

VA



U.S. Department
of Veterans Affairs

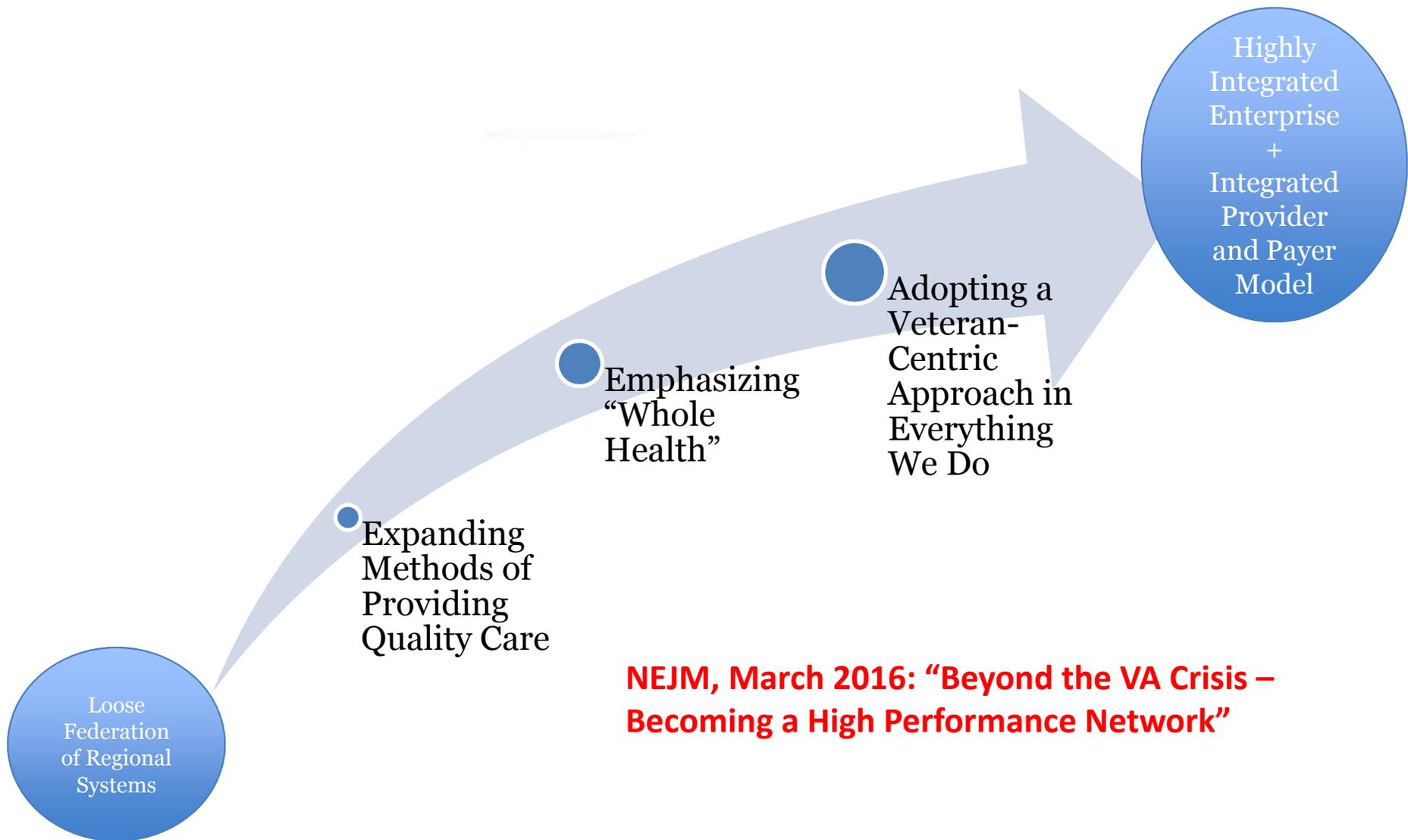


Building on Excellence

**Deputy Secretary of Veterans Affairs
Sloan D. Gibson**



VA is Building a High Performance Network



NEJM, March 2016: “Beyond the VA Crisis – Becoming a High Performance Network”



Transforming VA Health Care



- Building on our strengths – VA outperforms the private sector in many areas
- Adopting a Veteran-centric “whole health” approach in everything we do
- Changing the way VA thinks about Access – MyVA Access
- Becoming more effective and efficient in our core operations
- Modernizing contact centers to improve access
- Enhancing management tools to improve Veteran experience and outcomes
- Leveraging scale to share best practices across the VA network
- Modernizing and better leveraging technology, to include EHR
- Overhauling the health care enrollment process
- Boosting staffing levels – leadership and clinical
- Leveraging our scale to build a world class end-to-end supply chain
- Streamlining care in the community and developing an integrated provider-payer system



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Outperforming Private Sector on Many Measures



- JAMA, February 2015: 30-day risk-standardized **mortality rates lower** than those of non-VA hospitals for acute myocardial infarction and heart failure.
- American Journal of Infection Control: In five years, **MRSA infections declined** —
 - 81% in VA Spinal Cord Injury units (AJIC May 2013)
 - 69% in VA Acute Care facilities (AJIC Nov 2013)
 - 36% in VA Community Living Centers (AJIC Jan 2014)
- The Independent Assessment: VA performed the **same or significantly better** than non-VA providers on 12 of 14 effectiveness measures in the inpatient setting.
- The Independent Assessment: VA performed **significantly better** on 16 outpatient HEDIS measures compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs.
- A 2015 study published in the peer-reviewed journal Psychiatric Services: VA mental health care was **better than private-sector care** by at least 30 percent on all seven performance measures, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment.
- A 2015 UC Davis study: Outcomes for VA patients **compared favorably** to patients with non-VA health insurance, with **VA patients more likely to receive** recommended evidence-based treatment.



American Customer Satisfaction Index



VA has outperformed the private sector in customer service for a decade.

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
VA Inpatients	83	84	83	85	84	85	85	84	84	81	86
VA Outpatients	80	82	83	81	83	82	83	82	82	79	80
Private-Sector Hospitals	71	74	77	75	77	73	76	76	78	76	74

* Source: American Customer Satisfaction Index



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Taking Advantage of VA's Scope to Provide Whole Health



	PRIVATE SECTOR	VETERANS HEALTH ADMINISTRATION
PEER SUPPORT		X
CRISIS LINES		X
TRANSPORTATION		X
CAREGIVERS		X
HOMELESSNESS SERVICES		X
MEDICATION SUPPORT		X
BEHAVIORAL HEALTH INTEGRATION		X
CLOTHING ALLOWANCES		X
LIFE LONG RELATIONSHIPS		X
SINGLE EMR PLATFORM		X
WORKS WITH MOST LEADING MED CENTERS		X



Emphasizing “Whole Health”



“Our “whole health” model of care is a key component of the VA’s proposed future delivery system. This model incorporates physical care with psychosocial care focused on the veteran’s personal health and life goals, aiming to provide personalized, proactive, patient-driven care through multidisciplinary teams of health professionals.”

David J. Shulkin, M.D.

N Engl J Med 2016; 374:1003-1005



The Future Vision: Whole Health Partnership, moving from Sick Care to Health Care



1. **Whole Health Pathway** - partners with Veterans at the point of enrollment and creates an overarching personal health plan that integrates care both in the VA and the community.
 - Improves access to the system and promotes patient empowerment
2. **WellBeing Center** - offers of complementary and integrative health (CIH) services and skill building.
 - Proactive, integrative health approaches
 - Not diagnosis or disease based
3. **Medical Care**-VA or community, or both
 - PACT, specialty clinics, etc.
 - Includes: healing environments, healing relationship, complementary and integrative health approaches, personal health planning



Reducing Barriers to High Quality Mental Health Care



- Recent research finds that the quality of VHA treatment of mental health problems surpasses that available in the community.
<http://ps.psychiatryonline.org/doi/10.1176/appi.ps.201400537>
- VHA has integrated mental health services into primary care and other settings to minimize barriers to care. In FY15 VHA provided over 1.09M visits in primary care settings, an increase of 8% from FY14.
- In September 2015, VHA surpassed 1.8M encounters in providing telemental Health services, expanding its role as a world leader in telehealth and telemental health services, including services provided directly into the Veteran's home.
- Mobile apps such as PTSD Coach (developed by VA in collaboration with DoD's T2), online resources such as www.MakeTheConnection.net, and web-based self-help courses enhance access and engagement.



Improving Access to VA Mental Health Services



- VA provided MH treatment to more than 1.6M Veterans in FY15 and the demand is growing exponentially
- On average, VA completes more than 500,000 mental health appointments every month with an average wait time of 3 days from the preferred date.
- This rate of increase is more than three times that seen in the overall number of VA users
- Between FY05 and FY15, the number of Veterans who received mental health care from VA grew by 80 percent
- In 2005, 19 percent of VA users used mental health services, and in 2015, the figure was 28 percent
- In response to the growing demand VA has increased mental health staffing, but more is needed to keep pace with the increase in encounters
- All patients newly requesting or referred for VHA mental health services are evaluated within 24 hours by a Licensed Independent Provider to determine the urgency of the need for care

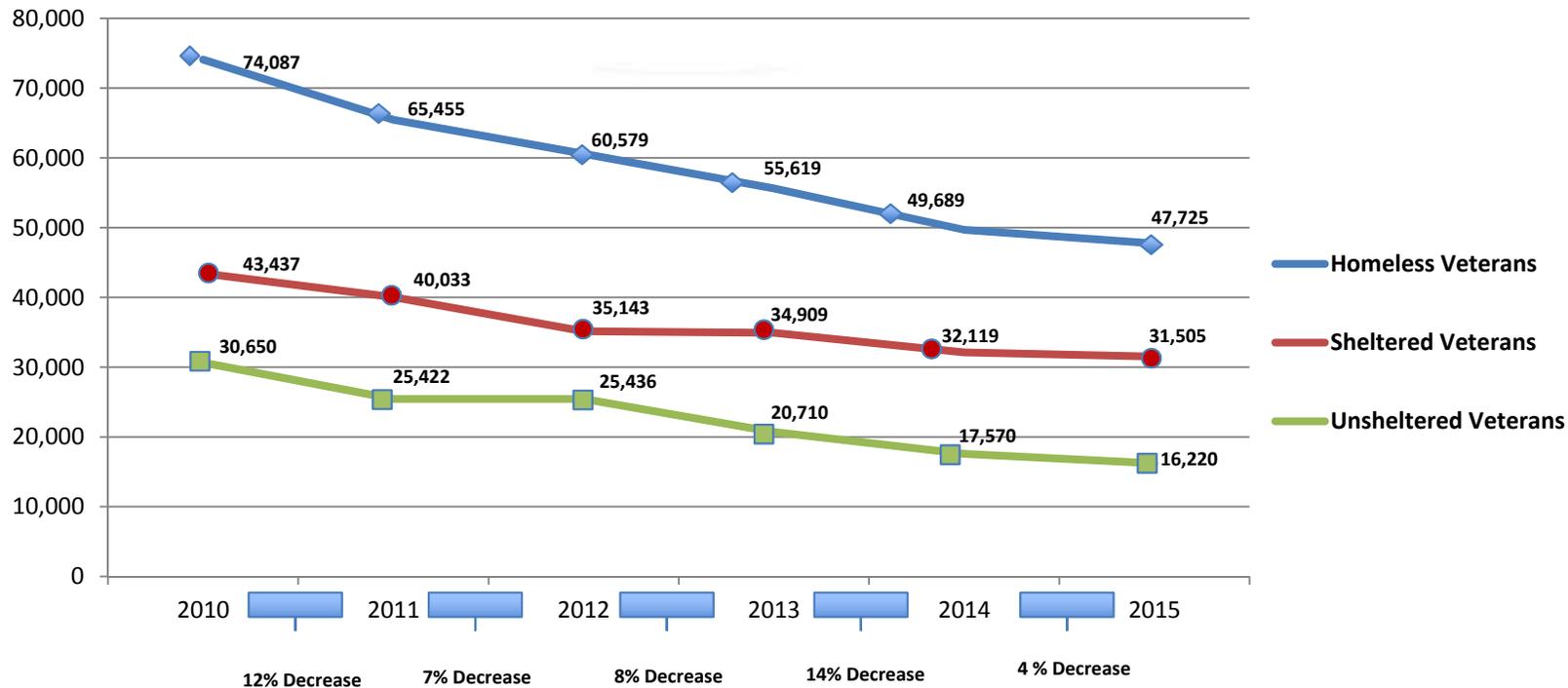
VA is committed to providing Veterans with access to high quality mental health care in the time, place, and manner that are needed



Reducing Veteran Homelessness through Delivery of Integrated Healthcare and Supportive Services



◆ Total Homeless Veterans ● Sheltered Veterans ■ Unsheltered Veterans



36%
Decrease
from 2010
to 2015

27%
Decrease
from 2010
to 2015

47%
Decrease
from 2010
to 2015

The 2015 Annual Homeless Assessment Report was released November 19, 2015. Veteran homelessness has declined by 36 percent between 2010 and January 2015, with unsheltered homelessness among Veterans decreasing by 50 percent. Several communities have ended Veteran homelessness, and we expect other communities across the country to follow. For continued progress and achieving the goal, we must sustain the right systems and resources.



Transforming VA Health Care



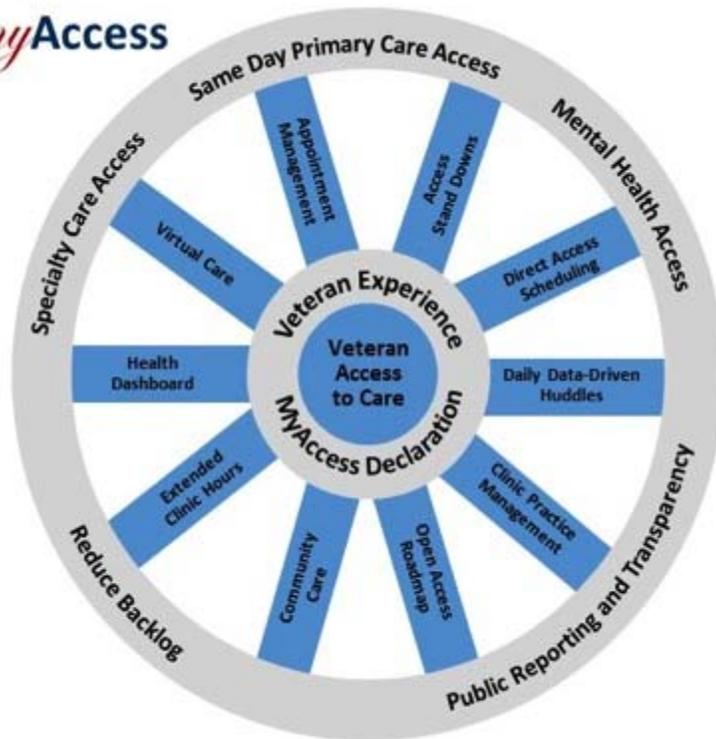
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MyVA Access Conceptual View



myAccess



- Goal is to provide same day access to primary care by December 2016 (defined as ability of facility to address Veteran's clinical needs the day s/he calls or visits a VHA Medical Center)
- Central to this vision is commitment to enhanced access and a consistent set of expectations regarding what a Veteran deserves when s/he enters any VHA facility
- Spokes of the wheel represent enabling practices, activities, and programs that enhance access



Providing Timely Access to Care by Need



One-day “**Access stand-downs**” — simultaneously in all VA Medical Centers — to meet urgent-care needs of patients and ensure Veterans at greatest risk seen first.

Focus:

- Pending appointments more than 30 days from a Veteran’s preferred date
- Electronic Wait List entries older than 7 days from the “create date”

Standardized Reports:

- ‘Locked Down’ List, Pending Appointments: Over 30 days in Level 1 clinics
- ‘Real Time’ Data, Pending Appointments: Over 30 days in Level 1 clinics
- ‘Locked Down’ List, EWL: Great than 7 days for Level 1 clinics
- ‘Real Time’ Data, EWL: Greater than 7 days for Level 1 clinics

***April 14, 2016 Case Study in NEJM Catalyst - <http://catalyst.nejm.org/va-stand-down-resolved-56000-plus-urgent-care-consults/>**



Access Stand Downs



Stand Down Preparations

Data	Goals	Process
<ul style="list-style-type: none"> • Pending appointments • Electronic Waiting List 	<ul style="list-style-type: none"> • Assess pending appointments • Reduce EWL • Review Choice list from TPA and determine if Veteran should be brought back for VACIC • Focus on Process Improvement 	<ul style="list-style-type: none"> • Data availability • Educational support • Facility data review and classification • Tracking Tool • Facility contact and assessment • Lean Forward

'Day of' Activities

Facilities	VACO
<ul style="list-style-type: none"> • Contact Veterans as needed • Open Clinics • Reduce waitlists • Review Choice list from TPA and determine if a duplicate appointment should be cancelled; additional information needs to be provided; care should be provided through VACIC • Local Stakeholder Engagement • Focus on Process Improvement 	<ul style="list-style-type: none"> • VACO Staff Traveling to High Volume Sites to Assist with Stand Down Effort • VACO will be operating an Operations Center to Monitor Events and Track Progress throughout the day



February 27 Access Stand Down

Identified 81,000 Veterans identified as waiting more than 30 days for a pending appointment in a Level 1 (most urgent) clinics:

- 93% assessed by February 27
- 99% assessed by March 15

Identified 3,319 patients waiting more than 7 days on the Electronic Wait List (EWL) for an appointment in a Level 1 clinic:

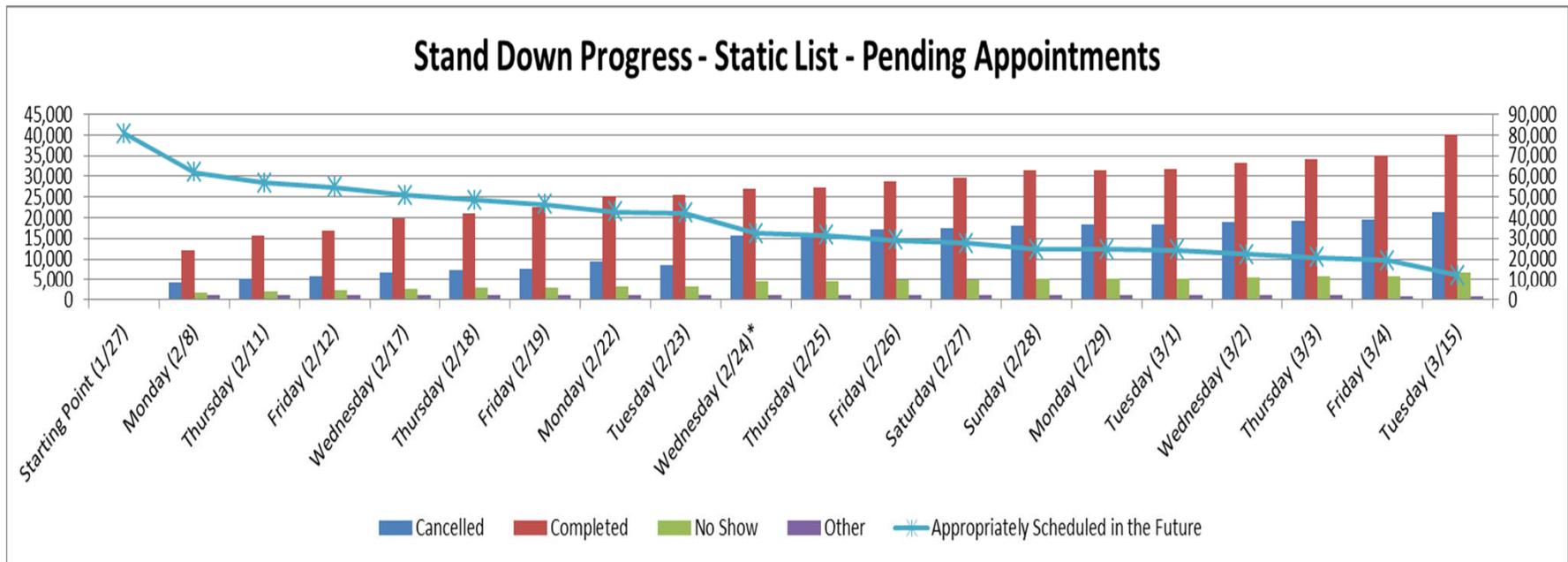
- 80% given an appointment immediately
- 83% given an appointment by March 15



Access Stand Down Results



VA has taken action on 99% of the original 81,000 pending appointments identified in the Stand Down Population.



	Cancelled	Completed	No Show	Other	Appropriately Scheduled in the Future
Starting Point (1/27)	0	0	0	0	80,810
Thursday (3/15)	21,225	40,116	6,743	711	12,015



Access Stand Down “Key Takeaways”



1. When access to care becomes a systemic problem, it is critical to identify and address the highest-priority needs of patients first.
2. Communicating expectations and objectives to leadership and staff is essential to success, and every staff member must understand his or her role in achieving it.
3. Systemic problems require the development and implementation of new processes that will sustain success and prevent problems from recurring in the future.
4. Stand Downs, which address significant organizational needs, followed by system improvements, should be considered as tools to address both short-term and long-term objectives.



Prioritizing Clinical Needs



*my*VAaccess Declaration

We aspire to provide access to care
based on the following core principles:

- ★ Provide timely care, including same day services in Primary Care, as needed
- ★ Provide timely Mental Health care, including same day services, as needed
- ★ Provide Veterans medically necessary care from another VA Medical Center, while away from their primary facility
- ★ Respond to routine clinical inquiries within 2 business days
- ★ Offer appointments and other follow-up options upon leaving clinic
- ★ Actively engage Veterans for timely follow-up if a clinic is canceled due to unforeseen circumstances
- ★ Integrate community providers as appropriate to enhance access
- ★ Offer Veterans extended clinic hours, and/or virtual care options, such as Telehealth, when appropriate
- ★ Transparently report access to care data to Veterans and the public

We the undersigned dedicate ourselves to pursuing the above principles:



U.S. Department
of Veterans Affairs





Deployment of New Model of Access



Deployment strategy:

- Systems engineers will be deployed to sites with greatest access need.
- Two champions from every facility are initiating projects to achieve Declaration items.
- Projects will include best practices already in place throughout system.

Denver conference, April 13-14:

- 472 attendees – systems engineers, facility champions
- Goal: Launch deployment of sustainable access changes
- Workshops on all solutions and best practices



New Access Measurements



“I think as we move forward, what we're going to find is that average wait times are a very poor gauge for timeliness of care for a large, integrated health system. You don't really find that out in the private sector.

That's one of the reasons we're boosting our patient satisfaction measurement activities, because I think patient satisfaction is going to become central. Even at a 14-day standard, if the veteran needs to be seen today, we've failed that veteran.”

Deputy Secretary Sloan Gibson
Senate Veterans' Affairs Committee
July, 16, 2014



Measuring Veteran Satisfaction



- Veteran satisfaction is now our principal index for assessing access.
- Veterans typically access the VetLink kiosk at the beginning of their visit, so we have added an access-related question:

"How satisfied are you that you got today's appointment when you wanted it?"

Completely Satisfied

Satisfied

Neutral

Dissatisfied

Completely Dissatisfied



VetLink Access Results



126,130 responses submitted from 08/31/15 to 09/04/15:

Completely Satisfied or Satisfied	89.1%
Neutral	7.8%
Dissatisfied or Completely Dissatisfied	3.0%

172, 632 responses submitted from 10/26/15 to 10/30/15:

Completely Satisfied or Satisfied	89.0%
Neutral	8.0%
Dissatisfied or Completely Dissatisfied	3.0%

177,910 responses submitted from 12/14/15 to 12/18/15:

Completely Satisfied or Satisfied	89.4%
Neutral	7.8%
Dissatisfied or Completely Dissatisfied	2.7%



Survey of Health Experience of Patients (SHEP)

- Administered and analyzed by an independent contractor
- Based on industry-standard Consumer Assessment of Health Providers and Systems (CAHPS), allowing benchmarking with private sector
- 120,000 surveys distributed each month by mail and online
- 40% response rate
- SHEP/CAHPS Access questions:

Q6 : In the last 6 months, when you phoned this provider's office to get an appointment for care you needed right away, *how often did you get an appointment as soon as you needed?*

Q9 : In the last 6 months, when you made an appointment for a check-up or **routine care** with this provider, *how often did you get an appointment as soon as you needed?*



What Veterans tell us about their experience



	VA vs. Private Sector (Adjusted for age, education, and health status)
Private Sector (CAHPS Composite)	
Access (based on % always getting care when needed)	6 points <i>lower</i> than private sector
Communication	About the same
Provider Discusses Medical Decisions	About the same
Self-Management Support	About the same
Comprehensiveness (attending to mental and emotional health as well as physical health)	6 points <i>higher</i> than private sector
Office Staff	About the same

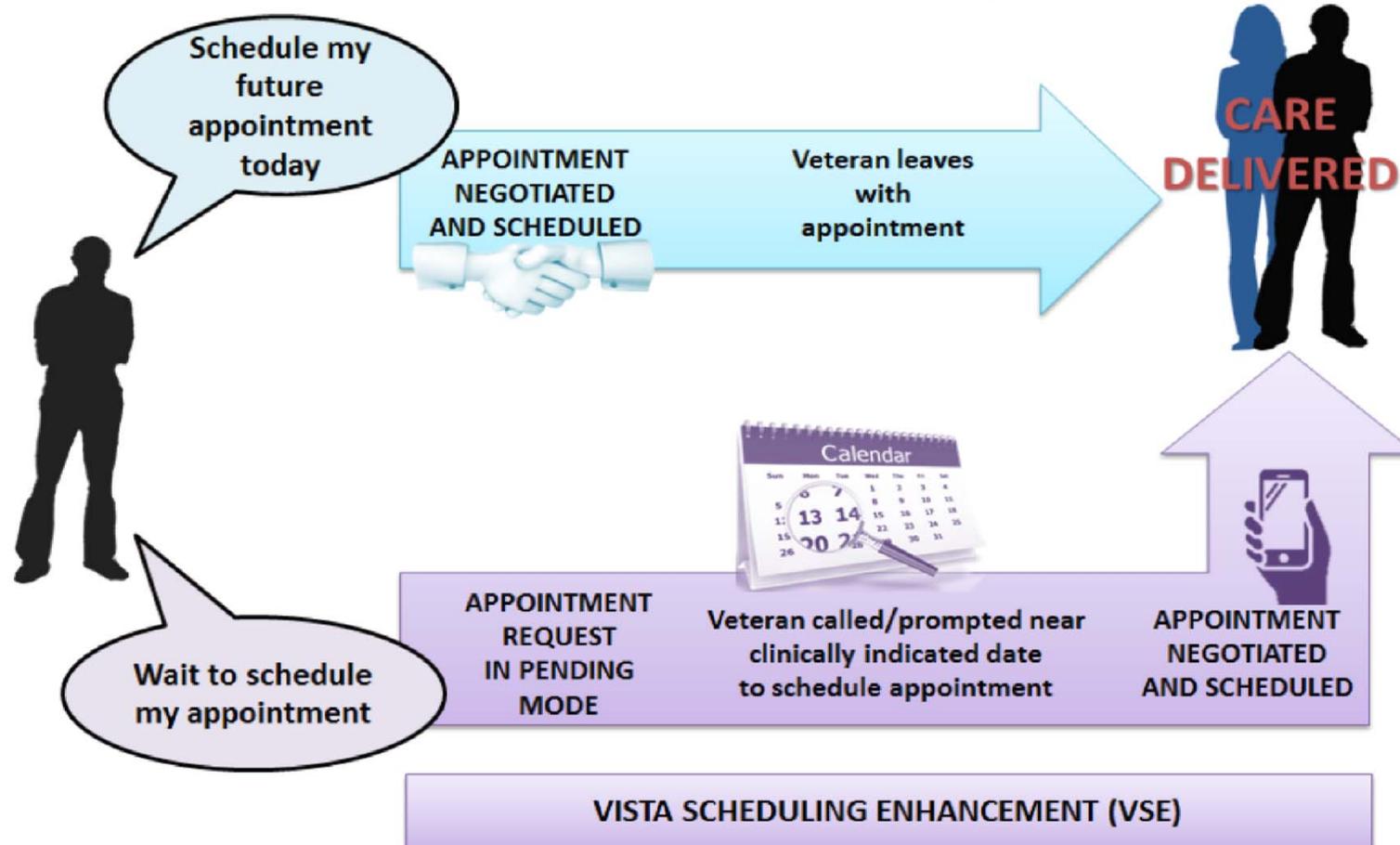
Source: Survey of Health Experiences of Patients (SHEP) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) benchmarking database



“Patient Centered” Scheduling



PATIENT-CENTERED APPOINTMENT REQUEST PROCESS





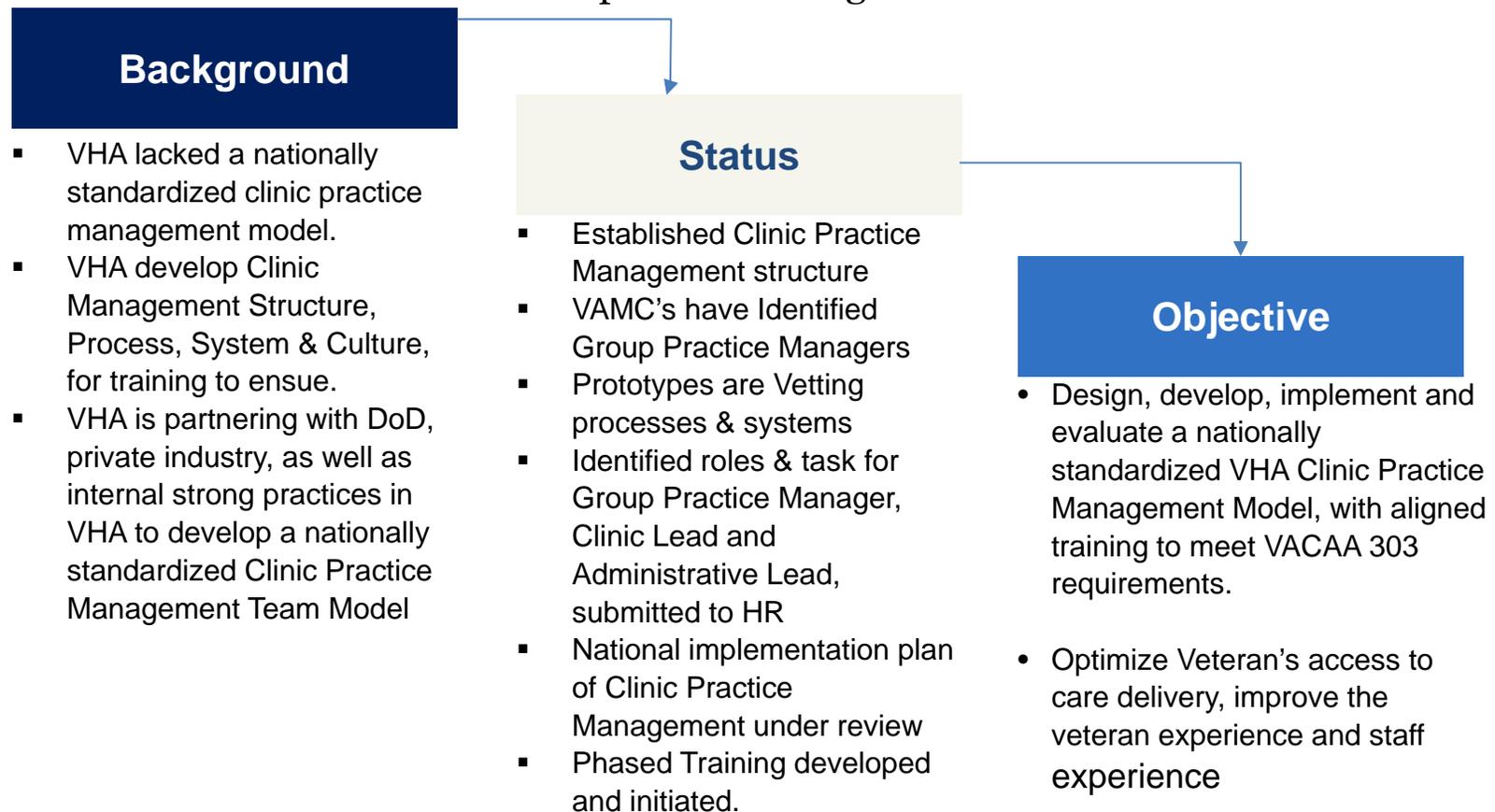
Increasing Access and Improving the Veteran Experience

Group Practice Managers



OVERVIEW

Commence role-specific clinic management training program, to provide in-person, standardized education on systems and processes for health care practice management





Audiology & Optometry Direct Scheduling



Practice Originated at Bay Pines VA Healthcare System Will be adapted and implemented at all facilities

Problem Statement:

- Scheduling bottleneck caused by a cumbersome and bureaucratic process for Audiometric and Optometric services.
- Complex and redundant scheduling caused frustrated employees and was a barrier to access.



Practice Summary:

- Implemented direct scheduling process that eliminated redundant consultations and consolidated clinic profiles.
- Standardized communications with HAS to eliminate scheduling confusion and delays.

Benefit:

- Reduced wait times for Audiology and Optometry appointments
- Increased Veteran access to care
- In-process national rollout which will result in increased access to care across VHA



Medical Support Assistants (MSAs)



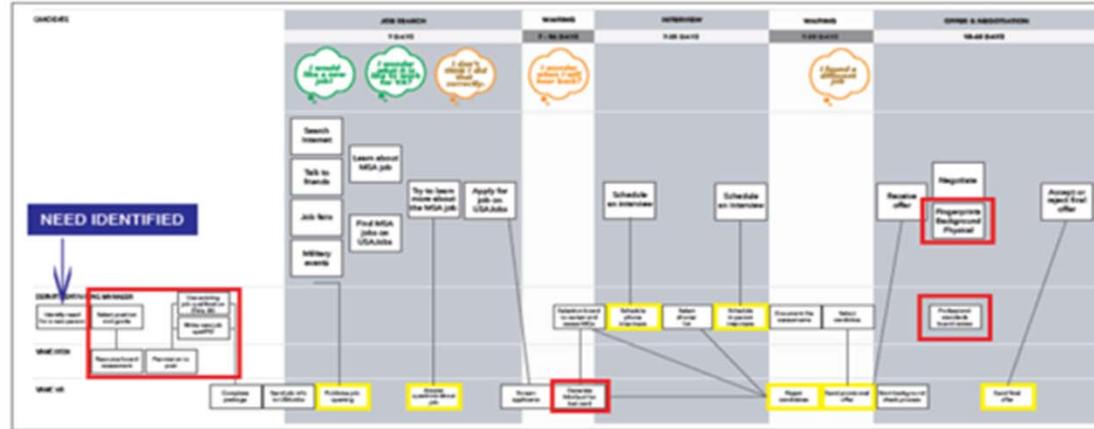
- 1. Hire Right, Hire Fast:** Speed up hiring of MSAs to within 30 days using standardized assessments of applicants' customer-service aptitude.
- 2. Standardized Onboarding:** Provide new MSAs standardized two-week onboarding and hands-on training in systems and customer service.
- 3. Vista Scheduling Enhancements & Own the Moment:** Support existing MSAs with training on a better scheduling tool, Vista Scheduling Enhancements, and on Veterans Experience "Own the Moment" principles.



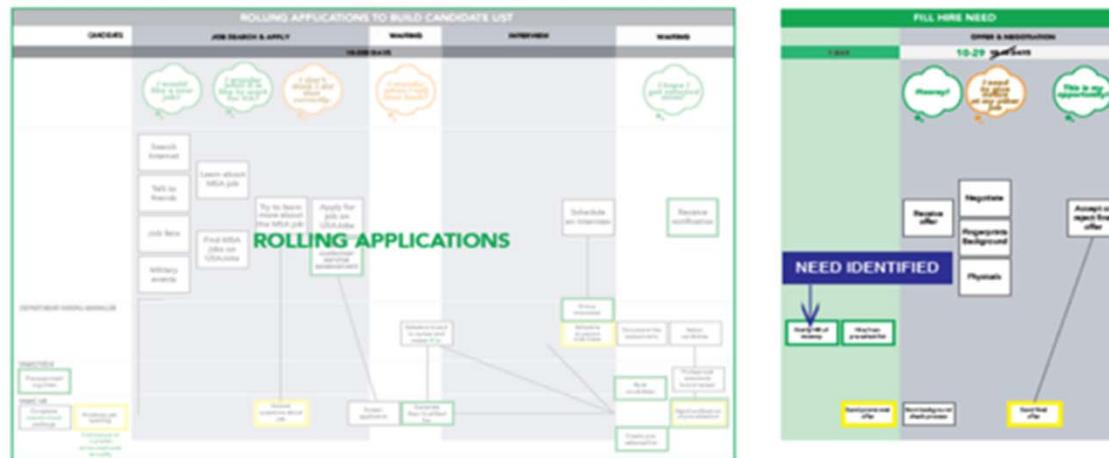
MSAs: *Hire Right, Hire Fast*



**CURRENT
TIME TO HIRE:
4-6
MONTHS**



**NEW
TIME TO HIRE:
30 DAYS**



WORKING DRAFT, PRE-DECISIONAL, DELIBERATIVE DOCUMENT

July to December implementation in all VAMCs

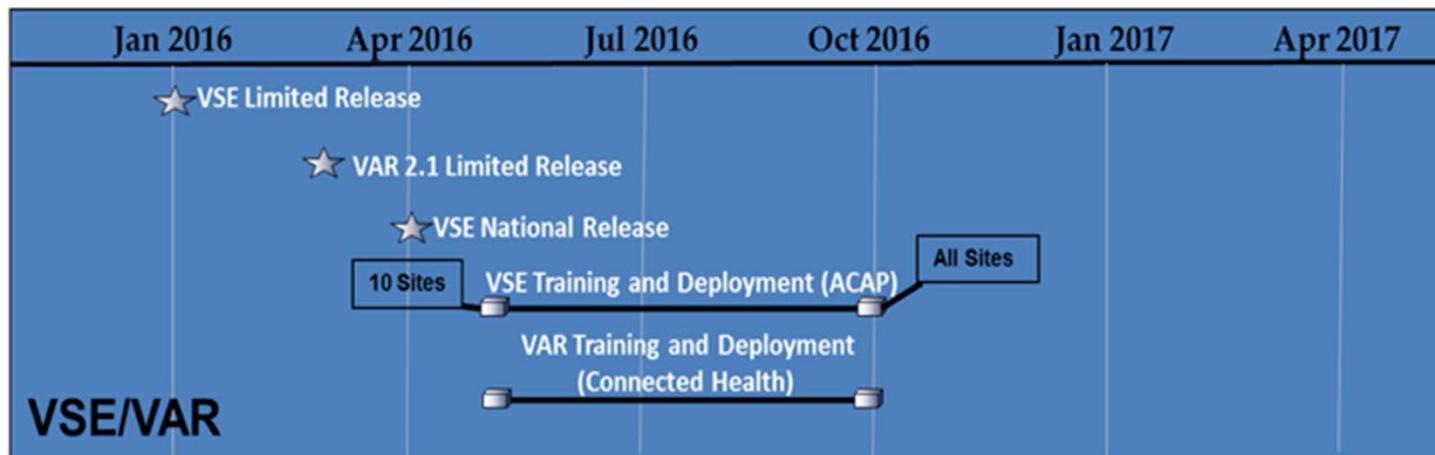


Mobile Scheduling App



Veteran Appointment Request (VAR)

- Enables Veterans to view, schedule, track, and cancel primary care and mental health appointments
- Piloted at 4 locations in 2015 — positive feedback from the overwhelming majority of Veterans
- Field testing by 7,000 Veterans in West Haven, CT, scheduled for May
- Expected to be available to all Veterans by end of 2016





Demo of Veterans Appointment Request by Dr. Neil Evans



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Increasing Physician Productivity



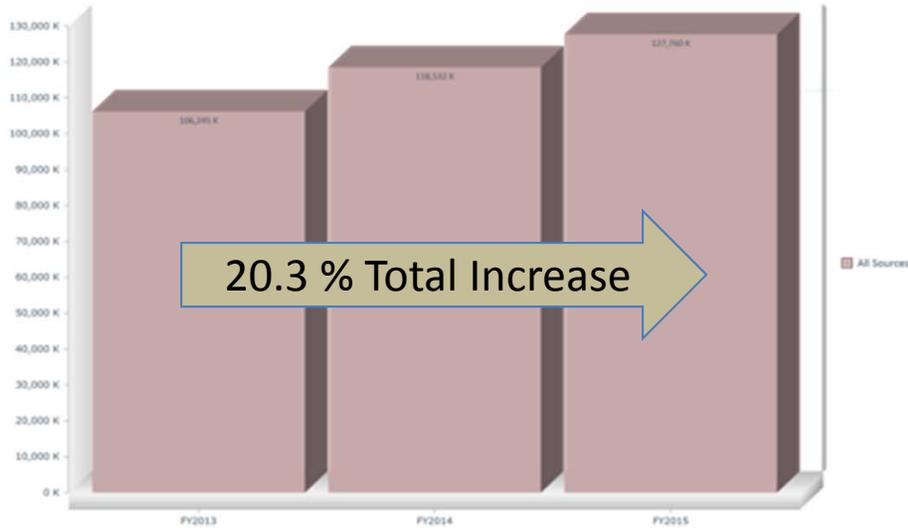
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Physician Productivity by Pay Period (2 weeks)

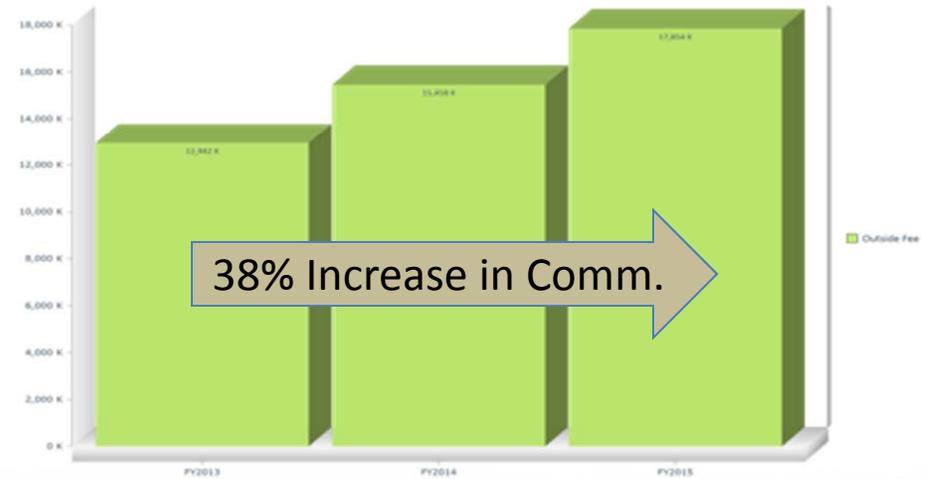
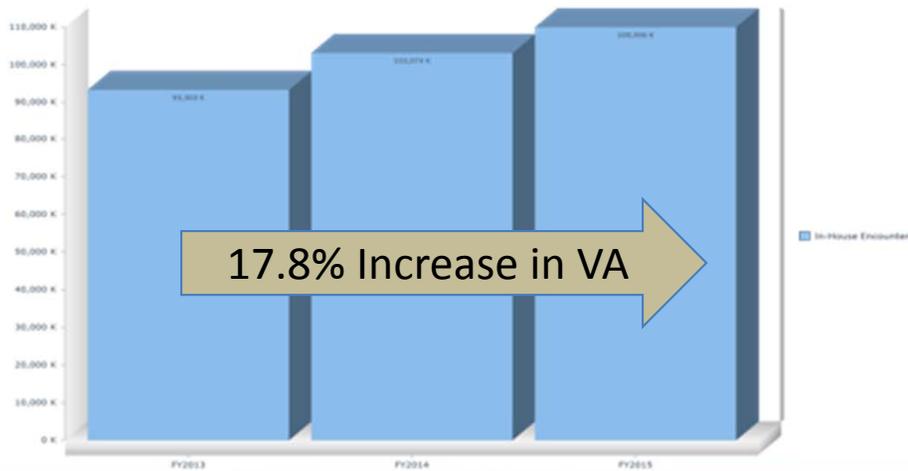
Productivity = wRVU/Clinical FTE	Average <u>Per</u> Pay Period (2 Weeks) Productivity			
	FY 14 (26 PP)	FY 15 (26 PP)	Most Recent	% Change
			40 PP's = 18 Mths	Most Recent vs. FY 14
Allergy and Immunology	111	116	119	6%
Cardiology	227	250	249	10%
Chiropractic	114	120	119	4%
Critical Care / Pulmonary Disease	189	210	206	9%
Dermatology	301	307	306	2%
Endocrinology	119	134	134	13%
Gastroenterology	268	284	280	4%
Geriatric Medicine	87	93	93	6%
Hematology-Oncology	130	149	148	14%
Infectious Disease	113	133	132	17%
Internal Medicine	102	107	106	4%
Nephrology	230	229	227	-2%
Neurological Surgery	174	188	188	8%
Neurology	130	148	146	13%
Obstetrics & Gynecology	105	108	107	2%
Ophthalmology	288	300	295	3%
Optometry	175	200	199	14%
Orthopaedic Surgery	184	195	194	6%
Otolaryngology	192	209	206	8%
Pain Medicine	118	133	136	15%
Pathology	159	175	174	10%
Physical Medicine & Rehabilitation	114	126	125	10%
Plastic Surgery	158	159	157	0%
Podiatry	158	177	176	11%
Psychiatry	128	144	144	12%
Psychology	79	86	86	9%
Radiology	205	218	219	7%
Rheumatology	123	137	137	11%
Surgery	158	167	164	4%
Thoracic Surgery	176	198	195	11%
Urology	191	208	207	8%
Vascular Surgery	215	238	231	7%



Annual clinical work has significantly increased over the last 3 years – inside and outside VA



Fiscal Year	Source of Care	Unique Patients	Work RVU	Work RVU Per Unique
FY2013	All Sources	5,909,270	106,244,945.63	17.98
	In-House Encounter	5,876,933	93,303,220.64	15.88
	Outside Fee	1,021,609	12,941,724.99	12.67
FY2014	All Sources	6,022,280	118,532,087.21	19.68
	In-House Encounter	5,980,739	103,074,259.84	17.23
	Outside Fee	1,215,349	15,457,827.37	12.72
FY2015	All Sources	6,128,303	127,759,981.90	20.85
	In-House Encounter	6,069,142	109,905,782.36	18.11
	Outside Fee	1,361,260	17,854,199.54	13.12
Growth Percentage(FY13_14)	All Sources	1.9%	11.6%	9.5%
	In-House Encounter	1.8%	10.5%	8.6%
	Outside Fee	19.0%	19.4%	0.4%
Growth Percentage(FY14_15)	All Sources	1.8%	7.8%	5.9%
	In-House Encounter	1.5%	6.6%	5.1%
	Outside Fee	12.0%	15.5%	3.1%
Growth Percentage(FY13_15)	All Sources	3.7%	20.3%	16.0%
	In-House Encounter	3.3%	17.8%	14.1%
	Outside Fee	33.2%	38.0%	3.5%





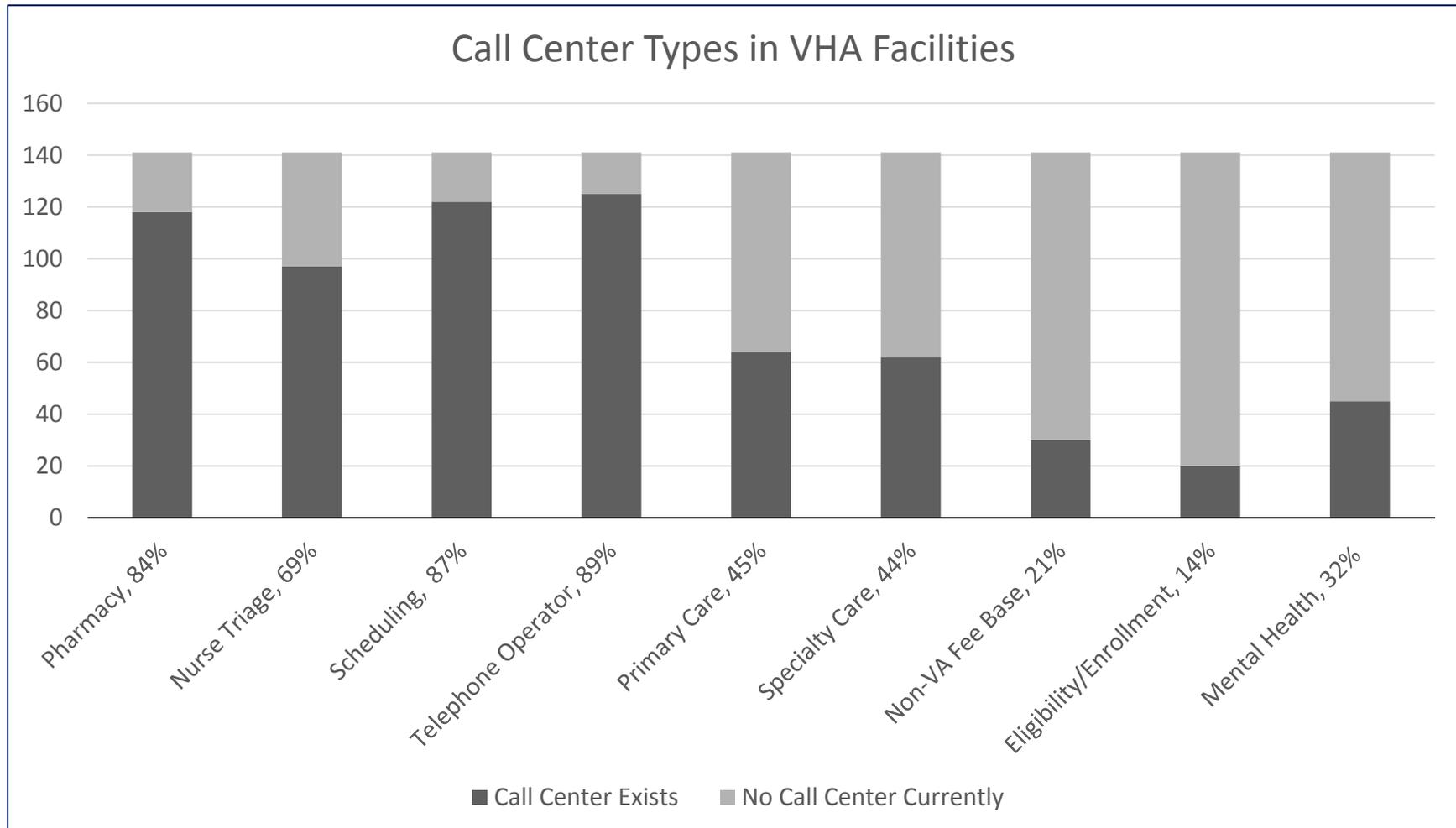
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VHA Call Centers



* Data is as of 3/25/2016 survey and phone validation data



Call Center Performance Dashboard

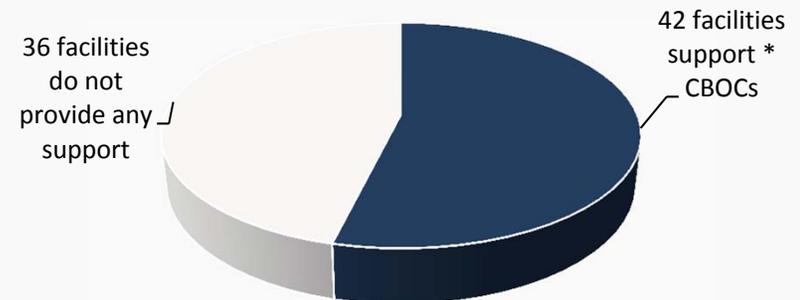


VAMC STATUS:

VAMCs with 4 critical call centers	78
VAMCs with 3 critical call centers	36
VAMCs with 2 critical call centers	18
VAMCs with 1 critical call center	6

Critical Call Centers: Telephone Operator, Scheduling, Pharmacy and Daytime Nurse Triage

54% of VAMCs with the four critical call centers currently support* some or all of their CBOCs



*Some level of service to some of the CBOCs

Critical Call Centers GAPS (GOAL = 0) — # of facilities lacking specific critical call



The objective of the Performance Dashboard is to track progress toward ensuring that every VAMC offers four critical call-center services, incrementally providing support for affiliated CBOCs.



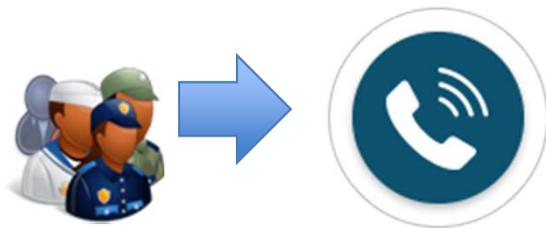
Call Center Modernization



An Enterprise Contact Center platform

- revamping the multi-center contact model
- launching a single access point for Veterans
- while improving existing call centers by phases

Phase 1: Federated



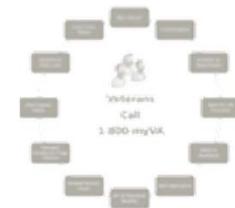
Leverage existing solutions and establish a federated call center

Phase 2: Standardized



Standardize call center operations - metrics and measurements

Phase 3 and 4: Optimized



Establish and maintain an integrated framework allowing VA Customers to reliably access and obtain authoritative and uniform information of VA benefits and services



Increasing Responsiveness at Contact Centers



- Increased staffing in the HRC to meet inbound call activity.
- Local VAMC call-center improvements focused on scheduling, nurse triage, pharmacy, and operator capabilities.
- All medical centers to be supported by a contact center covering as a minimum:
 - Scheduling
 - Pharmacy
 - Operator
 - Nurse Triage
- WHEN (Weekends, Holidays, Evenings, and Nights) service currently exists for all Veterans, provided by 12 centers covering all of VHA.
 - After normal business hours, WHEN Nursing triage centers serve as a continuum of care for Veterans.
- Improvements to the Veterans Crisis Line



Transforming VA Health Care



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- Adopting a Veteran-centric “whole health” approach in everything we do
- Changing the way VA thinks about Access – MyVA Access
- Becoming more effective and efficient in our core operations
- Modernizing contact centers to improve access
- **Enhancing management tools to improve Veteran experience and outcomes**
- Leveraging scale to share best practices across the VA network
- Modernizing and better leveraging technology, to include EHR
- Overhauling the health care enrollment process
- Boosting staffing levels – leadership and clinical
- Leveraging our scale to build a world class end-to-end supply chain
- Streamlining care in the community and developing an integrated provider-payer system



Management Tools Improving Outcomes & the Veteran Experience



- Strategic Analytics for Improvement and Learning Value Model (SAIL)
- Early Warning System (EWS) for Monitoring Facility Performance
- Productivity Tools
- Healthcare Operations Dashboard



Management Tools Improving Outcomes & the Veteran Experience



Strategic Analytics for Improvement and Learning (SAIL)

- SAIL is an internal learning tool that provides meaningful, actionable information about improvement opportunities at every VAMC.
- Web-based balanced scorecard model
- Measures, evaluates, and benchmarks quality and efficiency
- Data updated quarterly and partly daily
- Offers high-level views of healthcare quality and efficiency
- Enables executives and managers to examine a wide range of existing VA measures
- Deployed on VA intranet in July 2012
- Published SAIL Scorecard table on “VA Quality of Care” website in January 2015



How Is SAIL Data Used?



- Measure both relative performance and absolute improvement
- Benchmark both VA and non-VA hospitals
- Spotlight successful strategies of VA's top performers
- Offer custom views of data to help pinpoint strengths and opportunities for improvement
- Facilitate sharing of strong practices for high-quality, efficient healthcare across VA systems
- Goal-setting calculator to set staged goals for improvement
- Trigger systems to alert users to declines in performance
- Sustainable Accountability: SAIL outcomes are included in every VAMC Director's performance evaluation.



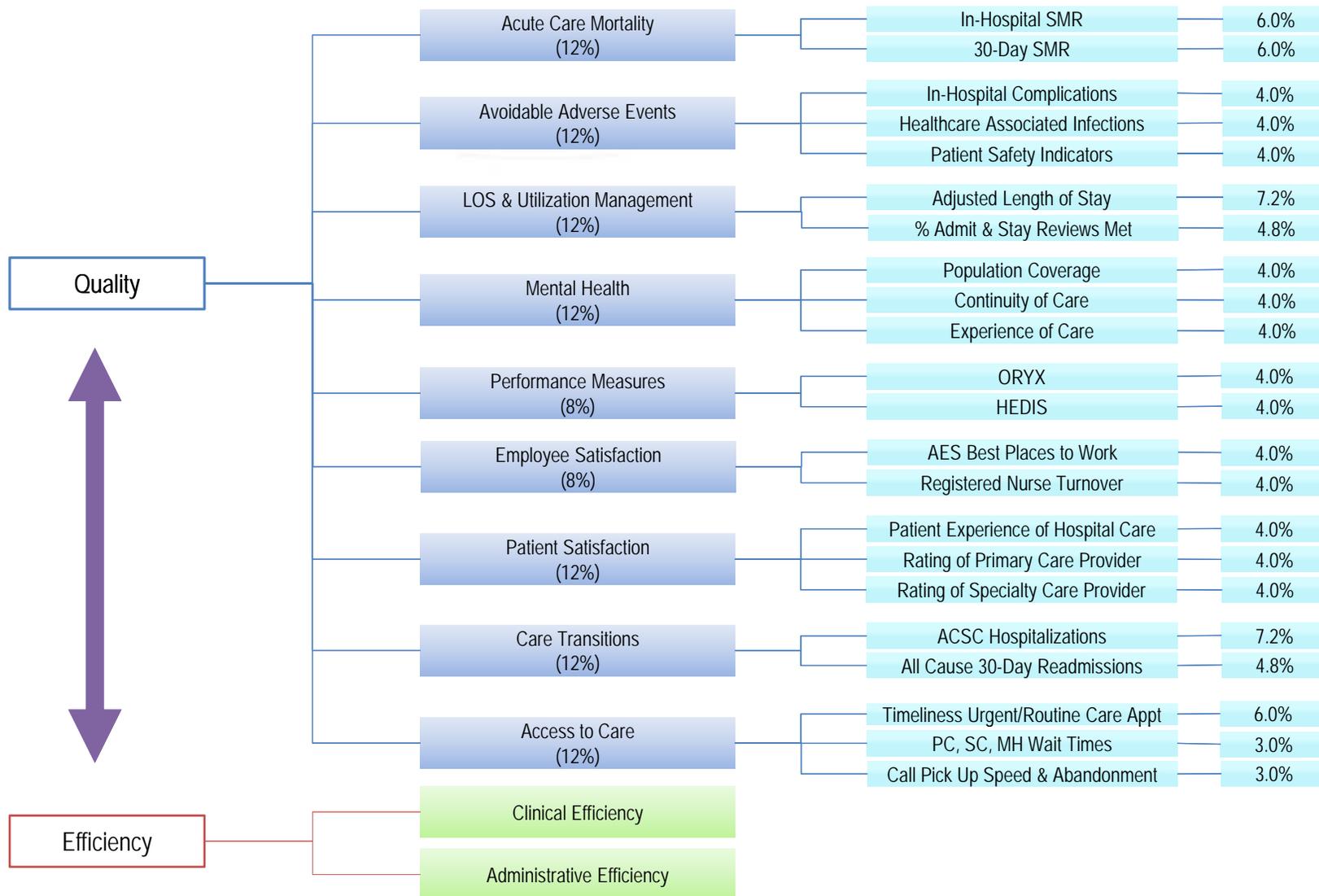
What Exactly Does SAIL do?



- Collects data from VA's 128 acute inpatient medical or surgical care VAMCs, and sorts it into five comparison groups based on VA standards for hospital complexity level and intensive care unit level
- Adds data from 18 facilities without acute inpatient medical or surgical care (Ambulatory Care Centers, Rehabilitation Centers, and Outpatient VAMCs) to allow benchmarking on available measures
- Assesses 27 quality measures in areas such as mortality, complications, and patient & employee satisfaction, which are organized into nine domains
- Includes an efficiency domain to assess overall efficiency
- Draws data from existing measures prepared by VHA Program Offices and VA national databases
- Provides a composite 1-to-5 star rating for each VAMC in overall quality

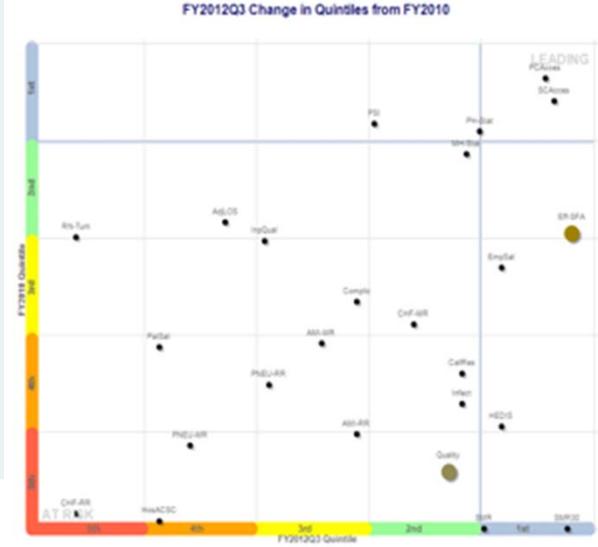
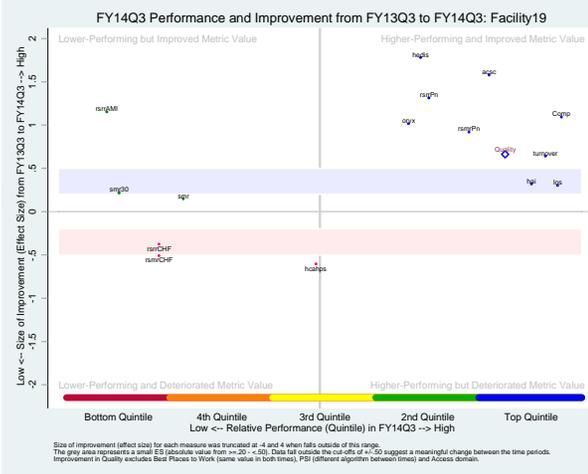
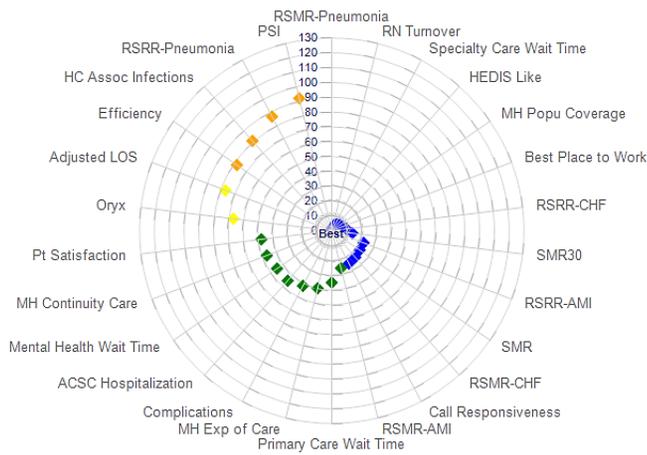


What Exactly Does SAIL measure?





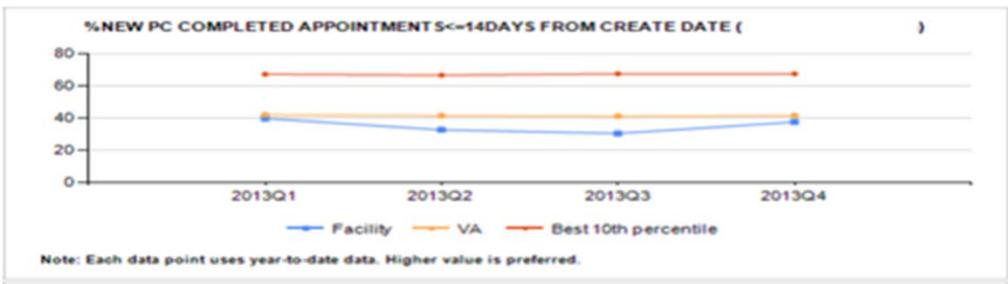
Visual Analytics



VA Metric	Weight (%)	Domain	Facility Names																				
Adjusted LOS	10	LOS																					
Compliance	10	Compliance																					
Efficiency	10	Efficiency																					
ACSC Hospitalization	8.07	ACSC/Health Status																					
HC Assoc Infections	5	HAQPI																					
OSD	5	Performance Resources																					
OGX	5	Performance Resources																					
PSI	5	HAQPI																					
SMR	5	Acute Care Mortality																					
SMR2	5	Acute Care Mortality																					
Employee Satisfaction	3.3	Customer Satisfaction																					
PH Satisfaction	3.3	Customer Satisfaction																					
SM-Turnover	2.5	Customer Satisfaction																					
Call Responsiveness	2.5	Customer Satisfaction																					
Specialty Care Wait Time	2.5	ACSC/Health Status																					
Primary Care Wait Time	2.5	Access																					
OSD-CHF	2.5	OSI RSMR/SMR																					
OSD-Pneumonia	2.5	OSI RSMR/SMR																					
Specialty Care Wait Time	2.5	Access																					
Special Health Status	1.67	ACSC/Health Status																					
Physical Health Status	1.67	ACSC/Health Status																					
OSD-AMI	1.67	OSI RSMR/SMR																					
OSD-CHF	1.67	OSI RSMR/SMR																					
OSD-Pneumonia	1.67	OSI RSMR/SMR																					

Facility Name	Efficiency Score	Efficiency Opportunity	Efficiency Gap	Efficiency Improvement	Efficiency Target	Efficiency Status
Facility 19	1.2	1.5	0.3	0.2	1.5	Improvement
Facility 20	1.1	1.4	0.3	0.1	1.4	Improvement
Facility 21	1.0	1.3	0.3	0.0	1.3	Improvement

Metric	Fac A	% Improvement	% Difference	Notes
Acute Care Mortality	0.21	0.22	-0.01	Lower acute mortality
Employee Satisfaction	0.85	0.86	-0.01	Higher employee satisfaction
Specialty Care Wait Time	1.5	1.4	0.1	Lower specialty care wait time
Primary Care Wait Time	2.5	2.4	0.1	Lower primary care wait time
OSD-CHF	2.5	2.4	0.1	Lower OSD-CHF
OSD-Pneumonia	2.5	2.4	0.1	Lower OSD-Pneumonia
Specialty Care Wait Time	2.5	2.4	0.1	Lower specialty care wait time
Physical Health Status	1.67	1.66	0.01	Higher physical health status
OSD-AMI	1.67	1.66	0.01	Lower OSD-AMI
OSD-CHF	1.67	1.66	0.01	Lower OSD-CHF
OSD-Pneumonia	1.67	1.66	0.01	Lower OSD-Pneumonia





Benchmarking Top Performance



Measure	Measure Unit	Preferred Direction	Facility	Benchmark	10th-50th-90th ptile
Acute care mortality					
1. Acute care Standardized Mortality Ratio (SMR)	O/E	↓	0.659	0.389	0.389 - 0.841 - 1.199
2. Acute care 30-day Standardized Mortality Ratio (SMR30)	O/E	↓	0.791	0.717	0.717 - 0.965 - 1.158
a. AMI RSMR	%	↓	8.726	8.155	8.155 - 9.141 - 10.394
b. CHF RSMR	%	↓	7.507	6.311	6.311 - 7.661 - 9.636
c. Pneumonia RSMR	%	↓	7.565	7.53	7.530 - 8.579 - 9.879
Avoidable adverse events					
1. In-hospital complications	O/E	↓	0.955	0.644	0.644 - 0.981 - 1.462
2. Healthcare associated infections (HAI)					
a. Catheter associated urinary tract infection	inf/1k device days	↓	1.042	0.000	0.000 - 0.943 - 2.123
b. Central line associated bloodstream infection	inf/1k device days	↓	1.301	0.000	0.000 - 0.532 - 1.920
c. Ventilator associated events	events/1k device days	↓	6.897	0.000	0.000 - 2.375 - 11.785
d. Methicillin-resistant Staphylococcus aureus (MRSA) infection	inf/1k bed days	↓	0.121	0.000	0.000 - 0.076 - 0.265
3. Patient safety indicator (PSI)	O/E	↓	0.857	0.000	0.000 - 0.736 - 1.294
Length of Stay and Utilization Management					
1. Adjusted length of stay	days	↓	3.708	3.655	3.655 - 4.372 - 5.088
2. Utilization management					
a. Admission reviews met	%	↑	76.541	86.598	58.869 - 73.618 - 86.598
b. Continued stay reviews met	%	↑	73.446	79.316	48.276 - 67.297 - 79.316
Care Transition					
1. Ambulatory Care Sensitive Condition hospitalizations	hosp/1000 pts	↓	23.784	18.867	18.867 - 25.531 - 31.510
2. Hospital-wide 30-day readmission rate	%	↓	12.426	10.561	10.561 - 12.520 - 13.329
a. Cardiorespiratory cohort	%	↓	14.386	11.809	11.809 - 15.085 - 17.012
b. Cardiovascular cohort	%	↓	11.016	5.952	5.952 - 11.232 - 13.719
c. Medicine cohort	%	↓	14.17	12.276	12.276 - 13.787 - 14.765
d. Neurology cohort	%	↓	8.445	3.303	3.303 - 9.298 - 12.504
e. Surgical cohort	%	↓	8.562	6.115	6.115 - 8.839 - 10.238

NOTE: 61 percent of VA medical centers improved quality of care over the past 12 months in areas including: mortality rates, length of stay, ambulatory care sensitive condition hospitalizations, and avoidable re-admissions for congestive heart failure.



Determining “Improvement”



Absolute vs. Relative Improvement

1. Did the hospital improve on the metric but not in the ranking?
2. Did the hospital improve both on the metric and in the ranking?

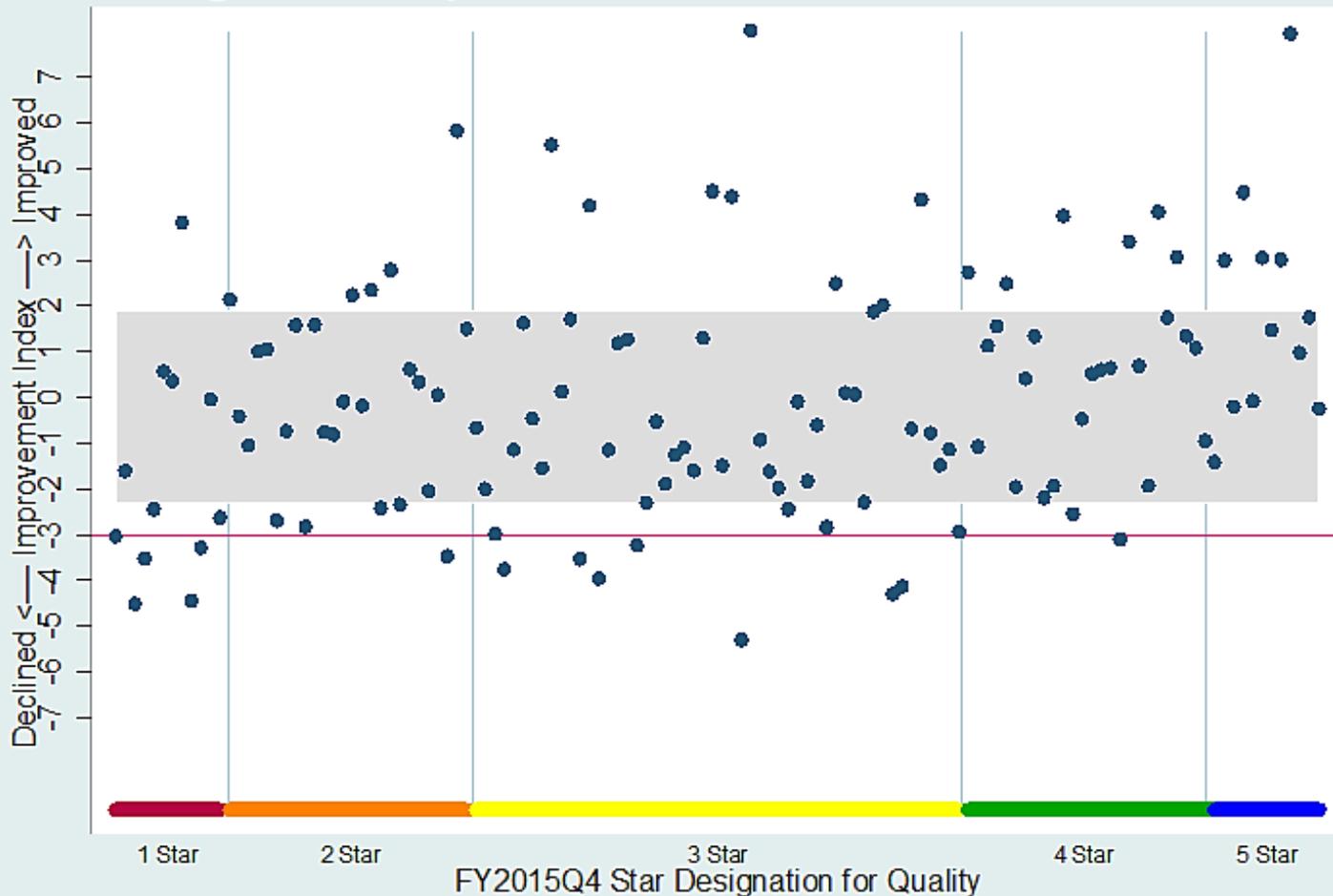
Metric	Rank	Note
+	+	No Question
+	-	You tell me
-	+	You tell me
-	-	Get Involved



Consider Improvement Over Time in Addition to Star Designation



Star Designation vs. Improvement Index: All Facilities FY2014Q4 to FY2015Q4



← Facilities with small change in overall quality; about 60% of facilities

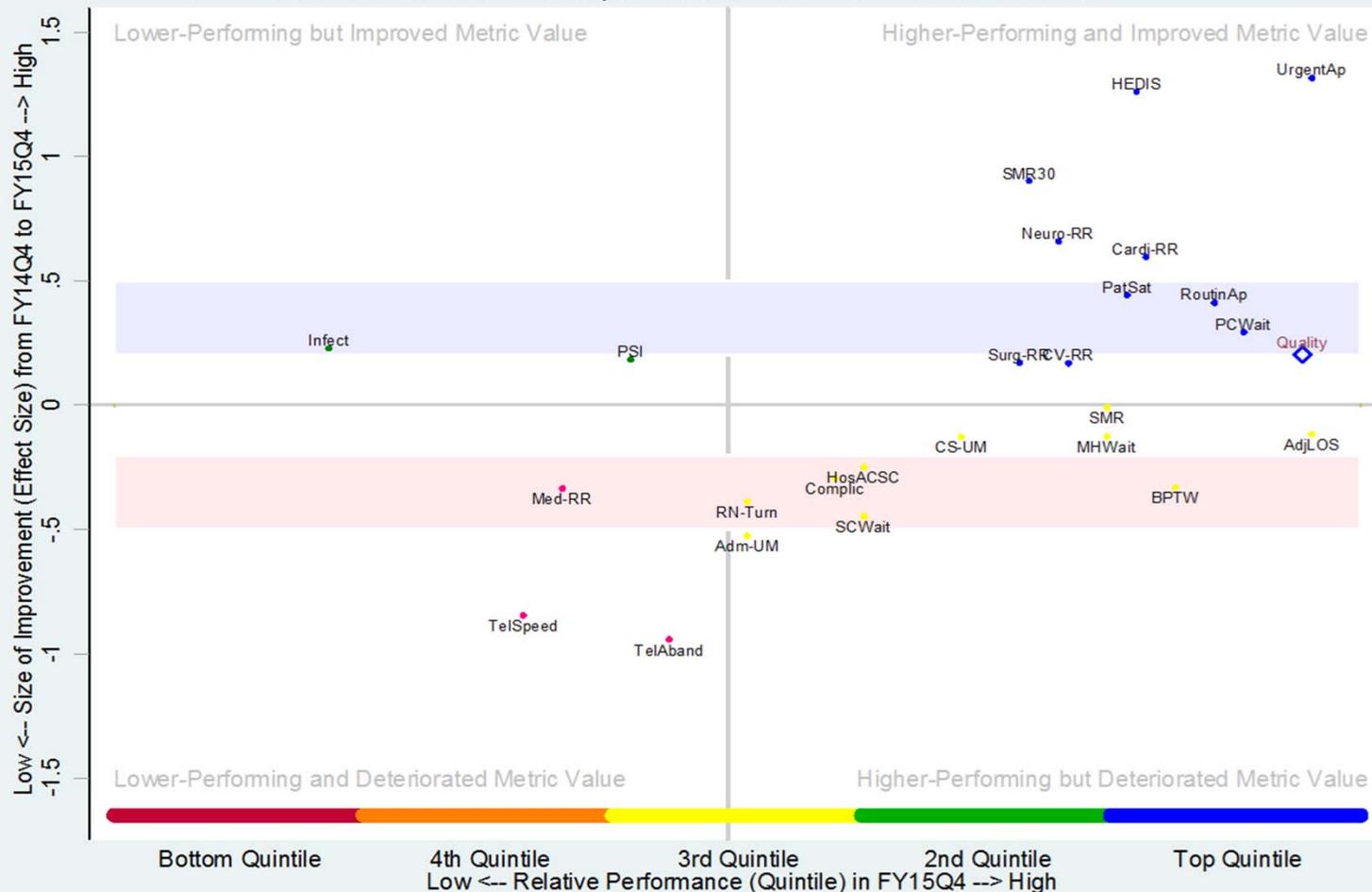
Pink horizontal line: improvement index in the bottom 10%
Improvement Index excluded RSRR (different models) and Mental Health Domain



Degree of Improvement & Relative Performance



FY15Q4 Performance and Improvement from FY14Q4 to FY15Q4



Size of improvement (effect size) for each measure was truncated at -4 and 4 when falls outside of this range. The grey area represents a small ES (absolute value from ≥ 0.20 - < 0.50). Data fall outside the cut-offs of ± 0.50 suggest a meaningful change between the time periods. Prior and current period Best Places to Work score were based on 2014 and 2015 survey data, respectively. Improvement in Quality excludes Mental Health domain.



Comparing VA and Truven



VA out-performs Truven health systems in in-hospital mortality, patient safety events, AMI and CHF 30-day mortality, and length of stay.

FY15Q4	VA	Truven	Difference	% Difference	
Mortality index	0.85	1.00	-0.15	-15.0	lower in-hospital mortality
Complication index ¹	0.98	1.00	0.02	2.0	
Patient safety index	0.75	0.99	-0.14	-14.0	lower patient safety events
CMS AMI 30-day mortality rate ²	14.35	14.60	-0.25		lower AMI 30-day mortality
CMS CHF 30-day mortality rate ²	10.90	11.70	-0.80		lower CHF 30-day mortality
CMS Pneumonia 30-day mortality rate ²	11.50	11.80	-0.30		
CMS AMI 30-day readmission rate ²	18.75	17.80	0.95		higher AMI 30-day readmit rate
CMS CHF 30-day readmission rate ²	23.50	22.70	0.80		higher CHF 30-day readmit rate
CMS Pneumonia 30-day readmission rate ²	18.10	17.50	0.60		higher Pneumonia 30-day readmit rate
Average length of stay	4.40	5.00	-0.60	-12.0	shorter length of stay
Inpatient core measure performance ³	97.98	98.00	-0.02		
Patient perception of hospital care	255.24	262.6	-7.36	-2.8	lower patient perception of care score

Truven peer group health systems are all but the 15 top health systems in the 2015 study. To be comparable, we excluded the top 5% (6 facilities) VA facilities for this comparison.

¹Complication Index: TR based on 47 conditions and VA based on 7 endorsed by NQF and studied on US non-federal acute care hospitals

²CMS RSMR and RSRR based on CMS Hospital Compare measures for FY2014Q3 (July 2011-June 2014)

³ORYX measures are based on AMI, CAP, CHF and SCIP composites

Values are median, highlighted green if VA value is more favorable; highlighted red if Truven's value is more favorable.



Early Warning Systems (EWS)



- **Relative Performance:**
 - Statistical Process Control system for relative performance compared to other VAMCs over time
- **Absolute Improvement:**
 - Change in overall Quality compared to the facility's performance one year ago
- **Soft Data Calculator:**
 - Risk of experiencing system-wide deteriorations based on leadership vacancy, employee turnover and survey data



Stratifying At-Risk and High-Performing Facilities



At Risk

- **High:** All-time low performer OR risk score in the 99th percentile
- **Watch:** Declined and low performing in last year OR risk score in the 90th percentile. (Any medical center in this category with a star rating of 1 is treated as a high risk.)
- **Medium:** Risk score in the 75th percentile

High Performing

- **Outstanding:** All-time high performer with no meaningful decline in absolute index OR praise score in the 99th percentile
- **Excellent:** Improved & high performing in last year OR all-time high performer with meaningful decline in absolute index OR praise score in 90th percentile
- **Good:** Praise score in 75th percentile

NOTE: Percentiles of praise and risk scores are based on distribution of SAIL main facilities



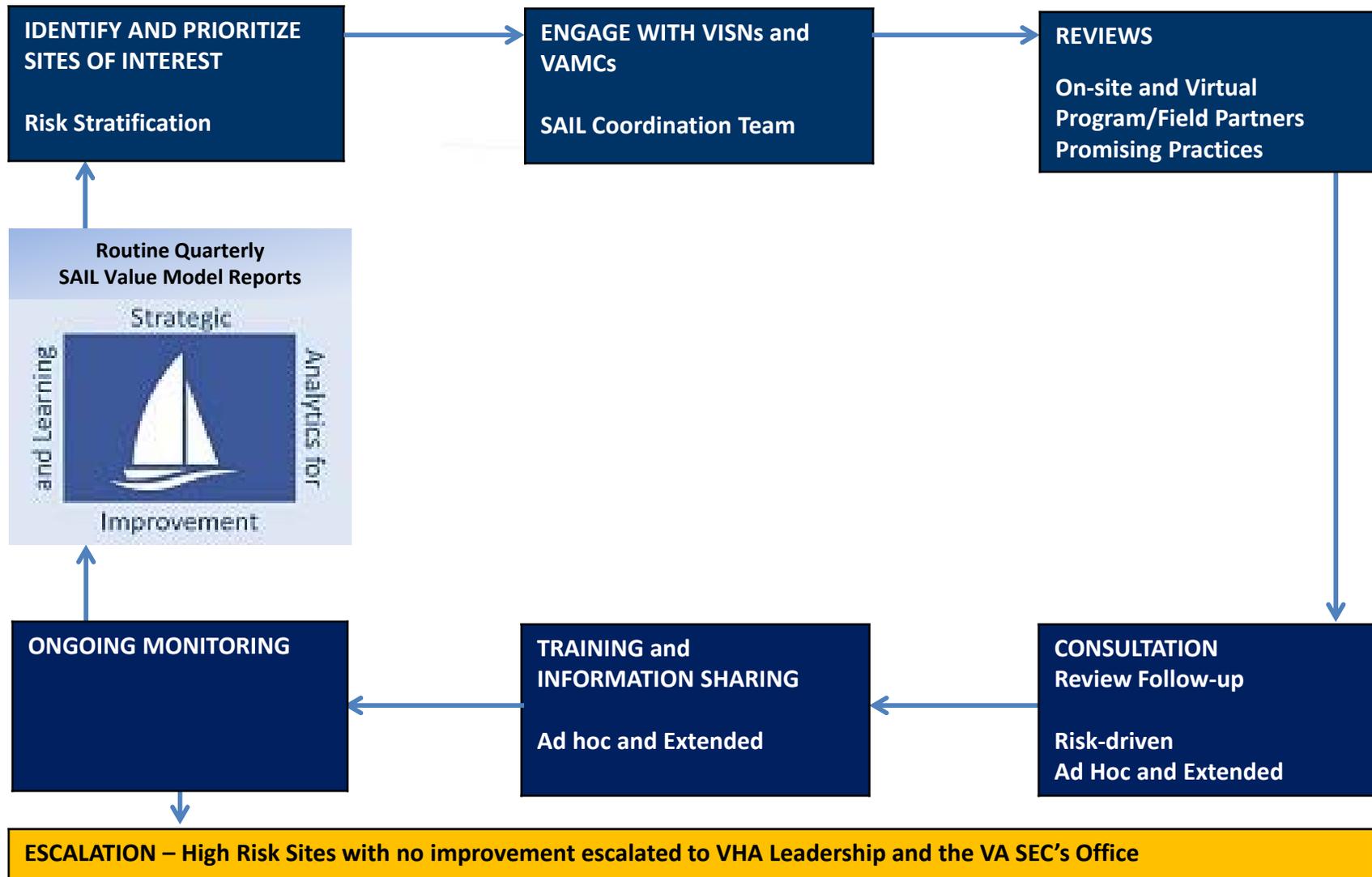
Uses of Stratification Systems & EWS



- Proactively reach out to facilities with the highest risk
- Prioritize VISN and facility requests for consultation
- Define the recommended level of consultations
 - Deep Dive: On-site comprehensive review of SAIL report
 - Short Dive: Phone consultation to review strengths and opportunities and potential contributing factors
 - Metric Opportunities: Review pre-defined metric areas where improvement is needed
 - Extended Consultation: Bi-monthly or quarterly calls following Deep Dive, Short Dive, and metric consultation
 - Tool Education: For surveillance and management of SAIL domains and metrics
 - Referral Network: OAR maintains a repository of strong practices from facilities that agreed to share with other facilities upon request.

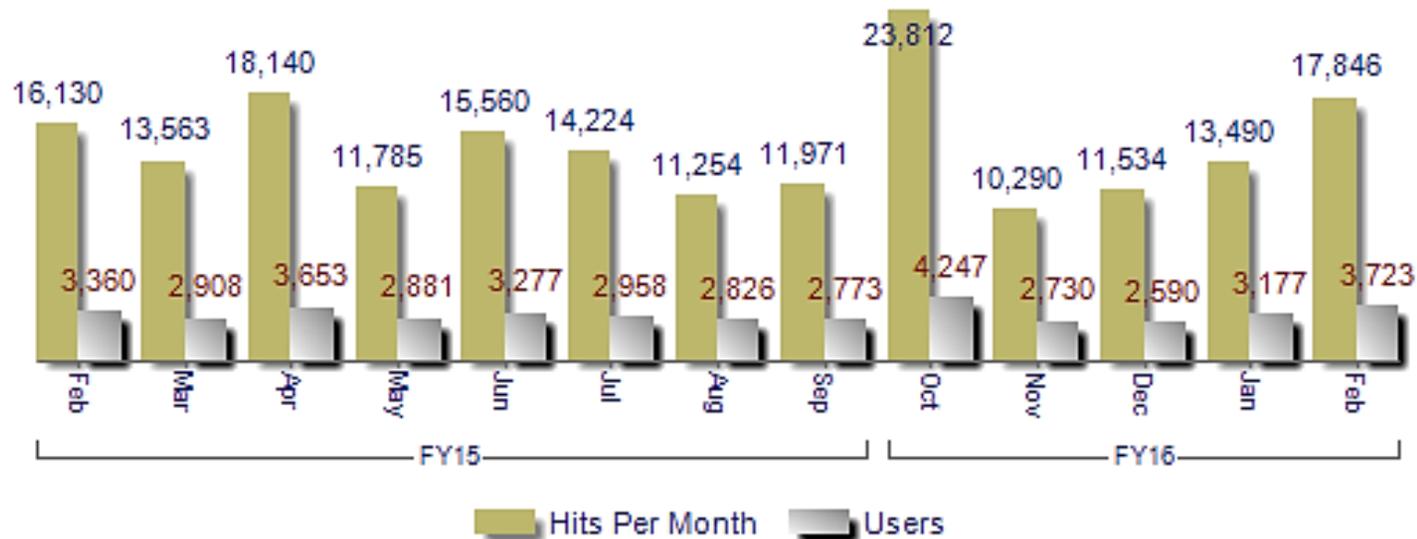


SAIL Consultative Activities





SAIL Web Hit & User Count Statistics

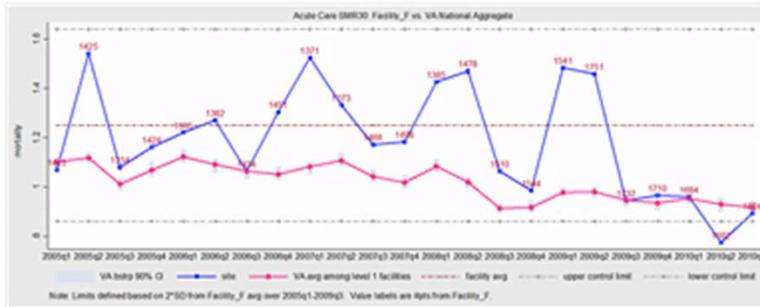


Quality		FY16		FY15		FY14	
Quality Management Products	Type	Hits / Users		Hits / Users		Hits / Users	
Strategic Analytics for Improvement and Learning (SAIL)	Rpt	76,972	9,091	160,415	14,461	69,271	6,643

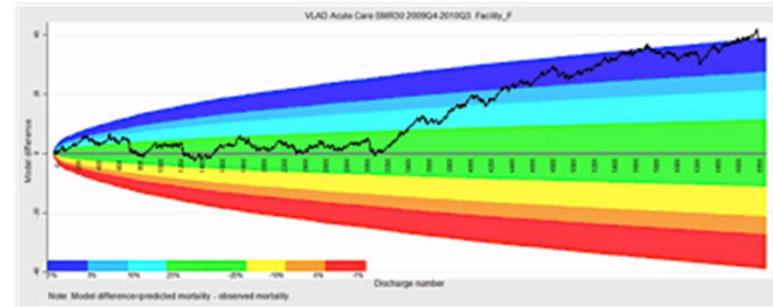
Latest update: 101,385 hits and 10,959 active users 4/8/2016



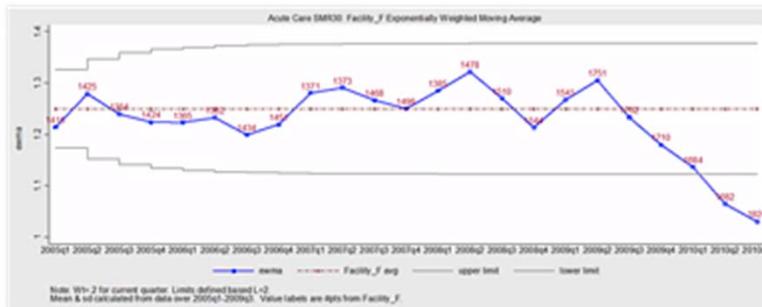
Statistical Process Control Charts



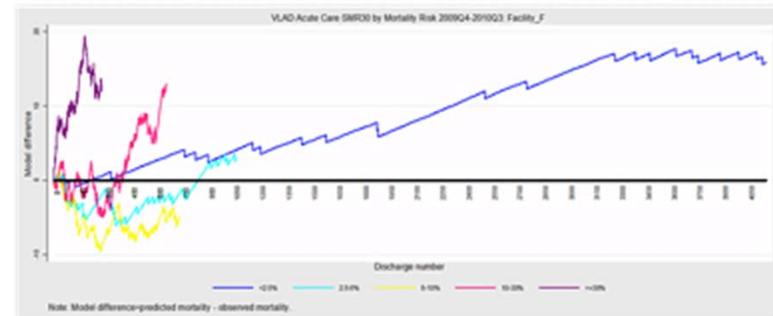
Hybrid XMR



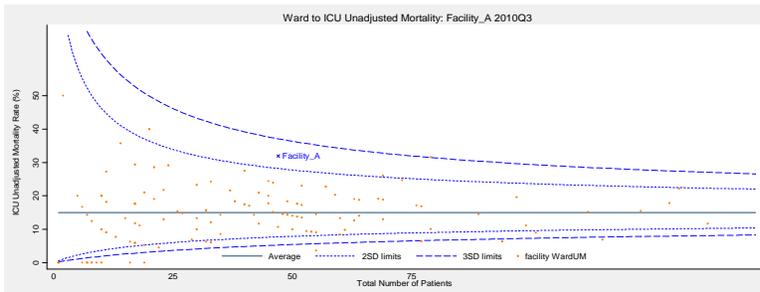
Variable Life Adjusted Display (VLAD) – Rocket Tail



Exponentially Weighted Moving Average (EWMA)



Variable Life Adjusted Display (VLAD) by Severity level



G Charts →

← Funnel Charts





Use of Statistical Process Control Chart & Trigger System

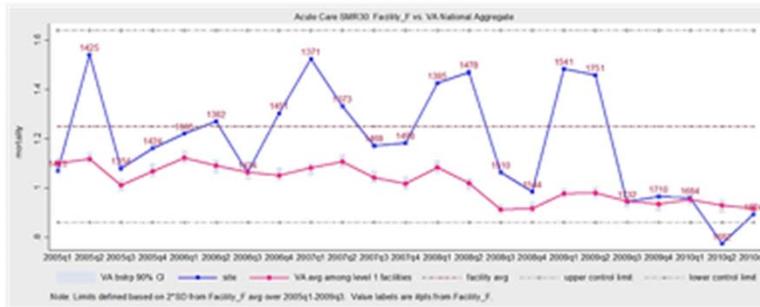


	Update Frequency	Mortality	LOS	CSI	Complications	PSI	Scheduling	Consults	No Shows & Clinical Cancellation	Specialty Physician Productivity
G-Chart	Daily	✓			✓	✓				
Hybrid XMR	Bi-Monthly						✓			
	Monthly	✓	✓				✓	✓	✓	✓
	Quarterly	✓	✓	✓						
EWMA	Bi-Monthly						✓			
	Monthly	✓	✓				✓	✓	✓	
	Quarterly	✓	✓	✓						
VLAD	Quarterly	✓								
Funnel Plot	Quarterly	✓								

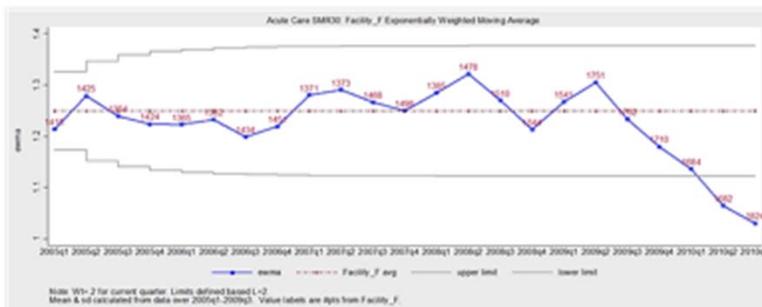
- Scheduling has push function to leadership.
- Check marks are hyperlinked to Program Office report website.



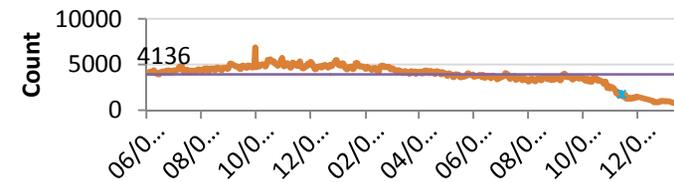
Developing a National Awareness Trigger System for High-Value Information



Connecting Organizational Triggers and Measures Together



Urgent Consults Pending >7 Days (1/18/2016)





Healthcare Operations Dashboard



- Provides real-time data to the field in a format that helps facilities monitor the operational effectiveness and efficiency of the VHA healthcare system.
- Provides actionable intelligence and situational awareness through analysis of operations data.
- Serves as the authoritative source to support effective communication, reporting, and information dissemination to internal and external stakeholders.

NOT FOR PUBLIC RELEASE

Daily Dash | Current Focus | Utilization | Access to Care | Longest Waits | Productivity | Patient Experience | Employee Satisfaction | Space | Staffing | VA Community Care | Sandbox | Info & Links

The Daily Dash (Last 12 Months) ▾

Healthcare Operations Dashboard

Choose Facility: All

Choose Group: All

Internal Use Only

Feedback

Rate Dashboard

Measure Definitions

Help Desk

HOT SPOT (Last 12 Months) (All, All, All)

Measures	FEB.FY15	MAR.FY15	APR.FY15	MAY.FY15	JUN.FY15	JUL.FY15	AUG.FY15	SEP.FY15	OCT.FY15	NOV.FY15	DEC.FY15	JAN.FY16
Activity (Completed Appts)	5,091,565	5,830,026	5,813,318	5,273,573	5,751,079	5,589,640	5,422,364	5,661,371	5,748,562	5,094,754	5,424,099	780,187
Established Pt % within 30 Days of PD	97.46%	97.50%	97.62%	97.77%	97.55%	97.50%	97.36%	97.32%	97.36%	97.01%	96.86%	96.70%
New Pt % within 30 Days of PD	95.37%	95.22%	94.95%	94.96%	94.37%	93.98%	93.67%	93.00%	92.57%	91.92%	91.48%	94.81%
New Pt % within 30 Days of CD	82.61%	81.74%	81.10%	81.35%	79.62%	79.22%	80.01%	79.41%	80.23%	80.25%	79.51%	70.40%
Pending Appointments												6,061,563
Pending Appointments Over 30 Days												544,573
Pending Appointments Over 90 Days												86,194
EWI Open Records												49,569
Not Show Rate Combined	14.84%	15.80%	13.00%	13.23%	13.01%	13.21%	13.11%	13.37%	13.20%	13.48%	13.52%	12.79%
Cancelled by Clinic Before Appt Rate	7.87%	7.80%	7.54%	7.75%	7.79%	8.05%	7.87%	7.68%	7.71%	7.87%	8.18%	8.43%
Recall Reminders												5,913,456



Healthcare Operations Dashboard



- One-stop shop to monitor and assess healthcare operations at VA facilities across the country
- Spans key domains such as utilization, access, productivity, staffing, space, patient experience, employee satisfaction and VA community care
- Builds on 17+ standardized, time-tested cubes developed by VSSC and ABI
- Leverages Pyramid Analytics options such as graphing, data mining, global slicers, and export/print
- Updated daily with drill-to-patient detail
- Current Focus tab informs field of current executive leadership focus and priorities
- Sandbox tab includes draft views currently being explored and tested
- Companion to Clinic Practice Management Dashboard
- Links to SAIL, SHEP/PCMH, SPARQ, Clinical Access Index and much more



Transforming VA Health Care



- Building on our strengths – VA outperforms the private sector in many areas
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- Changing the way VA thinks about Access – MyVA Access
- Becoming more effective and efficient in our core operations
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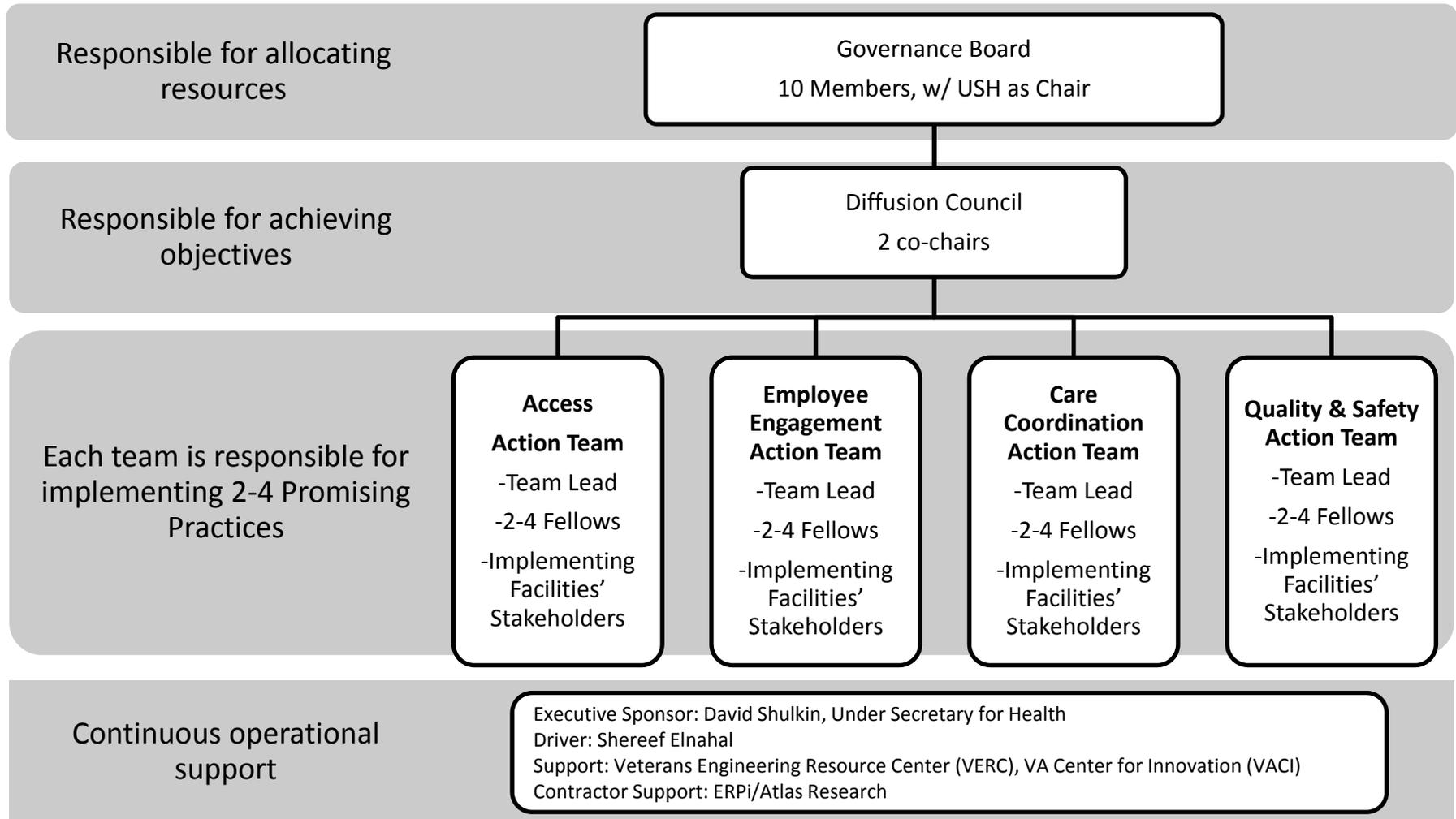
Utilizing VA's Strategic Advantage of Scale to Identify And Disseminate Best Practices



- Until recently, there has been no systematic way to continuously surface best practices in care delivery from the field, and diffuse those practices to other facilities.
- The Diffusion of Excellence Initiative :
 - **Empowers employees** to promote innovation sharing and drive a supportive culture of continuous improvement
 - **Institutionalizes a process** and mechanism for systematically diffusing and implementing promising practices throughout the system
 - **Minimizes negative variation** in practices by diffusing innovative and industry recognized best practices across the system.
 - Solves some of VHA's most pressing challenges in care delivery.
 - Creates a learning health system



Diffusion of Excellence Org Structure





Diffusion of Excellence Initiative Diffusion Framework





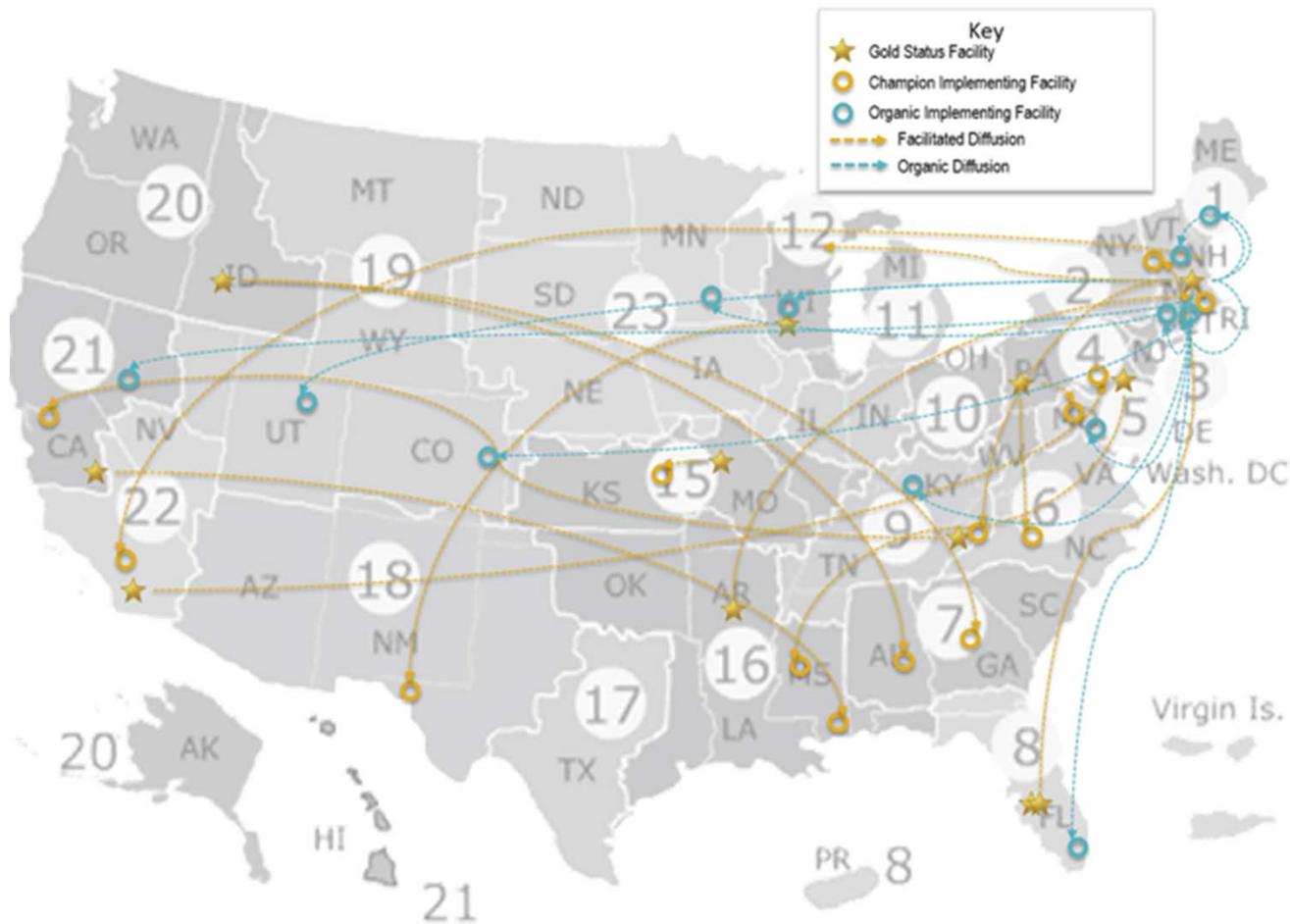
Diffusion of Excellence Initiative: *Accomplishments At a Glance*



- **What we've done:** Established the Promising Practices Consortium and Diffusion Council
 - Community to promote promising practice sharing between facilities and diffusion of best practices, and Council to advise on the strategy for diffusion.
- **What we're working on:** Facilitating the Diffusion of Gold Status Best Practices
 - Selected Gold Status best practices from those submitted to Consortium through Shark Tank exercise. Medical centers facing similar challenges will receive support in facilitating replication of these practices at their facilities.
- **What's next:** Establishing a Sustainment Strategy
 - Establish a mechanism for incentivizing and institutionalizing the identification and diffusion of practices at the Network and national levels.



Current Diffusion Efforts





Integrated Operations Platform: VA Diffusion of Excellence Hub



Shark Tank Practices Projects Barriers

FY16 Gold Status Promising Practice
13 Gold Status Practices were selected by VHA from 21 finalists out of 250 submissions in FY16. Gold Status Practices are being replicated across VHA through facilitated implementation by action teams.

Improving Access to Care @ Columbia MO VAMC

Access Data Dashboard to Improve Clinic Management

Clinic access metrics (no shows, wait times, clinic utilization, etc.) are posted monthly on an accessible dashboard.

Prev < | Implementing this practice? | View implementations

Project Update View Projects

Overview
An overview of this practice

Video introducing this practice →

Projects implementing this practice

Legend

- In Planning (2)
- In Progress, On Track (0)
- In Progress, Not On Track (0)
- Completed (0)

The Practices Repository highlights practices being diffused across the system



IOP Insights for MyVA Access Governance



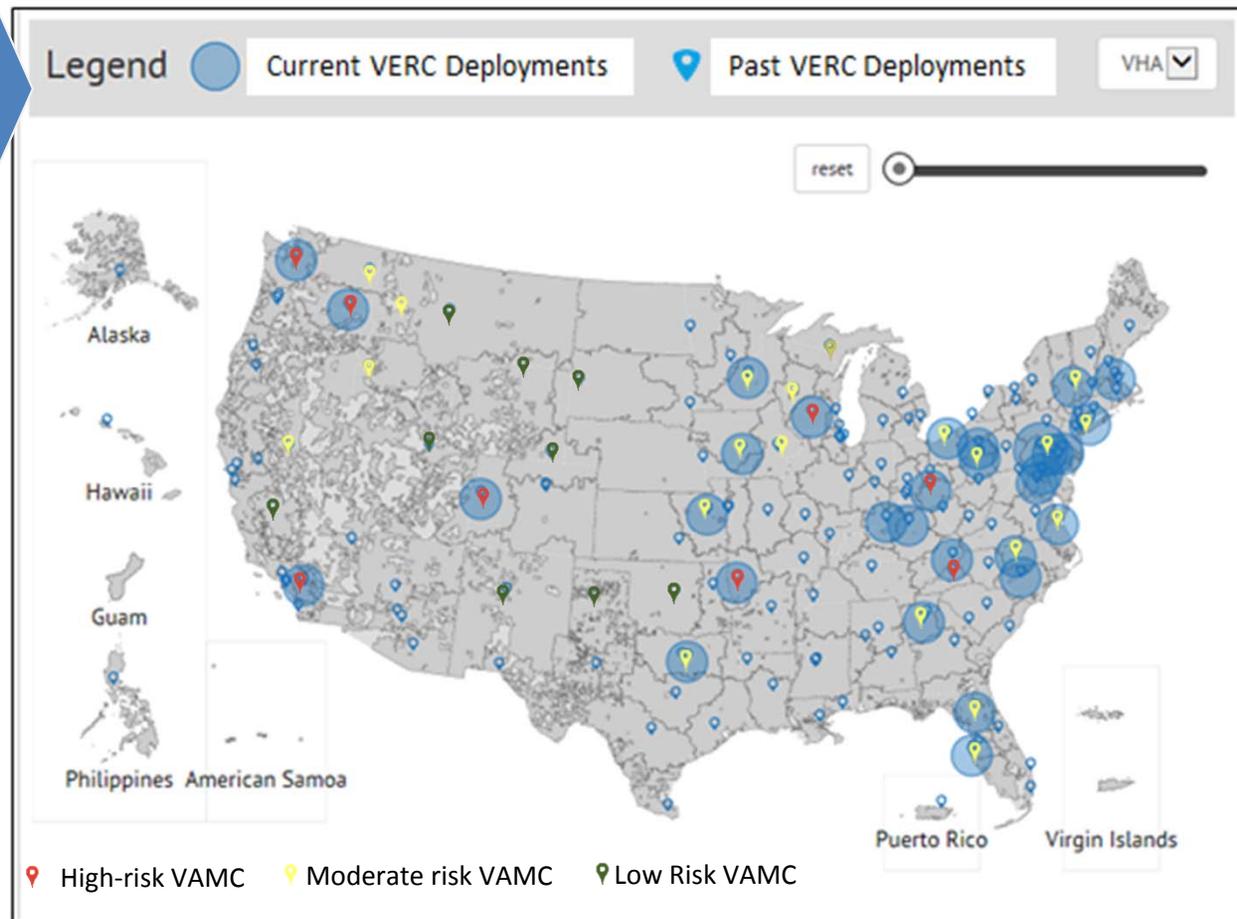
Where have VERC teams deployed to?

Which solution sets are VAMCs implementing?

Which milestones have VAMCs accomplished?

What barriers are VAMCs currently encountering?

What is the overall implementation status at each VAMC?



Sample data. For illustration only



ACCESS TO CARE BEST PRACTICES



Improving Same Day Access Using RNCM Chair Visits



Practice Originated at: Boise VA Medical Center
Will be adapted and implemented at: Carl Vinson VA Medical Center (Dublin, GA), Central Alabama VA Health Care System

Problem Statement:

- Primary care providers' schedules were full and nursing staff were overwhelmed, which led to delayed care to patients.
- New patients were difficult to accommodate, and were often "ping ponged" to different service lines. The ER and urgent care saw an increased number of non-emergent, routine concern patients.
- Provider recruitment and retention was difficult.



Practice Summary:

- Patients assigned to an RN Care Manager-Provider to evaluate and treat acute system concerns and unstable chronic disease conditions.
- Clerical associates assisted in triage of patients requiring same-day care services who did not have prior appointments, triggering follow-up steps for same-day appointment scheduling.
- Incorporated telephone clinics to increase same-day access demand and focused on reducing rework.
- Defined RN role, which included encounter set up and training on the type of information to gather during chair visits.

Benefit:

- Increased same-day access to Veterans without overloading PCP (**Same Day Access rates > 90% upon request**)
- Decreased urgent care/emergency room usage at the main facility despite ongoing growth at the clinic.
- Increased continuity of care



Increasing Access to Primary Care with Pharmacists



Practice Originated at: William S. Middleton Memorial Veterans Hospital (Madison, WI)
Will be adapted and implemented at: El Paso VA Health Care System

Problem Statement:

- A lack of team-based care and overworked primary care providers with high turnover rates led to decreased access to primary care
- A lack of communication with pharmacists, understanding of pharmacist scope of practice, and resources available for patients with chronic diseases
- Minimal Clinical Pharmacy Specialists (CPS) dedicated to primary care and pharmacists did not have scope of practice



Practice Summary:

- Implemented educational campaign to increase awareness among PCPs regarding pharmacy resources available for chronic disease management
- Integrated CPS into PACT team, eliminated tasks that lowered scope of practice, and provided guidance on appropriate diseases for CPS triage
- Instituted population management and daily review of return-to-clinic appointments to reduce primary care provider overrun

Benefit:

- **Increased access to primary care, increasing primary care capacity by 28%**
- Improved management of chronic disease patients
- Increased availability and utilization of pharmacy resources



CARE COORDINATION BEST PRACTICES



eScreening Program



Practice Originated at: VA San Diego HCS

Will be adapted and implemented at: VA Ann Arbor HCS, Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA), & Lebanon VAMC

Problem Statement:

- PCPs are faced with an overwhelming workload and cumbersome processes regarding manual management of clinical measures/reminders
- Providers spend excessive time on administrative tasks rather than attending to patients



Practice Summary:

- Development of eScreening, a mobile technology interfacing with Computerized Patient Record System (CPRS) for immediate results documentation
- Veteran-directed reporting of symptoms, timely patient alerts, individualized patient feedback, and monitoring of treatment outcomes

Benefit:

- Improved care coordination and business processes
- Higher Veteran satisfaction rates
- Improved clinical impact



Regional Liver Cancer Tumor Board



Practice Originated at: Philadelphia VAMC

Will be adapted and implemented at: GV (Sonny) Montgomery VAMC (Jackson, MS)

Problem Statement:

- Sporadic patient referral from hub/spokes and lack of appropriate treatment for patients with complex cancer and liver disease requiring multidisciplinary team management, leading to unnecessary biopsies and late diagnosis



Practice Summary:

- Combining a regional telehealth-supported Liver Cancer Tumor Board, a web-based submission process, and a consolidated database to manage/track communications

Benefit:

- Improved access to care at the hub to deliver expert treatment
- Reduced number of unnecessary biopsies
- Shortened time for evaluation and first treatment



QUALITY AND SAFETY BEST PRACTICES



Planning for Future Medical Decisions via Group Visits



Practice Originated at: Central Arkansas Veterans Healthcare System
Will be adapted and implemented at: Bedford VA Medical Center

Problem Statement:

- Health care providers have limited time and resources to provide Veterans with guidance regarding Advanced Health Care Planning (AHCP)



Practice Summary:

- An interactive and patient-centered process to engage Veterans in planning for future medical decisions in a group setting, allowing for patients' wishes to be honored while reducing unwanted treatments

Benefits:

- Increased Veteran engagement in the AHCP process, increased adherence to Veteran wishes



Flu Self-Reporting Desktop Icon



Practice Originated at: VA Boston Healthcare System
Will be adapted and implemented at: Mountain Home VA
Medical Center & VISN 12

Problem Statement:

- Lack of ability to track flu vaccinations received outside the VA by VA employees



Practice Summary:

- With a click of a workstation icon, employees are able to report flu shots received outside the VA

Benefits:

- Improvements of 15-20% of flu vaccination reporting, increase in the amount of information relayed to Occupational Health for documentation into Occupational Health Record Keeping System



Code Tray Redesign



Practice Originated at: Boston VA Healthcare System

Will be adapted and implemented at: VA Loma Linda Healthcare System

Problem Statement:

- A disorganized medication tray leads to a prolonged search for medications during a code and medication distribution errors



Practice Summary:

- A simple, low-cost, alphabetically organized code tray

Benefits:

- Decreased drug search time and reduced medication distribution errors, reduced time to replenish used trays



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Joint Legacy Viewer (JLV)



- Provides a “patient-centric,” integrated view of a patient’s health data from VA, DoD, and community health partners on one screen
- Available at all VA Medical Centers since October 2014
 - Offered to VHA and VBA users in phases
- Supports interoperability through the seamless sharing of standards-based health information
- Record lookups surpassed 1 million last week
- As of April 10, 2016, there are 70,960 VA employees authorized to use JLV
 - Approximately 10,100 are VBA
 - 9006 new VA users were activated last week (April 4)
- JLV functionality will be transitioned to eHMP



Demo of JLV by David Waltman and Dr. Neil Evans



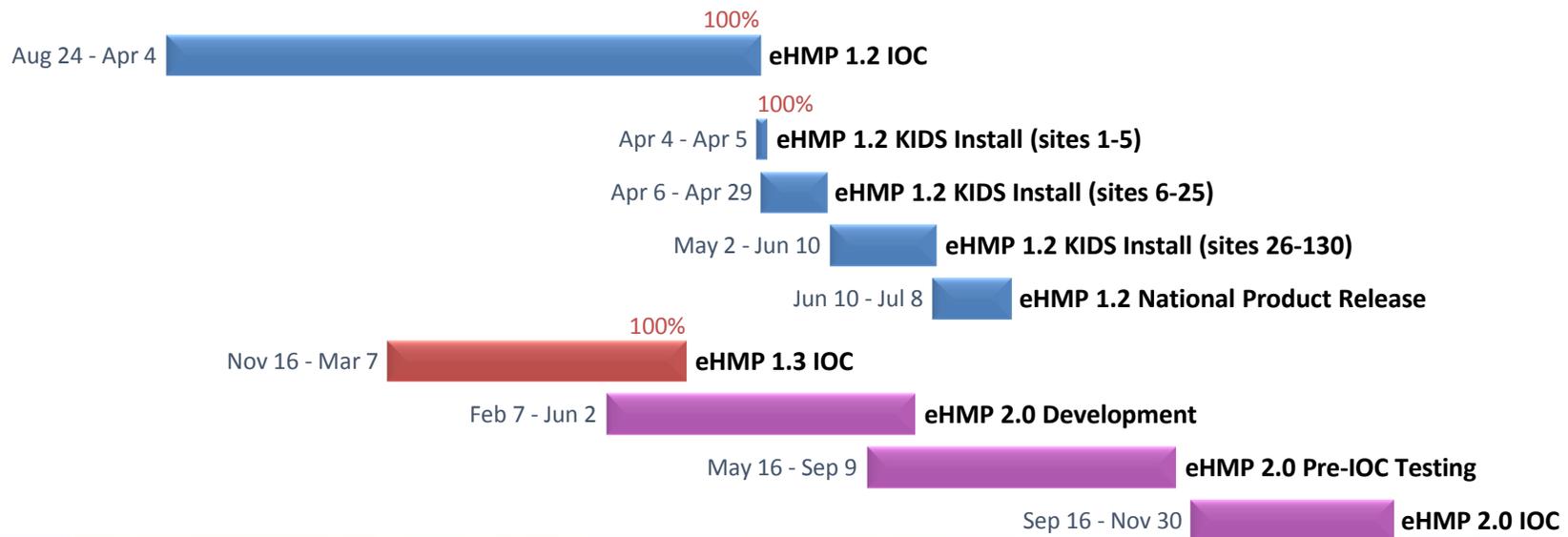
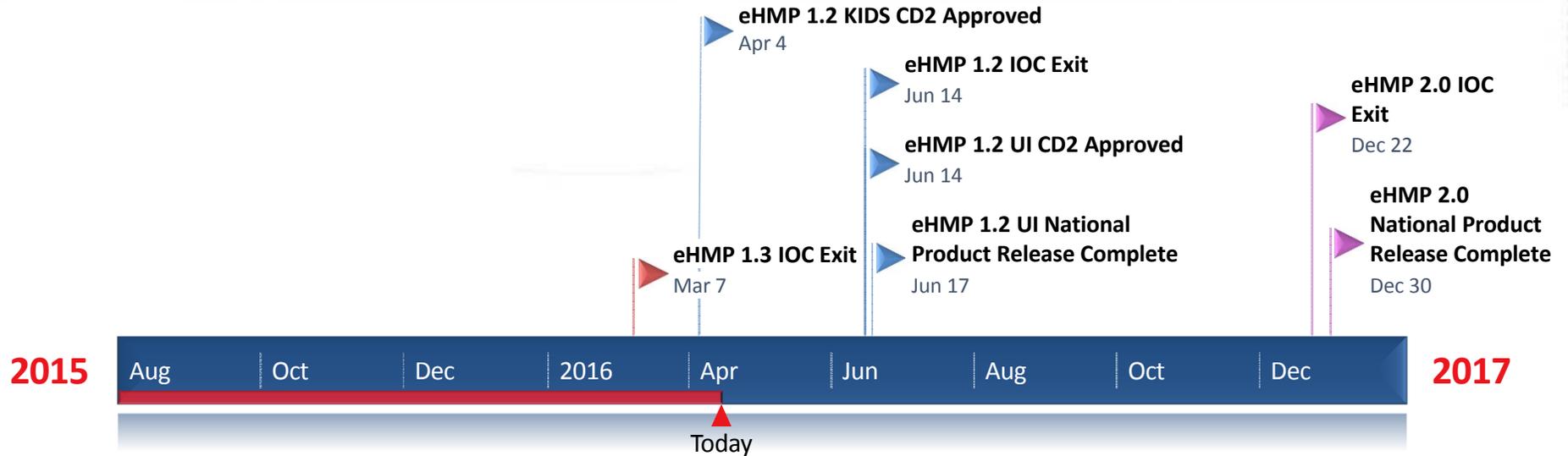
Enterprise Health Management Platform (eHMP)



- Supports VA frontline health care teams in delivering Veteran-centric, team-based, quality-driven care
- Delivers a modern, web-based user interface and supporting infrastructure
- Will ultimately replace Computerized Patient Record System (CPRS) as VA's primary point of care application
- Designed to rapidly integrate new solutions into an open standards, web-based platform
- Provides VA streamlined access to complete patient history from VA, DoD and community health partners in a single reliable, customizable, secure interface that is easy to use



eHMP Timeline





Demo of eHMP by David Waltman and Dr. Jonathan Nebeker



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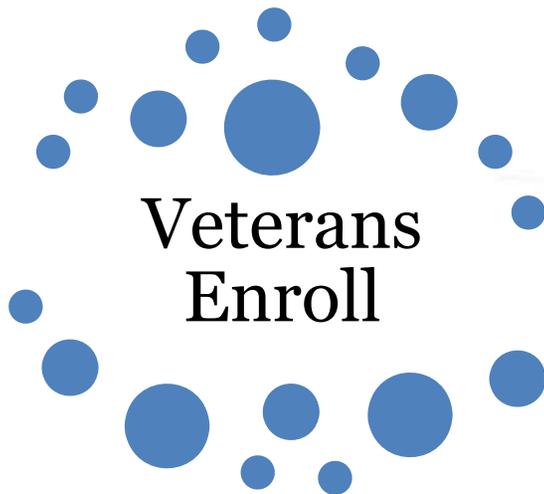
Completely Overhauling the Health Care Enrollment Process to Increase Access to Care for Veterans



- **“Welcome to MyVA” (W2MyVA) Initiative**
 - Personal phone calls to every newly enrolled Veteran from VA’s Health Resources Center
 - Provides overview of VA healthcare services and available benefits
 - Helps Veteran schedule first appointment
 - Answers questions
 - Introductory letter and personalized handbook sent to all newly enrolled Veterans
- **Enroll by Phone – Elimination of the “Wet Signature Requirement”**
 - VA amended regulations to allow Veterans to enroll for VA healthcare by phone without the need for a signed paper application
 - Effective June 5, 2016
- **True Online Enrollment on Vets.gov – Coming Soon**
 - Converting current online PDF application into an HTML form
 - Improves user experience
 - Automates process and reduces processing time



Overhauling the Health Care Enrollment Process



Online @ [Vets.Gov](https://www.vets.gov)
Call 877-222-VETS (8387)
Visit a VA Medical Center

VA staff provide personal
introduction to VA care and
benefits

- **True Online Enrollment** through new [Vets.Gov](https://www.vets.gov) website
- Enroll by phone made possible by the **Elimination of the “Wet Signature Requirement”**
- **Welcome to MyVA** offers Veterans a personal call within a week of enrolling in care



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Staffing Critical Positions



- **Medical Center Director and key VHA executive hires**
 - Dr. Richard Stone and Dr. Jennifer Lee, recently hired to key executive roles within VHA.
 - 76% of VA Medical Center Director positions are now filled with permanent appointments (~35 vacancies; does not include those pending onboarding)
 - 9 candidates selected for MCD roles, pending onboarding
 - 19 candidates nominated for final interviews
 - Title 38 legislative proposal
- **Clinical hiring.**
 - Increased net onboard staff by more than 17,000 employees (FY2015 through Feb. 29, 2016), Includes:
 - 6,000 nurses (RN, LPN & NA), 1,550 physicians, 112 psychiatrists, and 450 psychologists.
- **Improving VA / VHA hiring processes.**
 - Utilizing lean principles to create a more efficient and streamlined hiring process.
 - Simultaneous Rapid Process Improvement Workgroups (RPIW) throughout the country (VISNs 8, 15 and 23 as well as SES RPIW complete).
 - Team focused on regulation and policy changes that adversely impact hiring - making change where possible; proposing legislation where no internal relief exists.



Leadership Vacancy and Quality Star Designation / Ranking



Shorter average time and fewer number of executive positions vacant are associated with better quality star designation and ranking

Quality Star	Total Avg Years Vacant ^{1,2}	Executive Positions Vacant ^{1,2}	Avg Yr MCD Vacant	Avg Yr COS Vacant	Avg Yr Assoc Dir Vacant	Avg Yr Asst Dir Vacant	Avg Yr NE Vacant
1	0.14	0.92	0.30	0.02	0.06	0.12	0.16
2	0.16	0.65	0.21	0.21	0.09	0.15	0.15
3	0.10	0.70	0.13	0.12	0.12	0.07	0.05
4	0.06	0.57	0.08	0.11	0.00	0.05	0.06
5	0.12	0.33	0.03	0.44	0.02	0.00	0.00

Quality Rank	Total Avg Years Vacant ^{1,2}	Executive Positions Vacant ^{1,2}	Avg Yr MCD Vacant	Avg Yr COS Vacant	Avg Yr Assoc Dir Vacant	Avg Yr Asst Dir Vacant	Avg Yr NE Vacant
Rho	0.14	0.18	0.18	-0.08	0.18	0.13	0.19
p	0.104	0.038	0.029	0.350	0.037	0.351	0.023

Note: Leadership data current as 3/3/2016; SAIL Quality Star and Ranking from FY15Q4 release

Higher star designation and lower rank number is preferred

1: Executive Positions Vacant considers only MCD, COS, AssoDir and NE, due to the majority of facilities don't have AsstDir

2: A few facilities have more than one AssoDir. In this case, if one of them is on position, the AssoDir position is considered half vacant



Transforming VA Health Care



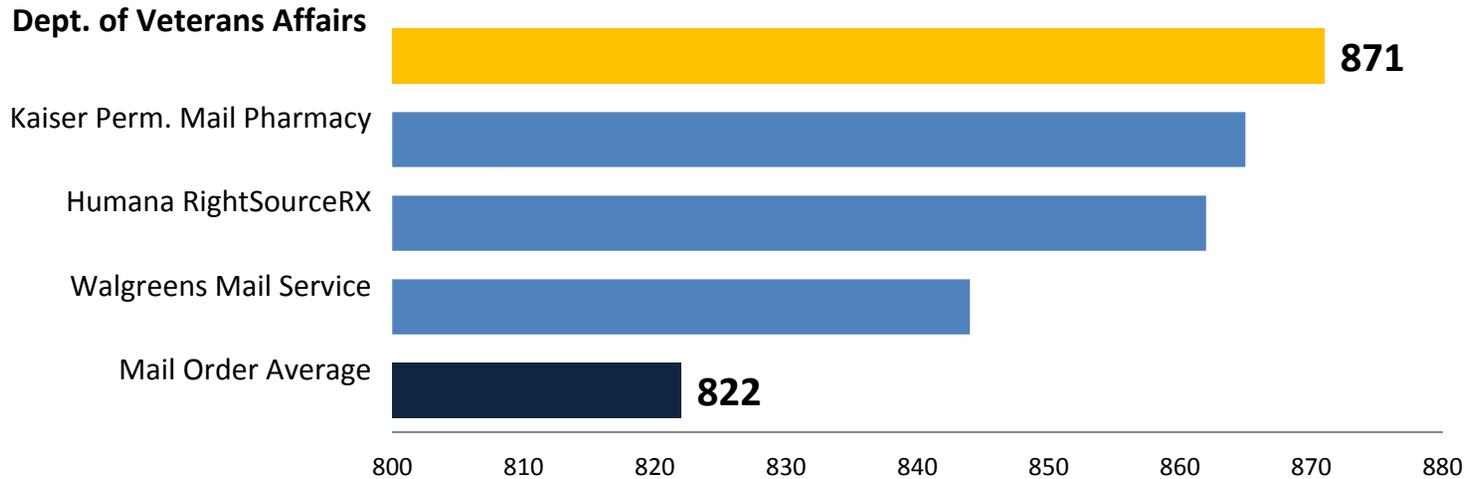
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Our Pharmacy is best in class

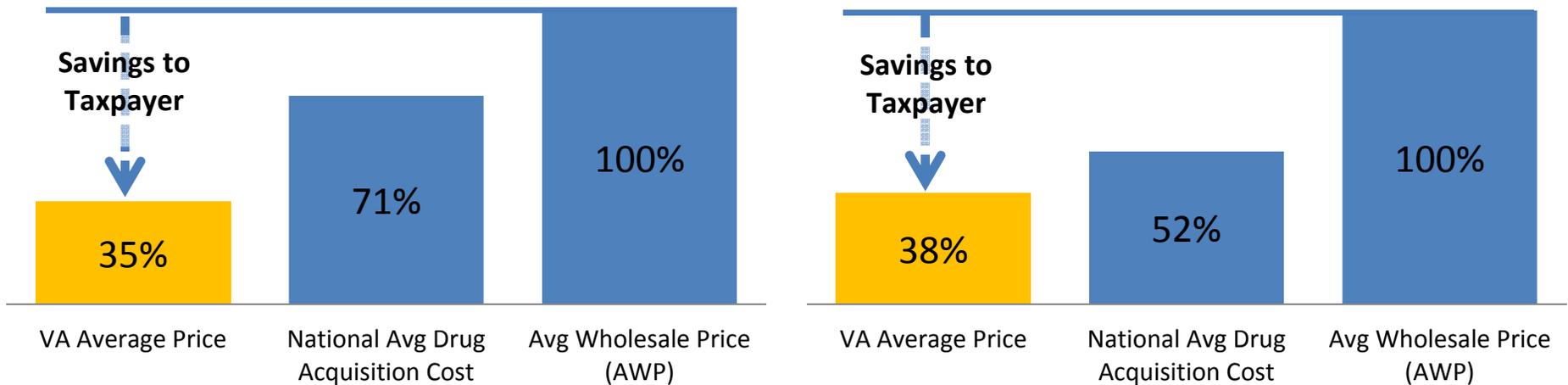


J.D. Power's Mail Order Pharmacy Overall Satisfaction



Branded Drugs - Average Unit Price

Generic Drugs - Average Unit Price



****\$750M cost avoidance through renegotiated pricing for Hepatitis C treatment (50% savings)**



VA building an Integrated Med/Surg Supply Chain in 2016



- **Transforming Supply Chain is one of 12 MyVA breakthrough initiatives in 2016**
 - New Medical/Surgical Prime Vendor contracts awarded in Apr 2016
 - Soliciting & negotiating for better pricing on over 10,000 items
 - Over 1,100 ordering officers to place demands on national contracts for 85% of all med/surg supplies
 - Replacing previous reliance on purchase cards for a majority of medical supplies
 - \$24.4M in supply chain costs have been avoided and are being redirected to Veteran outcomes; on track for \$150M by Dec 2016
 - National standardized data and product records across all VA facilities
 - Point of Use Solution for better inventory and demand management deployed to 32% of facilities
 - National Commodity Program Management Offices established to aggregate requirements and achieve pricing based on scale
 - Standardized Organizational Structure and workforce requirements leading to standardized processes and procedures



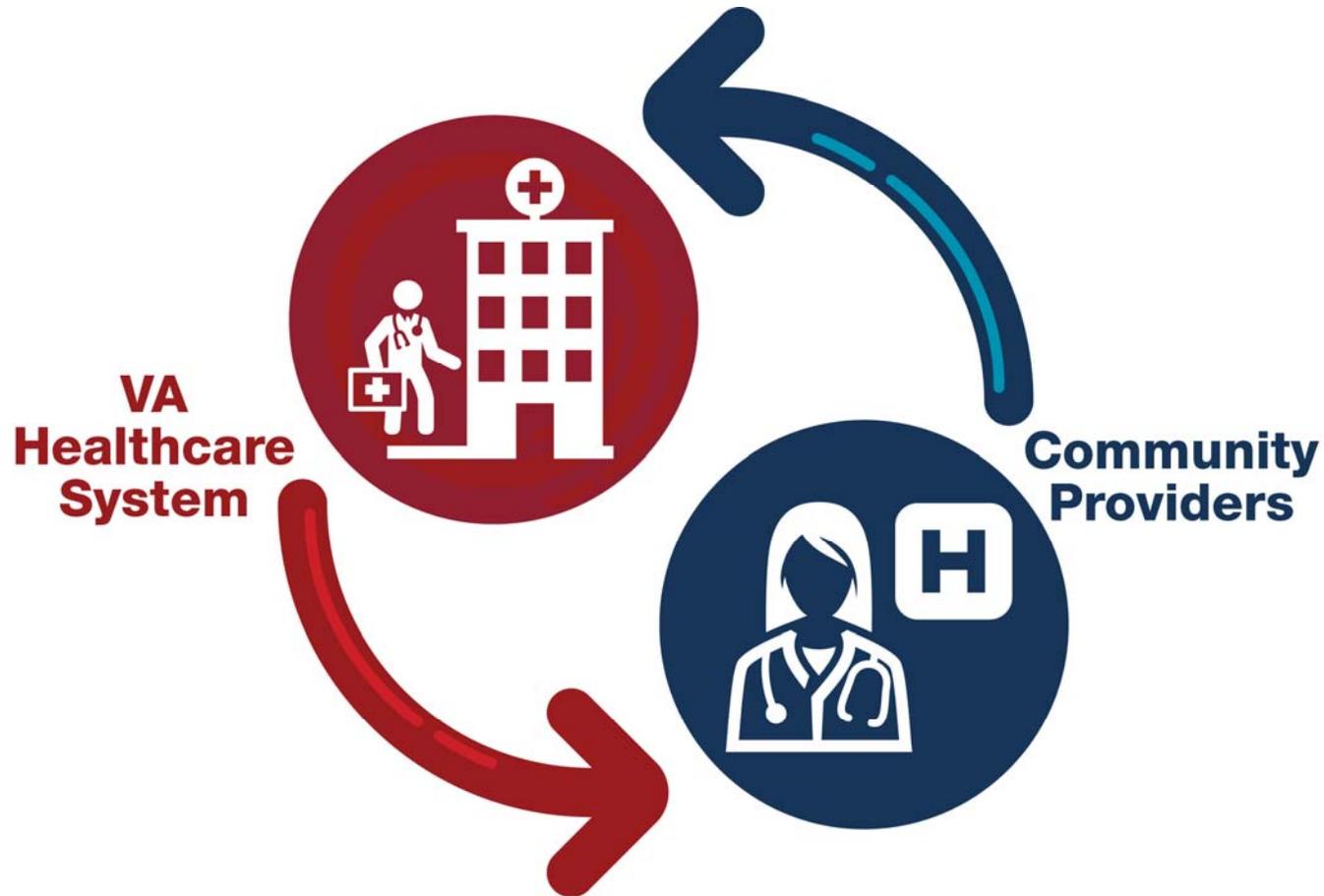
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Building a Integrated Health Network





Short- and Long- Term Approach

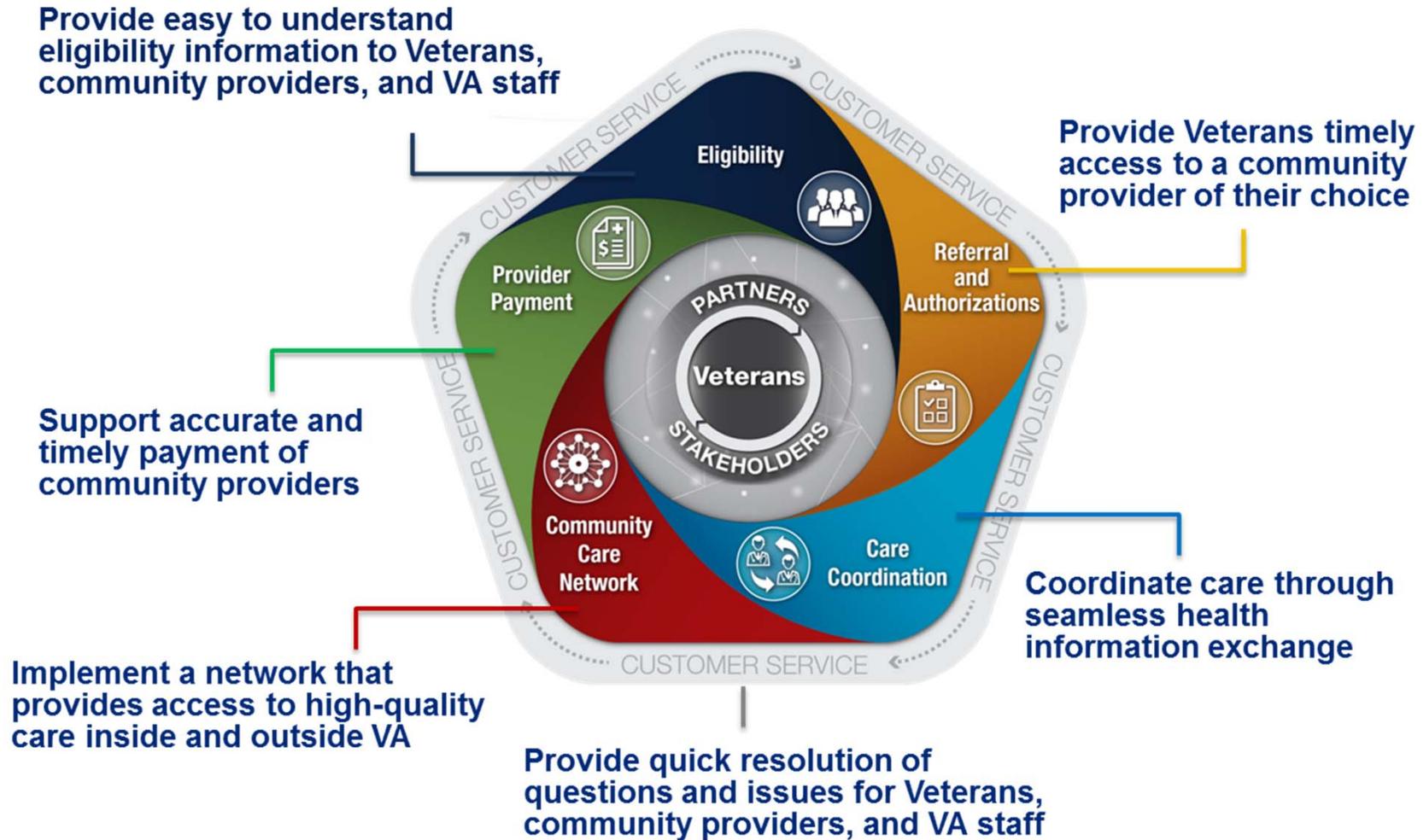


- VA is taking immediate steps to improve stakeholders' experiences while also planning and implementing long-term improvements for the new community care program.





Improving the Veteran's Journey





Approach to Improving the Community Care Experience

