical application software is not occurring at the level required;

3) the VA's leadership role in Health Information Technology (HIT) has been compromised. The Initiative is composed of four workstreams:

1. Adopt a Health/IT Collaborative Supporting Rapid Product Development and Delivery. This effort focuses on reengineering software requirement elaboration and software development processes through collaboration between the business owners and information technology staff.
2. Build a Health Management Platform to Transform Patient Care. This effort focuses on three areas: transforming the healthcare team experience, increasing patient engagement and satisfaction, and addressing population-based or healthcare systems aspects of care.
3. Create Health Informatics Capacity. This effort focuses on three areas focused on workforce development: developing competencies in analytics and informatics through education and recruitment; establishing career opportunities and developing social and professional networking communities.
4. Drive Communication and Change. This effort will develop communication and change strategies to establish an Initiative-wide roadmap, strategy, methods, tools, products and other communication and positioning vehicles to support achievement of Initiative milestones and deliverables.

In FY11 the Health Informatics Initiative demonstrated a new development model which embraced clinician driven software development solutions and created an infrastructure that supports transition from a client-server environment to a web browser environment. In FY12, the team will continue to develop functional modules and supporting infrastructure. It will also focus on development of analytic/informatics distance learning courses as well as opportunities for engaging clinicians in resolving clinical process problems encountered during software development. There are no implementation requirements for Networks in FY12.

POC: Tana Defa; (509) 968-3604

Research and Development

The research and development initiative has four work streams for FY11: genomic medicine, point of care research, medical informatics and information technology, and VA Central Office and field research resources.

Genomic medicine uses information on a patient's genetic make-up to tailor prevention and treatment for that individual. The Million Veteran Program, a partnership with Veterans, will enroll as many as one million Veterans in the next 5 to 7 years to establish one of the largest databases of genetic, health, and military exposure information.

Point of Care Research enables Veterans to be enrolled in comparative research projects at the time they are receiving usual clinical care. No extra patient visits are required, ant the outcomes are obtained by automated extraction of data from the medical record.

VA Informatics and Computing Infrastructure (VINCI) is creating a powerful and secure environment within the Austin Information Technology Center that will allow VA researchers to more easily access a wide array of VHA databases using custom and off-the-shelf analytical tools. The Consortium for Healthcare Informatics Research (CHIR) will provide research access to patient information in VA's computerized patient record system narrative text and laboratory reports by using natural language processing.

Finally, *VACO and Field Research Resources* is focusing on improving issues faced by VA researchers, including the length of time required to hire new personnel, contracting delays, research infrastructure deficiencies (conditions of the physical structures), and the need for a centralized research administrative management system. In FY12 Networks will:

107. Ensure facilities have adequate space for hosting the Million Veteran Program

POC: Timothy Hammond; (919) 286-6926