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VHA T21 Implementation Guidance

Office of Healthcare Transformation

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This year, we organized the T21 Implementation Guidance to focus more 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) 2013 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 (virtual care) using telehealth, secure messaging, MyHealth***e***Vet, Kiosks, web and mobile applications, and social networking tools, while improving more traditional forms of access through value stream analysis and solutions (System Redesign and Transportation). 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 2013-2018 VHA Strategic plan builds on these foundational elements, furthering VHA's vision of excellence and the Department's goals for a 21st 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 FY13-18 provides direction for VISN planning efforts. Continued implementation of the T21 Major Initiatives should be reflected in your VISN Strategic Plan.

A new VISN Management Review (VMR) template will be developed and, again this year, we plan to use our advisory group to help refine both the reporting tools and the process. The VMRs are intended to be consultative sessions during which we may evaluate progress, identify barriers and good practices, and collaboratively make midcourse adjustments.

General questions about this guidance can be directed to James Tuchschmidt of the Office of Healthcare Transformation, at (503) 880-7177, or 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. Behavioral health 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 system redesign principles 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, ***e***Consults, and Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO). Nationally, we are developing mobile applications, improving MyHealth***e***Vet functionality through online authentication and working on social networking tools.

Redefining what access means, VA will build a system of care without walls that, by 2015, will touch 50% 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 tele-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 right 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 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. Additionally, we will need to ensure that My Health***e***Vet and secure messaging are fully adopted and utilized, including by MH and all specialty care services. 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. In FY 13, Innovations in Consult Management (Electronic and Phone Consults) and SCAN-ECHO will be expanded to additional specialties and sites. To be most effective, SCAN-ECHO clinics should be staff with high performing interdisciplinary teams. FY 13 Phase II project expansion will be initiated for SCAN-ECHO, Specialty Care Mini-Residencies, and models of specialty care that incorporate comprehensive primary care services for special populations.

Non-institutional alternatives to traditional nursing home for dependent Veterans of any age are preferable in terms of cost, outcomes, patient and family preferences, and satisfaction. The vision for 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, Transition 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.

Patient Centered Care: At the core of the PCC Culture Transformation is an entirely new approach to health care that is a radical shift from our current system. VA health care of tomorrow must build on our successful quality improvements (prevention and chronic disease management) to patient-centered health care that optimizes the health and well-being of our Veterans. 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. The development of a recovery-oriented, patient centered model, moving from disability to ability, is one example of how this change is reflected in Veteran care today. 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, family caregivers, providers, and other staff/team members. The "Voice of the Veteran" is a key component, which needs to be consistently elevated during all planning (i.e., enabling patient authorization of information sharing and enabling patient self-reported data to become visible to the health care team). In the end, we must develop patient care practices that support patient ownership of their health and well being, as well as their plan of care.

Eliminate Veteran Homelessness: 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 homelessness 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 MH stabilization, substance use disorder treatment services, enhancement of independent living skills, vocational and employment services, and assistance with permanent housing searches and placement.

TACTICAL REQUIREMENTS

1. LEADING TRANSFORMATIONAL CHANGE:

a. Ensure that service line leadership understand the vision and have an appropriate plan to support PACT, Specialty Care, and MH needs of Veterans.

b. Ensure that resources are aligned to support those plans.

c. Ensure that mechanisms are in place to identify and advance strong practices, and that teams, particularly in PACT, Specialty Care, and Mental Health, have the time to systematically improve their clinical process.

d. Ensure the adoption of My Health***e***Vet and of 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.

e. Develop within PACT new process 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.

f. 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.

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.

2. STAFF COMPETENCIES AND RESILIANCY:

a. Ensure that PACT and Specialty Care staff have completed training to acquire the competencies, skills, and ability to achieve the desired PACT outcomes.

b. Ensure that appropriate staff have completed training to acquire the competencies and skills emphasized in TEACH for Success, Motivational Interviewing, and health behavior coaching.

c. Ensure that Women's Health teams have received appropriate gender specific health care skills training 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 skills and ability, including training in Rapid Process Improvement training, the time to actively improve access, reduce No Show rates, increase system efficiency, and improve the quality of care.

f. Ensure that Specialty Care Mini-Residency master preceptor staff 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.

i. Ensure that My Health***e***Vet Coordinators receive appropriate education and re-education (as appropriate) on My Health***e***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, both to promote patient-centered models of long-term care and to ensure that cost-effective options are employed.

3. BUSINESS CAPABILITIES:

a. Ensure the existence and development of a robust Health Promotion, Disease Prevention (HPDP) program that embraces the Healthy Living messages and integrates them into clinical care. Teams have patient centered communication 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, and operating room and Emergency Department flow.

e. Ensure that a portfolio of Inpatient Informatics Tools developed in FY 11, including the Bed Management Solution (BMS) and the Emergency Department Integration Software (EDIS), are fully implemented.

f. Ensure a Veteran-centric environment by improving access through leveraging telehealth (HT, CVT, SFT) and other non-face-to-face modalities, e.g., SCAN-ECHO, E-Consult, for delivering care in an effort to ensure that 50% 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.

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 (30% by the end of FY 13 and 50% by end of FY 14)

c. Establish, where appropriate, eConsult clinics for specialties in which there are 2.0 or more clinically mapped physician full-time equivalent employees (FTEE): (2.0 FTEE can be two physicians or a sum of multiple part-time physicians) no later than September 30, 2013. The following specialties are usually in high demand by Primary Care and we recommend they be established early:

- Cardiology
- Gastroenterology
- Anesthesia
- Nephrology
- Urology
- Endocrinology
- Hematology/Oncology
- Pulmonary
- Neurology
- Geriatrics/Dementia

d. 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.

e. Ensure that at least 15% of Veterans receive telehealth-based services (HT, CVT, SFT) by the end of FY 13 and meet the telehealth visit rates to accomplish these goals by the end of FY 13.

f. Ensure that at least 15% of patients are registered with My Health***e***Vet and opt-in for secure messaging by the end of FY 13.

g. Meet or exceed a Virtual Care target of 30% by the end of FY 13 and 50% by the end of FY 14.

h. 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

i. 70% of all PACTs in a VISN will have ≥ 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%.

j. Engage at least 6% of each PACT team's assigned panel in MH evaluation and treatment as appropriate.

k. Implement HPDP Program Handbook (1120.02) and meet or exceed the associated HPDP metrics (T21 performance measure) and Prevention metrics (FY 13 Performance and Accountability Report (PAR) measures).

l. 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).

m. Meet or exceed targets for Frail Elderly Quality Indicators, including 75% of outpatients over age 75 screened for urinary incontinence (fe1); 80% of outpatients over age 75 screened for a fall in the prior year (fe3); 50% of those positive on the fall screen receiving a falls risk assessment (fe4); and 30% of those over age 75 undergoing a functional assessment (fe9).

n. Reduce No-Show Rates by 2%.

o. Maintain MH staffing levels [FY 13 staffing measure is still being developed by MH Operations].

p. 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.

q. Meet the 14-day access measure for new MH patients [this is an FY 13 PAR measure for MH; the exact definition is yet to be determined].

r. Meet the 14-day access measure for established MH patients [this is an FY 13 PAR measure for MH; the exact definition is yet to be determined].

s. Meet the 7-day follow-up measure post MH hospitalization [this is an FY 13 PAR measure for MH; benchmark and data source for FY13 to be confirmed].

t. Provide OEF/OIF Veterans with a primary diagnosis of PTSD a minimum of 8 psychotherapy sessions within a 14-week period [this is an FY 13 PAR measure for MH; benchmark and data source for FY 13 to be confirmed] Benchmark for FY 13: 25% of eligible Veterans.

u. Meet the MH Treatment Coordinator (MHTC) Measure- Percent of VISNs that have 75% of appropriate Veterans having a MHTC identified in PCMM [this is an FY13 Management Performance Review measure for MH; Benchmark for FY13: 100%; data source for FY13 is VSSC].

v. 88% of HUD-VASH vouchers allocated will result in a Veteran becoming housed by September 30, 2013 (*NDPP Performance Measure*).

w. 60% of Veterans served in Grant Per Diem and Domiciliary Care for Homeless Veterans programs will discharge to independent housing (*T21 Performance Measure*).

x. 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 (*T21 Performance Measure*).