



Spotlight

ON EXCELLENCE

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A Word from the Acting Deputy Under Secretary: Dr. Gerard Cox

Recently, for National Healthcare Quality Week, I was asked to reflect upon my experience in health care quality and improvement. In preparing my remarks, I realized how fortunate I’ve been to witness the development of the health care quality movement for almost 35 years and to now bring that experience to the Veterans Health Administration (VHA). As a military doctor and physician executive, I’ve seen quality improvement evolve from identifying “poor performers” to its current emphasis on improving processes. These experiences have not only shaped my views on health quality and improvement, they’ve also influenced how I view our unique role as the Office of Organizational Excellence (10E).

I first became involved with the clinical quality movement in the early 1980s (then, it was known as “QA”, or quality assurance) as an intern at the National Naval Medical Center at Bethesda. In military medicine, QA got its start with a nationally famous case involving a world-renowned cardiovascular surgeon. Recruited from private practice, this individual was a Navy Commander with oversight of the Bethesda Cardiac Surgery program. Not long after joining the program, it became clear to clinical staff that the doctor was having difficulty operating, and painfully clear that many of his patients were suffering post-operative complications. As it turned out, the surgeon was blind in one eye, resulting in a lack of depth perception that affected his surgical technique. Quality assurance approaches at that time were focused on finding fault for poor outcomes by identifying, and often disciplining, the responsible provider

(sometimes referred to as the “bad apple” approach). In this case, the cardiac surgeon was stripped of his clinical privileges, was reported to licensing authorities, and lost his ability to practice. Having found the “bad apple,” the system went no further to look for underlying flaws in the systems and processes of care that also may have contributed to poor surgical outcomes.



Fast forward to the mid-1990s, and the shift from QA to quality management. U.S. health care began to adopt the principles of Total Quality Management (TQM) from private industry, with thought leaders such as W. Edwards Deming and Joseph Juran at the fore. Dr. Deming, who wrote extensively about the post-World War II recovery of the Japanese automotive industry, introduced the concept of quality control and use of measurement charts. For those of us in medical and clinical leadership, this constituted an entirely new area and skill set. It also marked the critical shift I mentioned earlier about quality improvement; i.e., away from individuals, and toward the need to address flawed systems and broken processes.

On a more personal level, this new focus led to my seeking training in TQM as a strategic planning facilitator for several organizations. Eventually I decided to pursue a graduate degree in health administration. Around that time, I became fascinated with the shift in American health care from quality

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management to performance improvement, and from evaluating structure and processes to measuring clinical outcomes.

By the early 2000s, the clinical quality movement was beginning to embrace Six Sigma and Lean, and I was moving into positions of leadership through service chief and service line leader roles to positions in the C-Suite. I applied my knowledge of quality and performance improvement as an emergency department service chief, primary care service line leader, associate director (or hospital COO) and eventually medical center director (or hospital CEO).

“I have come to believe that we need to build a balanced integration of quality improvement, and oversight into the VA health care system. These elements are critical to making system-wide improvement in Veterans’ health care.”

These experiences have shaped my view of 10E in two key ways.

First, I have come to believe that we need to build a balanced integration of quality improvement, and oversight into the VA health care system. These elements are critical to making system-wide improvements in Veterans’ health care. They also embody what we are trying to accomplish in 10E. Our work is to keep VHA’s collective sight trained on the need to continually monitor the outcomes of our programs even as we continue to measure outcomes and manage quality and safety.

Second, our office plays a vital role helping VHA promote [a just culture](#); one that learns and improves by opening identifying and examining its own weaknesses, and where employees feel safe and emotionally comfortable in the work environment. In my view, integrity is inextricably linked with quality. While it is true that broken systems and faulty processes lead to faulty outcomes 90 – 95 percent of time, it is also the case that, five to 10 percent of the time there are individuals, who purposefully fail to perform the job. These individuals must be held accountable, while at the same time, their colleagues, who stay mission-focused, should be assured they are supported.

I look forward to sharing more of these reflections with you, and working together to continuously improve health care quality for our Nation’s Veterans. ♦

Excellence in Action: **VA and the GAO High Risk List —** **Getting to the Root Causes** **VA Health Care High Risk** **Management Task Force**

Every two years, at the start of a new Congress, the Government Accountability Office (GAO) calls attention to agencies and program areas that are determined to be high risk due to their vulnerabilities to fraud, waste, abuse, and mismanagement, or are most in need of transformation. In 2015, VA was added to the GAO’s “high risk list” for five issues evident across the Department: ambiguous policies and inconsistent processes, inadequate oversight and accountability, information technology challenges, inadequate training for VA staff, and unclear resource needs and allocation priorities.

Since then, VA has been working diligently to address these concerns and systematically follow GAO’s process for reporting. It also has been using innovative approaches to solicit needed feedback from the field.



“VA’s objective is not to simply ‘get off the list’, says Dr. Carolyn Clancy, VHA Executive in Charge, “but to resolve the underlying issues that placed VA on the High-Risk List and deliver the high quality of health care our Veterans need and deserve.”

The Department’s work began with chartering of the VA Health Care High-Risk List Area Task Force. Led by the Deputy Under Secretary for Health for Organizational Excellence, the Task Force includes five risk issue working groups, one for each of the risk issues identified by the GAO. In addition to developing a strategy for addressing these issues, the Task Force was charged with conducting analyses to determine the root causes of the risks, and begin working on action plans to address each risk.

To get at the heart of the challenges facing the field, the Task Force conducted listening sessions with staff at several VA medical centers. These listening sessions included meetings with medical center leadership, administrators and staff at three centers (Wichita, Kansas; West Haven, Connecticut; and Washington, D.C.), as well as three virtual sessions with Connecticut Community-Based Outpatient Clinics.

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Overseen by Task Force leads, the sessions provided insights regarding challenges facing the field, along with the beginnings of solutions to address those challenges. The listening session results were incorporated into a root cause analysis of the risk issues. Analyzing and coding listening session data and assessment reports revealed root causes of the five risk issues.

The analysis will help leadership within VA's Modernization effort better address root causes associated with health care risks. While it is a long-term, complex endeavor, the Task Force will continue to integrate with VA's Modernization efforts and other VA initiatives focused on solving health care delivery challenges ♦



Leadership Q&A: Dr. Shereef Elnahal

Assistant Deputy Under
Secretary for Health for
Quality, Safety and Value

How would you describe what your office does for Veterans, to a Veteran?

The Office of Quality, Safety and Value (QSV) ensures the Veterans Affairs (VA) health care system is dedicated to providing the right care at the right time to every Veteran. Not only is our goal to provide the right care, we provide the systems to make sure every member of the health care team, from front-line clinicians to facility managers, is working together for the best interest of the patient.

How does your office support Veterans Health Administration (VHA) staff in the field?

QSV supports field staff by sending experts into facilities to make sure the tools and systems designed to assist them with their jobs are operating at the highest levels. We interact with all levels of the field, from front-line clinicians to leadership, ensuring our Veterans' care is maintained in an innovative, efficient and safe manner. We have a hand in every aspect of care from beginning to end.

What lessons can private sector health care learn from VHA health care?

The most important lesson the private sector can learn from VHA health care is how to implement and execute quality care management. We have staff throughout the VHA system who are experts in quality and safety, and who are providing the right incentives to employees and staff to effectively and passionately do their jobs. From providing the most cost-effective method of treatment to providing the opportunity to give back to those who have given everything, the VHA system is better able to sustain care without competing employee incentives often found in the private sector that can sometimes inhibit value and quality of care.

What projects and initiatives are you working on that our readers should know about?

I am privileged to lead the most important public transparency effort in the history of health care for our Veterans by launching and continually refining the [Access to Care website](#), which delivers near real-time provider data to our patients. Secondly, I am proud of the creation of our Physician Ambassador Program, the largest physician volunteer program in the country. The program is helping to improve performance in care quality and accessibility by broadening the depth and reach of physician knowledge and expertise outside of the VHA system. Thirdly, we are continuing to enhance our community care effort through a single consolidated program that is easy to understand, simple to administer, and meets the needs of Veterans and their families, community providers and VA staff. The effectiveness of this partnership will allow VA clinicians to provide better care at the right time and at the right place.

Why did you decide to work at VA?

VA is the most mission-oriented organization in which I've ever worked. The commitment from our employees is unmatched. Knowing that I'm giving back to those who have given the most to our country and doing so with a group of people who are highly invested in the mission brings me great satisfaction and fulfillment.

Can you share an experience you had with a Veteran, or at a facility, that was an inspiring moment?

I had a very inspiring moment during my time as a medical trainee at West Roxbury VA Medical Center in Boston. I encountered a Veteran who, unfortunately, had a heart attack. He had driven all the way up from Providence, Rhode Island, which was about an hour and half away, with his debilitating symptoms. I asked him why he didn't seek care near his home and he said he trusted the doctors and staff at the West Roxbury VA facility more than anywhere else. It really made an impact on me then and continues to this day to make me confident that we are providing high-quality care through the VHA system, and the staff are always continuing to improve it. ♦

Feature from the Field: CBI All Staff Meeting — Moving from “little c to Big C”

by Dayna Rubino, Office of
Compliance and Business Integrity

From focusing primarily on insurance reimbursement to also looking at a broader portfolio of critical legal and regulatory risks facing VHA; and from being known primarily for oversight, to being seen as a VHA problem solver, collaborator and trusted business advisor: that’s the new strategic direction envisioned by VHA’s Office of Compliance and Business Integrity (CBI). This new direction, which CBI discussed at its September All Staff meeting, is what the Office is referring to as moving from “little c to Big C”.

Established 17 years ago, CBI has three strategic goals: 1) promote a culture of integrity; 2) manage and mitigate key legal and regulatory risks to the VHA; and 3) provide a common framework for compliance, leadership and communications to create an integrated compliance program throughout the VHA. Today, CBI is one of the program offices within the Office of Integrity,

which is workstream of the Office of Organizational Excellence.

CBI had two goals for its meeting: 1) align around CBI’s new strategic direction, and 2) build a greater sense of team.

Led by CBI Executive Director Matt Tuchow, the meeting brought together VACO CBI’s 38 staff members from across the nation including Washington, D.C., Secaucus, NJ (and other locations); many of whom had never before met face to face. The meeting’s numerous sessions and breakouts featured robust discussion around the concept of transitioning CBI from a “little c to Big C” compliance program.

Among the meeting’s many speakers were VHA Executive in Charge Dr. Carolyn Clancy, and Acting Deputy Under Secretary for Health, Dr. Gerard Cox, who both discussed CBI’s role in adding value to the VHA. Additionally, Drs. Clancy and Cox noted how this new strategy would strengthen compliance in VHA, as well as contribute toward building a culture of integrity.

Another meeting highlight featured a panel discussion among leaders of CBI’s “sister” offices (Internal Audit and Risk Assessment, Office of the Medical

Special thanks to the CBI Staff Conference Planning Committee for making this event possible: Pamela Bennett, Kimberly Pugh, Deborah Payne, Jasmine Rush, Larry Hendricks, Greg Crenshaw, Dayna Rubino, Terah Weidenhamer, Sarah Barker, David (Jack) Alston.

Thanks also to the CBI Spirit Committee: Sara Barker, Tamika Bridges, Terry Brown, Leann (Kehau) Canne, Sheila (Shae) Heng, Dayna Rubino, and Jasmine Rush.

Inspector, Management Review Service, National Center for Ethics in Health Care), whose leadership discussed plans for the coming year and areas of potential collaboration with CBI.

To achieve the All Staff Meeting’s second goal, team building, a series of team building exercises were completed and planned by the CBI Spirit Committee (a volunteer committee of CBI staff devoted to building CBI culture). CBI also participated in Emotional Intelligence training.

As an outcome of the meeting, CBI’s Executive Leadership Team will use the outputs of the sessions to assist in strategic and operational planning. Going forward, CBI plans to continue its transition from little c to Big C, as part of ongoing alignment with VA modernization and VA Secretary Dr. David Shulkin’s five priorities.

Summing up the three day meeting, CBI Executive Director Matt Tuchow said: “I think we made great progress in achieving the two goals for the meeting: aligning around our vision for the future and building our sense of team.” ♦



Members of the Compliance and Business Integrity Office met in Washington, D.C. to discuss how the Office can shift from little c to Big C.

What's Happening Now

December

Clinical Team Training (National Center for Patient Safety)

Columbia, Mo.
December 4-8

Goals of Conversations: Train-the-Trainer session (RN/SW/C/P) (National Center for Ethics in Healthcare)

Orlando, Fla.
December 5-7

What Is Moral Distress? A discussion with Dr. Ann Hamric (National Center for Ethics in Healthcare)

TMS Learning Module
December 8

My Voice Matters Training (National Center for Patient Safety)

West Palm Beach, Fla.
December 11-15

The 29th Annual Forum on Health Care Quality, Institute for Healthcare Improvement (Quality, Safety & Value)

Webcast
December 12-13

10E Town Hall (Front Office)

Webcast
December 14

January

VHA Improvement Advisor Academy – Session 3 (Systems Redesign and Improvement, Systems Reliability & Consultation)

Vancouver, Wash.
January 9-11

Ethics and Professionalism Grand Rounds: “Boundaries in the Patient-Provider Relationship” (National Center for Ethics in Healthcare)

Webcast
January 11

Clinical Team Training (National Center for Patient Safety)

El Paso, Texas
January 22-26

Clinical Team Training (National Center for Patient Safety)

El Paso, Texas
January 29-February 2

Goals of Care Conversations: Train-the-Trainer session (MD/PA/APRN) (National Center for Ethics in Healthcare)

Minneapolis, Minn.
January 30-February 1