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# VHA T21 Implementation & Sustainment Guidance

Office of Strategic Integration

Department of Veterans Affairs

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The T21 Implementation Guidance is organized to focus on systems of care and intended outcomes rather than specific programmatic requirements. Although this document is intended as guidance only, its organization may be helpful to leaders when they develop their Fiscal Year (FY) 2014 performance and strategic plans.

The Major Initiatives (MI) were established by the Under Secretary for Health and funded by the Secretary of the Department of Veterans Affairs in an effort to systematically enhance the experience for America's Veterans. While acknowledging the complexity of the MI, the strategic vision of the transformation effort is one of an accessible, seamless, and coordinated system of care based on life-long relationships with patients and their families in which they are provided the tools and support to optimize their health and well-being. We will accomplish this through a variety of efforts. First, we will develop a more comprehensive, coordinated, and patient driven system of primary care, using the Patient Aligned Care Team (PACT), our medical home model, that not only focuses on disease management but on health and well-being. Second, access will be enhanced by establishing systems of care without walls (connected health) using telehealth, Secure Messaging, My HealtheVet, Kiosks, web and mobile applications, and social networking tools, while improving more traditional forms of access through value stream analysis and solutions (Systems Redesign and Transportation), including informatics flow applications and Flow Coordination Center (FCC) approaches for enhancement of inpatient flow and access. Third, we will align long-term care and specialty services to better support the PACT team and design long-term and specialty care options around the needs of patients instead of professional disciplines. Finally, the effort to specifically end homelessness is part of the Secretary's challenge to optimize the potential of all of America's Veterans.

The FY 2014-2019 VHA Strategic plan builds on these foundational elements, furthering VHA's vision of excellence and the Department's goals for a 21<sup>st</sup> century organization. Network leadership and Program officials must have a clear vision of how they will produce the major changes needed to bring about this transformation. It is a journey, and this guidance identifies major milestones on the path. Understandably, Network and Medical Center leadership must set priorities. While doing so, we ask that you ensure the development of a comprehensive plan and a disciplined framework for its execution over the next several years. The VHA Strategic Planning Guidance for FY14-19 provides direction for VISN planning efforts. Continued implementation and sustainment of the T21 Major Initiatives should be reflected in your VISN Strategic Plan.

In FY14, the VISN Management Reviews (VMR) will be fully integrated into the quarterly network reviews coordinated by the Deputy Under Secretary for Health Operations and Management. The Office of Strategic Integration (OSI) will continue to support this process through the provision of program office feedback and the evaluation of data as appropriate. General questions about this guidance can be directed to James Tuchschiidt of the Office of Strategic Integration, at (503) 880-7177, or [vha10a5action@va.gov](mailto:vha10a5action@va.gov).

**SUMMARY OF TRANSFORMATION INITIATIVES**

**Coordinated Health Care:** PACT is the foundational hub of VA's health care delivery system. It is predicated on a team-based model that ensures timely, proactive, patient centered, comprehensive services. Prevention and wellness are a major component of this model. Health behavior coaching and motivational interviewing are critical competencies necessary to realize this vision. Secure Messaging, telephone care, and telehealth services are all important tools. The primary care team should be supported by other services to ensure they can provide truly integrated care to meet the needs of their patients, including integrated mental health (MH) services. These teams should have the resources needed to coordinate care across the entire spectrum of services and to provide intensive case management for high-risk patients. Members from a variety of disciplines (e.g., pharmacy, psychology, social work, nutrition, and chaplain) may be included as part of the extended PACT team. The PACT model should be in place wherever a clinic intends to provide primary care services, such as Women's Health, Geriatrics, General Medicine, and some specialty clinics. Complete primary care for women Veterans, including gender specific care, must be available for women at all sites. Close collaboration and coordination with Specialty Care and long-term care, as well as with initiatives to end homelessness among Veterans, are all vital to providing comprehensive, whole-person care in our PACT.

**Improving Access:** The improvement of access has been one of the cornerstones of VHA's strategy. Safety, quality, patient satisfaction, and cost are all adversely impacted when appropriate and timely access to care is delayed. Access to outpatient, inpatient, long-term care, and procedure-based services can be improved by applying systems redesign strategies and by expanding alternatives to facility based care, such as Secure Messaging, clinical video telehealth (CVT), home telehealth (HT) and store and forward telehealth (SFT) services, eConsults, and Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO). Nationally, we are developing mobile applications, improving My HealtheVet functionality through online authentication, working on social networking tools, and developing and implementing a suite of informatics flow tools including Bed Management Solution (BMS), Emergency Department Integration Software (EDIS), and Surgery Quality and Workflow Manager (SQWM) with a focus on integrating these applications under a comprehensive flow management approach and associated business process development to optimize inpatient flow and create additional access to inpatient services across VHA.

Redefining what access means, VA will build a system of care without walls that, by the completion of 2014, will touch 30% of those using the VA system for their healthcare. Early data suggest that we can reduce visit rates, particularly for urgent care, and hospitalizations by improving access using telehealth-technologies and Secure Messaging. This not only improves our capacity to care for those who do need a physical visit or acute care, but it provides patients the opportunity to spend their lives

in more productive ways. Today, we have surgical teams providing post-op care by CVT, virtual specialty care clinics where local clinicians can be an active part of the team, and we are delivering psychotherapy into the patients' homes by (CVT) webcam. However, we have a lot to do to expand the use of these innovative systems of care.

**Specialty Care:** Leaders must ensure that specialty care services, including long-term care, are also timely, aligned with the PACT model of care in order to improve coordination and integration of care, and designed around the needs of patients. These challenges are particularly difficult in rural and underserved areas. We must invest in specialty care, including MH, to develop and sustain these vital services. Specialty Care is a critical component of VHA's comprehensive medical benefits. We must ensure that all staff are working to the top of their competency. For example, advanced practice nurses incorporated into specialty care teams can improve access and ensure that physicians are performing work that only they can do. Furthermore, mini-residencies and specialized training can develop new competencies allowing clinicians to fill critical needs, particularly in underserved areas. Training has also been made available for clinicians to gain additional specific skills and competencies in evidence-based psychotherapies and creative partnerships with community partners have the potential to improve outcomes.

The vision for Specialty Care Service (SCS)/Specialty Care Transformation (SCT) is to transform specialty care services into a more Veteran-centric environment by improving access through leveraging Telehealth and other non-face-to-face modalities for delivering care. The Specialty Care Neighborhood will interface with PACTs to provide coordinated, team-based care (Neighborhoods) in which all disciplines (e.g., nursing, pharmacy, social work, nutrition, and chaplains) are valued partners. This relationship will ensure the delivery of services across VHA is patient-centered and the coordination is timely, accessible, and of high quality. The focus will be on the Veteran experience and on shared decision-making. Specialty Care Neighborhood will leverage the use of Telehealth and other technologies to deliver care without requiring a face-to-face visit, for example, by using SCAN-ECHO and Electronic and Phone Consults. Building on the success of Secure Messaging in PACT primary care settings, full implementation across other clinical settings (e.g., Mental Health, Dentistry, Geriatrics and Extended Care) is required based on direct feedback from Veterans, many of whom indicate a strong desire to communicate electronically with "all of their VA health care providers." With the completion of implementing Secure Messaging throughout VA clinical care in 2014, increased My Health eVet and Secure Messaging clinical adoption and integration will enhance patient access to care in all settings, maximizing Veteran-provider-family collaboration, and ultimately optimizing Veterans' health and serving Veterans of all ages in urban and rural settings. Broad implementation of evidence-based specialty care will reduce readmissions and unnecessary clinic appointments, and decrease Veteran travel to tertiary medical centers and unscheduled visits to the emergency room.

**Non-Institutional Long Term Care:** Non-institutional alternatives to traditional nursing home care for dependent Veterans of any age are preferable in terms of cost, outcomes, patient and family preferences, and satisfaction. The vision for these patient-centered non-institutional alternatives to extended care is to match up local site strengths with local Veteran preferences and needs, by offering a broadened set of options. Approaches that have been validated in the professional literature and that have now been shown to be successful in pilots offered by VA include Dementia Case Management, Transitional Care (including medication reconciliation and preventive rehabilitation approaches), Program for All-inclusive Care in the Elderly, a range of face to face and telehealth-based caregiver support models, Hospital at Home, and modifications to Home-Based Primary Care and Adult Day Health Care for highly rural settings. NILTC supports the Geri Scholars program to expand geriatric expertise in order to assist in the utilization of successful models of care as PACTs become more facile and comfortable leveraging non-institutional alternative programs as part of their plans of care for frail and dependent Veterans. In addition NILTC supports Veteran Community Partnerships (VCP). VCPs, now in partnership with the emerging Office of Community Engagement, also promote the use of locally relevant VA and non-VA non-institutional care options for supporting the needs of Veterans who prefer to remain in their own homes and in the general community.

**Patient Centered Care:** Patient centered care is embodied in a system that prioritizes the Veteran and their values, and partners with them to create a personalized, proactive strategy to optimize health and well-being. The VHA's number one strategic goal is to deliver personalized, proactive and patient-driven healthcare or "Whole Health Care". The elements of Whole Health Care include three things at the highest level: "Me", the individual person (Veteran, patient, family member, employee) and the "Experience" and "Practice" of care. The experience includes healing environments and healing relationships and the practice includes the Proactive Components of Health and Well-Being and the Personalized Health Approach. Additionally, Whole Health reaches beyond the walls of the health care facility and includes the Veteran's support system and community

Whole Health requires a shift from the predominant medical paradigm of finding and fixing disease to one focused on optimizing health and well-being. While preventive care and state-of-the-art care for illnesses and disease remain foundational to healthcare, the model of the future shifts from "what's the matter" to "what matters" to the person in their life. This shift requires a change in the conversation we have with Veterans and each other and requires additional knowledge and skills in areas that advance health and well-being. The Personal Health Inventory is a self-reflection tool about a person's whole life and is a starting place for a deeper conversation.

Communication skills taught in TEACH for Success and Motivational Interviewing are important for listening to what matters, goal setting, and behavior change. The Office of Patient Centered Care and Cultural Transformation (OPCC&CT) offers additional

experiential education based on the principles of change theory and Whole Health so healthcare teams can better:

1) partner with Veterans to proactively take action toward behavior change that is present- and future-oriented; 2) recognize that optimal health extends beyond the absence of disease; 3) seek to support the Veteran in achieving the Veteran's vision of optimal "Whole Health" including their mental, physical, and social well-being; and 4) meet the Veteran where he/she is at in their life, based on their unique goals, values, preferences, and lifestyle to develop a personalized health plan based on what matters most to the Veteran.

Additionally, the OPCC&CT has curricula, tools, and toolkits to promote Whole Health. The clinical curricula complements traditional medical approaches by building upon existing skills, resources, and evidence-based and evidence-informed therapies that will allow VHA to more fully partner with and empower Veterans and their families. The cultural transformation will only be successful if all employees are engaged in health and well-being. Everyone has a role in creating and enhancing healing environments and developing continuous healing relationships. Personalizing the iCARE principles and honoring each person's values and beliefs are part of VHA's cultural transformation. Highly experiential educational modules and related resources are available to support staff in optimizing their own health and well-being and to embody the iCARE principles in their daily work. These tools are also located on the links listed above.

The Office of Patient Centered Care and Cultural Transformation has Field-based Implementation Teams (FIT) that assist VISN's and facilities, at their request, with an organizational assessment of where they are at in their patient centered care journey. These teams highlight strong practices and share innovations from across VHA and the private sector. FIT teams host Executive leader and middle manager engagement sessions focusing on creating a patient centered culture, infrastructure, and environment, engaging leaders as champions. FIT teams also hold staff engagement sessions which are experiential events that help staff members at all levels of the organization learn about healthcare from the patient's/family's perspective and highlight the important role each staff person has in the successful transformation of the culture.

One of the most crucial aspects of transformation is incorporating the voice of Veteran. The Veteran Experience Committee (VEC) and chartered subcommittees of the National Leadership Council ensure that the voice of the Veteran is at the table at the highest levels. Veterans partner with VHA through the VEC and local Veteran Councils, in designing and planning of the elements of Whole Health. An effective Veteran experience program and organizational structure supports the cultural change and ensures a positive patient experience is a fundamental value in VHA. Veterans' service, stories, and testimonials inspire us and serve as a beacon for our work.

Tools and toolkits are available to support the field in all elements of personalized, proactive, patient-driven care and are located on the HealthforLife VA cloud at: <http://healthforlife.vacloud.us/> and the OPCC&CT SharePoint at: <http://vaww.infoshare.va.gov/sites/OPCC/default.aspx>.

**Eliminate Veteran Homelessness:** VA is committed to preventing and ending homelessness among Veterans, and their families, by the end of 2015 and is poised to assist homeless and at-risk Veterans through the provision of a comprehensive continuum of care that includes: Outreach/Education, Prevention, Treatment, Income/Employment/Benefits, and Housing/Supportive Services provided in collaboration with Federal, state, local governments and community partners.

VA is positioned to assist homeless and at-risk Veterans in achieving their optimal level of functioning and quality of life through the provision of a comprehensive continuum of care that address the psychosocial factors surrounding homelessness while building the capacity of available residential, rehabilitative, transitional, and permanent housing supply. Promoting a Housing First approach, the continuum includes prevention and treatment services. These services include but are not limited to: primary and specialty medical care, mental health and substance use disorder treatment, case management, outreach, vocational rehabilitation/employment services, housing, and coordination of related services with VBA and NCA. The intent is for every eligible Veteran to have access to a safe, stable environment, and that there will be sufficient capacity so that all Veterans willing to accept services will be able to leave the streets and enter shelter/housing in order to stabilize and begin rebuilding their lives.



**TACTICAL REQUIREMENTS****1. LEADING TRANSFORMATIONAL CHANGE:**

- a. Ensure that service line leadership understands the vision and has an appropriate plan to support PACT, SC PACT (Neighborhoods) Specialty Care, and MH needs of Veterans.
- b. Ensure that mechanisms are in place to identify and advance strong practices, and that teams, particularly in PACT, SC PACT (Neighborhoods) Specialty Care, and Mental Health, have the time to systematically improve their clinical process.
- c. Ensure the adoption of My HealtheVet, Secure Messaging, and Telehealth programs that provide Veterans convenient alternatives to face-to-face care, improve access and reduce travel, particularly in support of PACT, Specialty Care, and Mental Health. This includes maintaining a MHV Voluntary Service Assistant Program to recruit volunteers and coordinate their outreach/training efforts to promote awareness of and participation in MHV, Secure Messaging, and other VA Connected Health products.
- d. Develop within PACT new processes of care that improve the outcome for high risk, complex patients by using the Patient Care Assessment System (link will be forwarded when available), intensive case management, and telehealth (CVT, HT and SFT) services.
- e. VHA recently adopted the strategic goal of providing Veterans personalized, proactive, patient driven healthcare. Review, enhance, and update, as appropriate, the facility PCC strategic plan developed in FY12. Ensure that it is in alignment with this new VHA goal, includes approaches to transforming business and clinical processes for patient-driven health care, and specifically addresses how the facility will elicit the voice of the Veteran in a structured and consistent manner (to include patient and family advisory councils and VSOs/POAs, listening sessions, patient rounding, patient shadowing). The plan should identify measures of outcome.
- f. Ensure that all necessary resources to support the continued rapid expansion of Clinical Video Telehealth are in place. During FY13, the CVT into the Home program was piloted and at the close of FY13 more than 2,000 unique Veterans were seen using this process. CVT into the Home service are forecasted to reach more than 10,000 unique Veterans in FY14.
- g. Ensure that local strategic planning adequately addresses the capacity, services, skills, and facility infrastructure to meet the needs of a growing female Veteran population.
- h. Ensure that all T21 NILTC clinics have the NILC four character alpha code (CHAR4) on the Decision Support System (DSS) clinic feeder keys for programs

implemented with T21T NILTC funding. The NILC code will be included in the GEC Non-Institutional Care (NIC) performance metrics beginning in FY2014. All clinics for all programs initiated with T21T NILTC funds should have this code. The code should not be removed when T21T funding ends and it should be added to any new clinics established for programs that were implemented with T21T NILTC funds. This is the means of following the continuation and expansion of these programs after the T21 funding ends.

## 2. STAFF COMPETENCIES AND RESILIENCY:

- a. Ensure that PACT, including Women's Health, Special Populations, and Specialty Care PACT (also referred to as SC Neighborhoods) staff have completed training to acquire the competencies, skills, and ability to achieve the desired PACT outcomes.
- b. Ensure that appropriate clinical staff have completed training and acquired the Veteran-centered communication and health coaching competencies and skills emphasized in TEACH for Success, and Motivational Interviewing training.
- c. Ensure that teams caring for women Veterans have received appropriate training to be able to provide comprehensive primary care to women and that these services are available at all sites of care.
- d. Ensure that staff have had appropriate training in the use of Secure Messaging and that they can integrate this modality into their clinical and business practices, with a suggested goal of 30% of Primary Care encounters through Secure Messaging by 2017.
- e. Ensure that staff have Advanced Clinic Access and Systems Redesign competencies, including training in Rapid Process Improvement, the time to actively improve access, reduce no-show rates, increase systems efficiency, and improve quality of care.
- f. Ensure that Specialty Care Mini-Residency master preceptor staff (primary care providers) have completed training necessary to acquire the competencies, skills, and ability to achieve the desired Specialty Care outcomes.
- g. Medical centers should work with the Office of Patient Centered Care to continue to develop and implement their PCC strategic plan. Resources are available through the OPCC/CT SharePoint site: (<http://vaww.infoshare.va.gov/sites/OPCC/default.aspx>).
- h. Ensure appropriate staff have training and competency in the use of Telehealth for safe and efficient operations of quality CVT, HT, and/or SFT programs. National Training requirements and resources are available and can be accessed at <http://vaww.infoshare.va.gov/sites/telehealth/default.aspx>.

- i. Ensure that My Health<sup>e</sup>Vet Coordinators and other staff with access to the My Health<sup>e</sup>Vet Administrative portal receive appropriate education and re-education (as appropriate) on My Health<sup>e</sup>Vet functionality, security, and privacy.
- j. Ensure that PACT and Inpatient discharge planning staff are familiar with the range of non-institutional alternatives to long-term care including Geri PACT, both to promote patient-centered models of long-term care and to ensure that cost-effective options are employed.
- k. Ensure that staff has the necessary geriatric expertise to provide optimal geriatric care to all elderly Veterans by encouraging staff participation in the NILTC supported Geri Scholars program.

### **3. BUSINESS CAPABILITIES:**

- a. Ensure the existence and sustainment of a robust Health Promotion, Disease Prevention (HPDP) program that embraces the Healthy Living messages and integrates them into clinical care. Ensure that appropriate clinical staff have Veteran- centered communication competencies and skills emphasized in TEACH for Success and Motivational Interviewing training programs.
- b. Ensure specialty services are designed around the needs of patients and in partnerships that optimally support the PACT teams.
- c. Ensure that female Veterans have access to gender specific services regardless of the site or circumstances of care, e.g. PACT clinic, Emergency Department, MH, or inpatient service.
- d. Develop robust and disciplined approaches to systems redesign to improve access and continuity of care, inpatient bed utilization/flow, and Surgical and Emergency Department flow.
- e. Ensure that the portfolio of Inpatient Informatics Flow Tools developed during FY 11-13, including the Bed Management Solution (BMS) and the Emergency Department Integration Software (EDIS), are fully implemented and actively in use in all VAMCs with inpatient beds and emergency departments, to ensure data transparency, availability, and support for patient flow improvement efforts.
- f. Ensure a Veteran-centric environment by improving access through leveraging telehealth (HT, CVT, SFT) and other non-face-to-face modalities, e.g., Secure Messaging, SCAN-ECHO, E-Consult, for delivering care in an effort to ensure that 30% of unique Veterans are engaged in these modalities of care by the end of FY 14.
- g. Ensure that local strategic planning adequately addresses the capacity, services, skills, and facility infrastructure to meet the needs of aging Veterans, particularly

in non-institutional settings, while advocating for patient-driven and personalized models of care.

- h. Develop a robust plan to eliminate Veteran homelessness by establishing a “no wrong door” approach in serving homeless Veterans and Veterans at-risk of becoming homeless. Implement outreach initiatives targeting chronically homeless Veterans and special homeless Veteran population groups (e.g., the seriously mentally ill; OEF/OIF/OND; women Veterans; Veterans with families; rural Veterans; etc.). Establish 24/7 rapid re-housing and support services, and right-size VA’s continuum of care to address the prevention, treatment, rehabilitation, and supportive housing needs of homeless and at-risk Veterans.
- i. Incorporate appropriate use of protocols and standing orders to support all team members practicing to the fullest extent of their education, experience and competence.
- j. Ensure that mental health informatics tools (e.g., Mental Health Suite, evidence-based psychotherapy progress note templates, patient record flags for suicide risk and for high risk patients, etc.) are fully implemented.
- k. Ensure that the NILC code as indicated in tactical requirements, is being collected in the DSS CHAR4 data cube. This is the means of following the continuation and expansion of the T21 NILTC programs after the T21 funding ends. The NILC code will be included as part of the GEC NIC performance metrics beginning in FY2014.

#### **4. BUILDING COALITIONS TO ENHANCE SERVICES**

- a. Build collaborative efforts with academic partners to improve the integration of training into the PACT model, including training in inter-professional care and the integration of MH in the PACT setting.
- b. Develop an active support network of community partnerships and collaborations to eliminate Veteran homelessness and ensure that Veterans have access to timely MH services.
- c. Integrate Veterans Benefit Administration and National Cemeteries Administration services in support of ending homelessness among Veterans.
- d. Collaborate with Department of Defense to provide seamless transition from active service to Veteran status.

#### **5. IMPLEMENTATION GOALS:**

- a. Meet or exceed the Primary Care Operations (10NC3) PACT Implementation Dashboard metrics.
- b. Meet or exceed the Virtual Care Metric, including the use of Secure Messaging, telehealth (CVT, HT and SFT), eConsults, and SCAN-ECHO (*Target 30% for FY 14*).

- c. Expand SCAN-ECHO access by increasing the number of Veterans in PACT clinics treated by providers through participation in SCAN-ECHO sessions. SCAN-ECHO clinics should be fully integrated teams that can provide comprehensive treatment planning and consultation.
- d. Ensure that at least 16% of Veterans receive telehealth-based services (HT, CVT, SFT) by the end of FY 14.
- e. Ensure that at least 50% of patients are registered with My Health eVet and 25% opt-in for Secure Messaging by the end of FY 14.
- f. Ensure that Community Based Outpatient Clinics (CBOCs) have at least three of the following services, not available on site, initiated via CVT and regularly available as clinically appropriate:
  - i. Diabetes Consultation or case management or group classes
  - ii. Pain Consultation or case management or group classes
  - iii. Dermatology (CVT and/or SFT)
  - iv. Cardiology Consultation
  - v. Geriatric Consultation and Assessment
  - vi. Palliative Care Consultation
  - vii. GI consultation or Pre-colonoscopy group visit
  - viii. Other Medical or Surgical Specialty consultation
  - ix. Respiratory follow-up or group visits (e.g. COPD, sleep apnea, home oxygen)
  - x. Neurology Consultation including follow-up for chronic neurologic conditions (Parkinson's, seizures, MS)
  - xi. Nutrition Consult or group classes
  - xii. Clinical Pharmacist visits
  - xiii. Social Work visits
  - xiv. MH assessment, diagnosis, and delivery of evidence-based psychotherapies
  - xv. Pre-op Visit or evaluation
  - xvi. Post-op Visit
  - xvii. Wound Care
  - xviii. MOVE! Weight Management Program
  - xix. Primary Care Women's Health (consultation for providers with experienced Women's Health Provider)
  - xx. Gynecology
- g. 70% of all PACTs in a VISN will have  $\geq 1.5\%$  of their assigned panel enrolled in HT and the aggregate percentage of all VISN PACT patients enrolled in HT will exceed 1.6%.
- h. Engage at least 6% of each PACT team's assigned panel in MH evaluation and treatment as appropriate.

- i. Implement HPDP Program Handbook (1120.02) and meet or exceed the associated HPDP metrics (T21 performance measures) and Prevention metrics
- j. Demonstrate or maintain improvement in the percent of obese patients engaged in the MOVE! Program (MOV6) and the percent of patients who receive intense and sustained treatment (MOV7).
- k. NILTC programs should meet or exceed 25% of target unique Veterans by the end of quarter 1, 50% of target by the end of quarter 2, 75% of target by the end of quarter 3 and 100% of target by the end of quarter 4. Monitoring of this performance measure will be completed through the monthly Temperature Check reports that all currently funded T21 NILTC programs are required to update on the NILTC SharePoint site.
- l. Reduce No-Show Rates by 2%.
- m. Fully implement use of Bed Management Solution (BMS) and Emergency Department Integration Software (EDIS) in support of daily operations in all VA Medical Centers with inpatient beds and Emergency Departments, respectively.
- n. Implement Emergency Department (ED) performance metrics utilizing the Emergency Department Integration Software (EDIS) application as the primary data source. These objectives include: 1) Reduce median elapsed time of ED/UCC visits (Metric 1.1: Reduction in median ED Length of Stay (LOS) for all patients not admitted to < 3 hours (median) by the end of FY 14.); 2) Reduce missed opportunities (Metric 2.1: Reduce Left Without Being Seen (LWOBS) in EDs to <4% by end of FY 14); and 3) Standardize ED/UCC operations to maximize efficiency (Metric 3.1: Reduce door to doc time to < 45 minutes by the end of FY 14; Metric 3.2: Reduce the door to triage time to < 15 min by the end of FY 14).
- o. Fully implement the Uniform MH Services Handbook in all facilities and CBOCs and partner with MH Services and MH Operations in identifying and improving practice variations. Benchmark: 100% of facilities will achieve and maintain 95% implementation.
- p. Establish and maintain at least one Behavioral Health Interdisciplinary Program team.
- q. 90% of HUD-VASH vouchers allocated will result in a Veteran becoming housed by September 30, 2014 (*NDPP Performance Measure*).
- r. 65% of Veterans served in Grant Per Diem and Domiciliary Care for Homeless Veterans programs will discharge to independent housing (*NDPP Performance Measure*).
- s. 65% of Veterans served in Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) will meet criteria for chronic homelessness at the time of admission to the HUD-VASH program (*NDPP Performance Measure*).

- t. 25% of Veterans engaged by VHA Homeless Programs will be unsheltered homeless Veterans (New *NDPP Performance Measure*).
- u. At least 1 Women's Health Provider trained in Women's Health Mini-Residency (or equivalent training) from every site of care (Medical Center and CBOC).