

Spotlight

ON EXCELLENCE

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RESOURCES

OE Website
<https://www.va.gov/healthcareexcellence/>

OE Pulse Page
<https://www.vapulse.net/groups/oe>

OE Intranet
<http://vaww.oe.rtp.med.va.gov/>

OE Sharepoint
<https://vaww.rtp.portal.va.gov/OQSV/SitePages/Home.aspx>

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

Three Lines of Defense (3LD): Underscoring Oversight, Accountability, and Collaboration



Two years ago, following VA’s placement on the Government Accountability Office (GAO) High-Risk List, VHA adopted a risk management model called the Three Lines of Defense (3LD). Based on an industry standard, this model is being deployed at VHA to strengthen oversight, promote higher levels of accountability and increase collaboration and communication between the field and VACO. In many senses, 3LD is our new “corporate philosophy”: one that entrusts and empowers all of us to be ever-mindful of Veterans’ health, safety, and welfare.

Today, this framework is not only helping us address the several management issues GAO identified, but is an integral part of VA Modernization and moving forward to ensure the highest quality of health care for Veterans. Further, the framework is wholly in step with VA Secretary Robert Wilkie’s goal that VA function as a “bottom up” organization, where leadership work in partnership with frontline staff.

Organizational Excellence (OE), through the Office of Integrity, is charged with leading this initiative, including an internal communications campaign that we’ll be rolling out in coming months. As a starting point for communicating this initiative, we recently featured 3LD at our OE Summer Town Hall. Joining us for a panel discussion

were: Dr. Karen Rasmussen, Director, Management Review Services (MRS), Mr. Toby Mathew, Chief Officer, Office of Disability Medical Assessment, and Ms. Deborah Kramer, Executive Director, Office of Internal Audit and Risk Assessment (IARA). We also engaged OE staff in a series of poll questions designed to shape our messaging about 3LD. Here is a brief overview of what we learned from one another.

First Line of Defense:

“Everyone, every employee, everyone who works at VHA conducts the first line of defense,” observed Dr. Rasmussen. “Everyone has some level of oversight in what they do.” To Dr. Rasmussen’s point, if you see a slick spot on a facility floor, or notice an unattended computer screen displaying confidential information, you are responsible for reporting and helping to address these issues.

At a more operational level, the first line of defense is at the point-of-service delivery, usually a medical center within a particular clinic, with a scheduling clerk, nurse manager, provider or individual service. Here, the focus is on internal controls and management. Each facility has policies or processes established to deliver specific programs (e.g., women’s health, mental

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health or suicide prevention). Someone at the front line develops policies and procedures to ensure that the established processes are working properly, that clinicians are doing their jobs well and that the desired outcomes are being realized for Veterans.

Second Line of Defense:

The second line of defense consists of oversight activities as the VISN level, where there are staff who interact with facilities in that region and perhaps the national program office level (for example, the National Surgical Office has appointed VISN Surgical Consultants at each Network office). The goal is to ensure VA’s policies are implemented with fidelity, and that facilities and program offices are functioning in the way intended, and producing the right outcomes for Veterans. As Mr. Mathews noted, “The second line engages staff in compliance, quality management, and risk activities that are designed to

support front line staff, supervisors and managers.”

Third Line of Defense:

The third line of defense is about providing independent assurance. By design, this function is outside of the operational chain, and performed by independent investigators and auditors who conduct objective assessment and provide that independent review to the VHA Under Secretary. Internally, this comprises much of the work by the Office of the Medical Inspector and IARA. We are “the honest broker,” explained Ms. Kramer, IARA’s Executive Director. “We are independent of management, and must stay objective.”

To gauge how well these themes resonated with 10E staff, we asked the following question before, and again after, our panel: “In your role, what principles of defense do you perform?” By far, most OE staff identified with the

second line of defense, with 60 percent signifying as such at the panel’s outset, and 68 percent by panel’s end. Those identifying with the first line remained constant (from 9.2 to 9.3 percent), while those identifying with the third line increased from 9.3 percent to nearly 14 percent. The fact that so many staff identified with the second line of defense, and many shifted toward the third, aligns with OE’s mission to provide oversight, expertise, and support to advance the highest standards of care, innovation, responsible stewardship, and ethical practice within the VA health care system.

Toward the end of the town hall, when we asked, “Who else within VHA should know about this,” the reply was, “Everyone.” That is exactly what we intend to do in the coming year – inform everyone at VHA. I invite you to join our efforts. ♦

Leadership Q&A: Vince Reed,



**Executive Director,
High Reliability
Systems and
Consultation (10E2C)
Office of Quality,
Safety and Value**

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

High Reliability Systems and Consultation (HRSC), together with our Quality Consultative Division (QCD) as the operational arm, promotes management processes and standardization practices across the VA health care system. HRSC helps the VA develop and employ repeatable processes to obtain consistent results – hallmarks of a High Reliability Organization. We implement management and standardization programs at many levels throughout VA, from

national program offices to facility service departments. These programs enable the VA to provide our Nation’s Veterans with better care and service in all areas, to include health, but also other earned benefits as well.

How does your office support VHA staff in the field?

Our primary mission from the start, and which continues today, is to improve Sterile Processing Service (SPS) administrative processes with high reliability management systems. The work in sterile processing is vital to safe patient care, and SPS is the front line in the battle against disease transmission. The success of the SPS governance tools has diffused to other services, and in some cases to whole hospital adoption.

We are also currently supporting the VA Office of Finance’s Financial Service Center and Debt Management Center in their journey to gain ISO 9001-2015 certification.

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

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Our most popular program for our customers is the SPS Specific Purpose Funding Program – which is an above-the-budget-line program that helps update, standardize and improve SPS equipment and processes. We also use this program for human factors-based improvements, including ergonomic work stations. This, combined with our quality governance tools and management systems, has helped SPS improve patient and employee safety.

HRSC and QCD provide direct support to facilities upon request. We currently have employees detailed full-time in facilities to address findings from external auditing agencies. When we are in a facility, from long-term detail to a short site visit, we become a trusted member of their team. We are there to help and improve. If we see an area for improvement, we will help with the solution.

Does High Reliability Systems and Consultation partner with any external organizations (e.g., other federal agencies, Veterans Service Organizations, nonprofits)? If so, how does this partnership serve Veterans?

HRSC partners with organizations, internal and external, to improve processes that directly affect Veteran care. We worked with the U.S. Food and Drug Administration to add validation and verification of cleaning methods to the reusable medical

equipment approval process. HRSC and QCD are voting participants on Association for the Advancement of Medical Instrumentation standards development committees. These standards refine procedures and quality checks for making medical instruments safe for clinical use. HRSC interacts with the U.S. Department of Defense in several joint venture hospitals across the country. All efforts aid delivery of safe and consistent care expected of a high reliability organization.

Why did you decide to work at VA?

I entered the civilian work force after retiring from the Air Force. I enjoyed my job, but something was missing – service. When the opportunity came to work for the VA, I immediately accepted. To be honest, I was not sure what I would be doing and initially thought the VA had made a mistake by choosing me. But I worked with many wonderful people in the beginning who showed me the ropes and kept me out of trouble. I still work with an amazing team and they continue to keep me out of trouble. I appreciate every one of them. More than two-thirds of our team are Veterans. We are blessed to have the opportunity to *serve*, not work for, an organization whose mission is to care for our country’s Veterans.

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

There are too many to list, but my experience with many of these heroes is they are not eager to share what they have done, but they are happy to tell you stories about their friends, including the ones they lost long ago. And that is humbling.

My father-in-law is one of those men who remains silent on most of his service. I only know he did close air support in Southeast Asia and did several tours sacrificing time with his family at home – even missing the birth of his first child.

There is a gentleman in our office who served in Vietnam, the Persian Gulf and Iraq. He would not want me to say his name, but I am proud to know him and work with him.

Recently, my garage door went off track and a Veteran showed up to fix it. He knew I was a Veteran (I was getting a discount) and I told him I worked for the VA. I saw he had some tell-tale scars of war and I got him to open up about what had happened. He was the lone survivor when his Humvee hit an improvised explosive device in Iraq, but would only tell me about his friends. He did tell me the VA was taking good care of him and that he had nothing but good things to say. We traded numbers and I look forward to seeing him again soon – just not to fix my garage door. ♦

Excellence in Action: Shared Governance—Shifting the Focus on Improving Quality and Safety

In response to VA being placed on the Government Accountability Office’s High-Risk List, the Office of Quality, Safety and Value (QSV) has taken steps to re-invigorate and support performance improvement in VA’s health care system. In early 2018, the Veterans Integrated Service Network (VISN) 10 piloted the implementation of a quality and safety shared governance framework at two VAMCs:

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the Aleda E. Lutz VA Medical Center, Saginaw and the VA Ann Arbor Healthcare System.

A shared governance framework provides empowerment to employees who are providing direct services to Veterans by giving them a voice and role in oversight and improvement activities around quality and safety. According to Karen Maudlin, Health Systems Specialist, QSV, who oversees the project, “When I reviewed the pre- and post-survey results from the pilot and saw the increased scores for the perception of shared accountability for patient safety and clinical quality between leadership and clinical teams, I knew we were onto something good.”

The pilot focused on improving communication, collaboration and accountability between leadership and frontline VA employees delivering care and services to Veterans. During the pilot, leadership was charged with setting expectations and providing resources necessary for their frontline teams to deliver the highest quality and safest care possible. Using the industry-standard performance improvement process “PDCA” – Plan, Do, Check, Act, leaders focused on delivering care that engages and respects the Veteran and family. The medical centers’ frontline teams were first provided data and other types of feedback to show how they were doing with regard to quality, safety, access and satisfaction outcomes. These teams combined that information with an assessment of their own observations and experience in caring for Veterans and identified issues that they wanted to improve. Improvement experts then helped them understand how to monitor and measure changes while they were trying new interventions.

After each cycle of improvement, the team reflected and decided how to move forward; that is, whether to spread and share the intervention with others, continue to tweak it, or cease using the intervention altogether because it wasn’t working as planned.

According to Sara Schroeder, Patient Safety Manager at Aleda E. Lutz VA Medical Center, “The conversations among frontline staff all the way to the Service Chief changed significantly with the pilot, with the focus now on how to improve care.”



Aleda E. Lutz VA Medical Center

The next step was for hospital leadership to attend a quality and safety meeting where each department shared what was working well and should be implemented across the facility. Staff were also given the opportunity to request additional resources from leadership to address problems. “Lessons learned from a VISN leadership perspective is that quality is owned, implemented and improved upon at the frontlines,” says Jane Johnson, VISN 10 Quality Management Officer. “It is a change of culture to go from quality departments reporting for other departments on quality, to quality teams in each department working with frontline staff toward outstanding outcomes for Veterans. Real innovation and advancement occurs when leadership, care and diffusion come together. It is challenging, but we are excited to continue to spread the shared governance approach.”

In late August, the shared governance project team kicked off phase two by sharing the tools and processes that were developed during the pilot with three more VA medical centers in VISN 10 – Cleveland, Cincinnati and Chillicothe. These three new sites will allow the project team to test these tools and processes in different environments. “Similar to the cycle of the learning and improvement philosophy we are instilling at our facilities, we are using that same philosophy to develop and spread our shared governance model,” Karen Maudlin added. ♦

Feature from the Field: Office of the Medical Inspector

For nearly 40 years, the Office of the Medical Inspector (OMI) has been an integral part of VHA’s oversight and compliance program. At the request of the Under Secretary for Health, OMI investigates quality of care issues in VA’s health care facilities based on whistleblower disclosures.

OMI also assembles and leads VA teams to investigate these disclosures that are referred to the department by the U.S. Office of Special Counsel (OSC), members of Congress, or VA and

VHA leadership. OMI assesses the substance of a disclosure through site-specific investigations. Investigators conduct record reviews, site visits, and interviews and make direct observations of conditions and people. When that work is completed, the office makes recommendations for improvements to the facility it is assessing, the VISN to which the facility belongs, and to appropriate program offices. Then OMI staff work with each of these entities to make sure any corrective actions it recommends are implemented.

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OMI's diverse investigations rely on specialized expertise from Human Resources, the Office of General Counsel, and subject matter experts throughout VHA, thus ensuring its investigations are thoroughly informed and its reports are of the highest quality.

At the start of a site visit, investigators tell medical center leadership they are looking at a disclosure by a VA employee or former employee. Facility leaders are required to maintain the integrity of the investigation. When investigators interview medical center employees, they tell them the information they provide is protected—and if anyone attempts to influence their testimony, discourages their cooperation, or treats them unfairly because of their involvement in an investigation, OMI refers this information to VHA's Office of Accountability and Whistleblower Protection.

“The four physicians and eight nurses on our staff are in the field about as often as they are in VA Central Office,” explains Dr. Erica M. Scavella, VA's Medical Inspector. “Nearly all our work involves a site visit. Multiple site visits are the exception, not the norm.”

In Fiscal Year 2017, OMI staff completed 27 investigations and consulted on an additional five. The majority of these cases were

for OSC. This year, their workload for all cases is projected to exceed 60.

Recommendations the office makes at one facility often have implications for VHA program offices and the health care system as a whole, so that potential problems elsewhere can be avoided. OMI also looks for patterns and trends in its reports to identify risks and vulnerabilities for all facilities, and promotes best practices it identifies.

“Recently, we've improved communication between OSC and VA, and have helped restore trust and credibility in VA's handling of whistleblower disclosures,” says Dr. Scavella.

OMI also protects whistleblowers by encouraging employees to take available training on the subject in VA's Talent Management System. The course contains important information on employee rights and responsibilities under federal whistleblower statutes.

“Our recommendations lead to process improvements at medical centers, at VISNs and throughout VHA,” concludes Dr. Scavella. “More importantly, what we do leads to improved health care for Veterans. We're very proud of that!” ♦

What's Happening at OE

The Office of Organizational Excellence invites you to send your events, conferences and publications for inclusion in this quarterly calendar. Please email your information to VHA10EDUSHOE1@va.gov.

September

Clinical Team Training Initial Urgent Care/Telemetry (National Center for Patient Safety)

September 10-14
Saginaw, MI

Inpatient Flow Academy Session 3 (Office of Systems Redesign & Improvement)

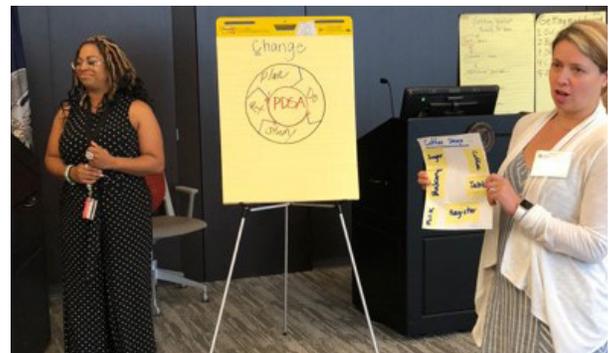
September 11-13
San Diego, CA

Patient Safety Conference PS101, CRQS, PSO Workshop (National Center for Patient Safety)

September 16-21
Orlando, FL

Face-to-Face Meeting for Work Group Members – Stroke CPG (Evidence Based Practice Program)

September 17-21
Falls Church, VA



Participants engaged in the 'Teach Back' exercise during Session 2 of the Inpatient Flow Academy held on June 19-21, 2018.

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**Writing Concise Responses in Plain Language Webinar
(Management Review Service)**

September 19

Adobe Connect and VANTS Conference Call

**Patient Flow Coordination Collaborative Learning Session 2
(Office of Systems Redesign & Improvement and the Office of
Emergency Medicine)**

September 19-20

Adobe Connect and VANTS Conference Call



Teams participating in the 'Have You Considered' exercise during Learning Session 1 of the Patient Flow Coordination Collaborative held on June 12-14, 2018.

Compliance and Business Integrity: All Staff Meeting

September 25-27

Washington, DC

October

Poster presentations at the IDWeek Conference (Public Health Surveillance and Research)

October 3-7

San Francisco, CA

1. "Comparative Effectiveness of High-Dose versus Standard-Dose Influenza Vaccines among Veterans: 2015-2016 and 2016-2017 Seasons"
2. "Post-Hurricane Maria Surveillance for Infectious Diseases in the Veterans Affairs San Juan Medical Center, Puerto Rico"
3. "Gonorrhea and Chlamydia Infections in the Department of Veterans Affairs (VA), 2013-2017"

Improvement Advisor Academy Session 2 (Office of Systems Redesign & Improvement)

October 16-18

Location TBD