2017

EXCELLENCE IN HEALTH CARE
FISCAL YEAR IN REVIEW

OFFICE OF ORGANIZATIONAL EXCELLENCE

VA

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Organizational Excellence

"No other VHA program office is charged with ensuring that clinicians—as well as program managers, patient safety managers, systems designers, and other staff—have the resources needed to ensure high-quality care for Veterans."

-Dr. Carolyn Clancy, Executive in Charge, Veterans Health Administration*

*title at the time of publication

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Foreword from the Acting Deputy Under Secretary for Health for Organizational Excellence

Fiscal Year (FY) 2017 was a transformational year for the Office of Organizational Excellence (OE). Established less than two years ago, our Office is recognized today as a champion for promoting integrity, risk mitigation, and transparency; a trusted source for developing critical data, tools, and analytics; and for its outstanding consultation, education, and training to the field.

At the national level, in FY17, OE played a vital role in numerous VA- and VHA- wide efforts and initiatives, from directing the VHA Health Care High-Risk List Area Task Force (Office of the DUSHOE) to being a lead office for the VA's Seek to Prevent (STOP) Fraud, Waste and Abuse initiative (Compliance and Business Integrity). Additionally, we collaborated across the VHA enterprise to develop and launch two new innovations: VHA's AccesstoCare.va.gov website, which allows Veterans and their caregivers to access patient wait time and quality of care data and compare VA facilities to their local counterparts (Health Systems Innovation Planning and Coordination, "HSIPC"; Reporting, Analytics, Performance Improvement and Deployment, "RAPID"); and the Physician Ambassador program, which has now recruited more than 500 licensed private sector physician and clinician volunteers to help address staffing shortages in areas and specialties (Quality, Safety and Value, "QSV").

In VA medical center clinics nationwide, we advanced our mission "to provide oversight, expertise, and support to advance the highest standards of care, innovation, responsible stewardship, and ethical practice" through site visits, training, dissemination of resources, and more. For example:

Providing Oversight

- The National Center of Patient Safety (NCPS) determined the applicability of FDA and manufacturer recalls—posting more than 700 recalls for devices, drugs, food, software and other goods—and directed facilities to take required action.
- Responding to VA and VHA Leadership referrals, the Office of the Medical Inspector conducted 30 comprehensive investigations, produced reports, and addressed 65 allegations.
- As part of VA's response to being placed on GAO's high-risk list, OE established a new Office of Internal Audit & Risk Assessment, including an Audit, Risk and Compliance Committee.
- In FY17, Management Review Service decreased the number of GAO recommendations by 28 percent over three years and implemented new processes for managing GAO recommendations.

Providing Expertise

- Through its longstanding partnership with the Department of Defense, the Evidence-Based Practice Group developed five clinical practice guidelines around opioid therapy, PTSD, diabetes, lower limb amputation, and lower back pain.
- External Accreditation Service and Programs, in collaboration with patient safety managers at the Boston VAMC, NCPS, and the Diffusion of Excellence initiative, assessed Joint Commission standards compliance and obtained approval for stocking facility AEDs with naloxone for immediate opioid overdose reversals.
- Public Health Surveillance and Research performed over 7,000 clinical tests from over 900 VAMCs through its public health reference laboratory in FY17, resulting in cost savings to VA of $2 million.

Providing Support

- In the wake of the hurricanes in Texas, Florida, and Puerto Rico, Systems Redesign and Improvement helped local facilities manage capacity through its bed management system (BMS) and made sure that the VHA providers sent to these locations had their credentials appropriately transferred for legal authority to work there through National Office of Credentialing.
- Product Effectiveness developed a Key Performance Indicators (KPI) measurement approach as a standardized mechanism for monitoring leading indicators of the measured drivers of performance, which can help local facilities manage risks before they become issues and help escalate reporting of issues that need attention and resources from VISN or national offices.
- Clinical Systems Development and Evaluation and the National Center for Ethics in Health Care

jointly developed a Goals of Care Conversations (GoCC) tool within the Patient Care Assessment System—a national, web-based app to help optimize health care, provided via Patient Aligned Care Teams—to identify, manage, and track completion of GoCC with high-risk patients.

- The Office of Health Equity, with assistance from VA Research, created a series of videos on hypertension that is helping Veterans with high blood pressure talk with their health care providers, take medication, and make lifestyle changes.

The following pages provide a snapshot of our many success stories in FY17. We invite you to read more about them and to visit our web site at www.healthcareexcellence.va.gov.

OFFICE ACCOMPLISHMENTS FY2017

OFFICE OF INTEGRITY

The VHA's Office of Integrity performs a critical role in ensuring the excellence of the health care and services Veterans receive. Its mission is to strengthen trust and confidence in the Veterans health care system by fostering an ethical and just organizational culture, and by integrating information from internal and external oversight activities.

Made up of five work units, the Office of Integrity consolidates compliance, ethics and oversight functions within a single organization. Through its monitoring, investigation, audit and ethics activities, the office provides independent internal assurance that VHA's risks and vulnerabilities are identified and addressed proactively and in an integrated manner.

Office of Integrity activities are organized around an industry-standard framework for strengthening controls and managing risk accountability known as the "Three Lines of Defense" model. This internal framework provides an integrated, multilevel approach to identifying risks and addressing problem areas within VHA's operations. Ultimately, however, all VHA employees have an important role identifying and addressing issues that affect the integrity of the Department of Veterans Affairs health system.

At VHA, the first line of defense is people, including front-line staff, supervisors, managers and facility compliance officers who implement policies, procedures and delegations of authority designed to care for Veterans and manage risk. The second line includes functions overseeing compliance and risk, and ensures that controls put in place by the first line operate the way they are designed to. The third line of defense is independent oversight to assure the highest level of objectivity, and focuses on effective governance, risk management and internal controls.

The Office of Integrity works every day to accomplish trust and confidence in Veterans' health care by providing awareness that VA has its own internal processes for reviewing and responding to issues, and by objectively identifying problem areas when we recognize them "

-Dr. Gerard Cox, ADUSH, Office of Integrity

Accomplishments

COMPLIANCE AND BUSINESS INTEGRITY

CBI HelpLine

One way in which CBI helps increase Veterans' trust is through its "CBI HelpLine," a toll-free phone number (1-866-842-4357) that handles calls from Veterans and VA stakeholders with concerns about VA business practices relating to coding, billing, and hospital reimbursement inquiries and allegations of waste, fraud, and abuse in that area. For the past ten years, these calls have been handled in-house by CBI employees.

On October 16, 2017, at the direction of the White House, VA began 24 hour a day, 365 day a year operation of a hotline (1-855-948-2411) for Veterans and their families to answer inquiries; document concerns about VA care, benefits and services; and expedite the referral and resolution of those concerns. Since then, the number of inquiries received by the CBI HelpLine has increased enormously—from 350 to 400 in an average year to 325 in two months alone. A new employee is currently being trained to help handle the additional call volume brought by referrals to CBI helpline from the new hotline.

Veterans or their family members can contact the HelpLine when they suspect noncompliant business practices in the context of the health care VHA delivers. VHA employees can also contact the HelpLine when they do not feel comfortable discussing their concerns with their direct supervisor or their local

compliance officer, or when they suspect the integrity of VHA's revenue operations has been jeopardized. Every effort is made to protect the confidentiality of the matter reported and the anonymity of those making a report. In addition, federal employees are protected by Whistleblower protection laws.

The CBI HelpLine largely supports Veterans who have already been transferred several times throughout the system, and who need help with hospital billing concerns. The CBI HelpLine provides those answers, good or bad, within fifteen calendar days, along with an explanation of VA's reasoning.

OFFICE OF THE MEDICAL INSPECTOR

Improving Veteran Care by Investigating Leadership and Employee Concerns

The Office of the Medical Inspector (OMI) improves the quality of VA care by investigating VHA leadership's concerns and employee whistleblower's complaints about VA health care to improve the quality of that care for Veterans. OMI conducts three types of investigations: (1) Whistleblower allegations referred to the Secretary of Veterans Affairs by the United States Office of Special Counsel; (2) Blue Cover reports for Congress in response to Veteran or employee complaints about the quality of care at VA facilities; and (3) Internal Reviews for the Under Secretary for Health to address problems and issues that have surfaced at VA facilities, or referrals of hotline calls from VA's Office of the Inspector General. In FY17, OMI responded to VA and VHA Leadership referrals and conducted 30 comprehensive investigations, produced reports and addressed 65 allegations.

INTERNAL AUDIT & RISK ASSESSMENT

Implementation of VHA's New Internal Audit and Risk Executive Governance Structure and Program Office to Enhance Oversight and Accountability

In response to the Government Accountability Office's (GAO) addition of VA health care to its High Risk List, and to enhance oversight and accountability, VHA established the Internal Audit and Risk Assessment Program Office and implemented a new Audit, Risk and Compliance Committee. This new internal audit capability and executive governance structure are comparable to audit and risk functions in other Federal agencies and are based on industry best practices for effective oversight and accountability at all levels.

This program impacts Veterans, front-line staff, Pentad and VISN Leadership and program offices, ensuring effective operations throughout.

MANAGEMENT REVIEW SERVICE

Providing Oversight of Audits and Reviews to Help Decrease Office of the Inspector General and Government Accountability Office Recommendations

VA's Office of the Inspector General (OIG) provides oversight of the Department's programs and operations through independent audits, inspections and investigations. VHA's Management Review Service (MRS) is VHA's principal liaison with both external oversight agencies. The Service assembles teams of subject matter experts to help OIG and GAO develop the focus, scope and methodology of their reviews, audits and inspections. It makes sure VHA's program offices comply with the standards and protocols that OIG sets and that both organizations' draft reports are reviewed and commented on in a timely manner. In FY17, MRS decreased OIG recommendations by 30 percent over one year, decreased GAO recommendations by 28 percent over three years and implemented new processes for managing GAO recommendations.

NATIONAL CENTER FOR ETHICS IN HEALTHCARE

Moral Distress Initiative

Moral distress occurs at work when an employee feels unable to act in accordance with his or her values or obligations. Seventy-seven percent of VA employees experience moral distress. Common causes in health care settings include difficulty speaking up, poor team communications and teamwork, concerns about patient safety, uncertainty about which practices are ethical and conflicts of values in end-of-life decision making. Moral distress can decrease job satisfaction, morale and job retention. These issues can directly affect patient safety and quality of care.

The National Center for Ethics in Health Care (NCEHC) has undertaken a nationwide initiative to identify, measure and address causes of moral distress across all facilities. NCEHC adapted the Moral Distress Assessment Tool for use in VA to help measure the overall level of moral distress and uncover the circumstances that cause it.

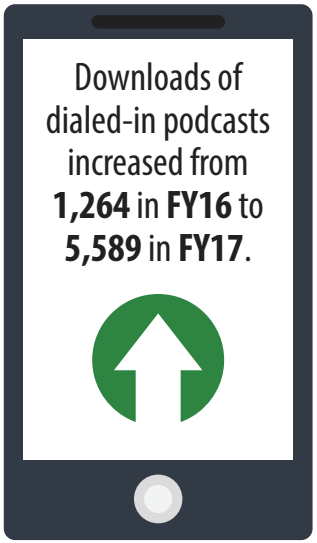
Leaders at all levels play an essential role in this process by fostering and sustaining a strong ethics culture in which employees are encouraged to "do the right thing" and speak up about their ethical concerns. Facility IntegratedEthics staff help to carry out the nuts-and-bolts work of capturing information on the sources of moral distress, identifying improvement strategies, and assessing the effectiveness of those strategies.

The initiative helps IntegratedEthics programs understand and identify sources of moral distress, measure the level of distress present in a group and begin to address it using quality improvement

approaches in preventive ethics and ethical leadership. Recognizing and counteracting moral distress helps improve patient care and supportive functions within VA medical centers. Responding quickly to moral distress has a positive effect on work engagement, work environments, collaboration among clinicians, patient safety and quality of care.

Dialed In: Helping Veterans Take Control of Their Health Care

NCEHC created a podcast that serves as a resource for Veterans and their families as they face difficult ethical decisions about health care. The series now includes six podcasts on a range of topics. In 2017, NCEHC launched an aggressive marketing campaign to increase Veteran access to the podcasts. This included adding the podcasts to the Veterans Health Library, iTunes and YouTube.



These podcasts can be found at www.ethics.va.gov/veterans_podcast.asp

Life-Sustaining Treatment Decisions Initiative

The Life-Sustaining Treatment Decisions Initiative is a national VHA quality improvement project led by NCEHC. The aim of the initiative is to promote personalized, proactive, patient-driven care for Veterans with serious illnesses by eliciting, documenting and honoring their values, goals and preferences. The initiative involves a new national policy to standardize practices related to discussing and documenting care goals and life-sustaining treatment decisions along with the tools, resources, education and monitoring to support clinicians and facilities in making practice changes.

The Goals of Care Conversations Train-the-Trainer Program delivered communication skills training to colleagues and trainees in their home facilities, preparing them to have goals-of-care conversations with seriously ill Veterans and their loved ones. In total, 204 nurses, social workers, psychologists, and chaplains and 147 physicians, nurse practitioners and physician assistants have completed the program.

Additional information can be found at www.ethics.va.gov/LST.asp

OFFICE OF QUALITY, SAFETY AND VALUE

The Office of Quality, Safety and Value (QSV) brings together the functional areas that support the experiences Veterans have with the Department of Veterans Affairs (VA) health care, and ensures that the way in which VA care is delivered is safe, timely, effective, efficient and patient-centered.

Functional areas included in QSV include quality management, accreditation oversight, evidenced-based clinical practice program, health systems innovation planning and coordination, utilization management, patient safety, risk management, medical staff affairs, public health and surveillance, product effectiveness and systems redesign. The role of the organization is to ensure every Veteran's experience with VA health care is high quality, patient-centered and seamless.

In addition to helping Veterans and their families receive world-class care, QSV helps the VA facilities collaborate with numerous other VA offices, other federal agencies, Veterans Service Organizations and those with a stake in ensuring VA provides Veterans with exceptional care.

QSV interacts 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"

-Dr. Shereef Elnahal, Assistant Deputy Under Secretary for Health for Quality, Safety and Value

Accomplishments

Built an Appropriate Governance Structure to Ensure that VA Business Requirements are Reflected in Expectations

QSV led the Data and Analytics Workgroup for the Electronic Health Record Modernization (EHRM) effort, which included collaborative efforts from field leadership, the Veterans Health Administration (VHA) Support Service Center, the National Surgery Office, and other stakeholders outside of QSV with Key Performance Indicators adequately defined pre-contract for the EHRM effort. QSV also submitted a robust technical review out of the QSV infrastructure that was critical for final negotiations.

This initiative affected EHR deployment by ensuring proper reflection of business requirements.

Successfully Launched and Brought into Sustainment the Physician Ambassador Program, Public-Facing Website and Press Release

This barrier-breaking toolkit allowed each facility to deploy the Physician Ambassador Program. A comprehensive communication plan is in development, with a plan for a White House event in 2018 to include representative physician ambassadors. Successful collaborations are in place with the American College of Physicians and the American Red Cross (ARC). Solidifying the partnership with the ARC, VA has executed a Memorandum of Understanding (MOU) with the ARC so their workforce can begin providing care in rural areas and areas in which it is generally difficult to recruit providers for permanent service, let alone physician volunteers. This MOU was executed and cleared with the general counsel of both VA and the ARC. Other external partnerships include Doctors Without Borders, with sessions dedicated to learning from their operating model with the intention of deploying volunteers in rural locations where they are needed most. In addition, collaborations with the American Academy of Family Physicians are in place to begin recruiting talented family practitioners for the initiative going forward.

The Physician Ambassador Program offers community health care professionals the opportunity to give back their time and expertise to our Veterans using the VA's state-of-the-art technology The VA's advanced medical technology and philosophy to provide evidence-based care to the most deserving and appreciative patients creates an extremely gratifying environment in which to work "

-Dr. Jan Basile, a volunteer and retired primary care chief at VAMC Charleston

Overall, the program was successfully launched in over 120 facilities with over 1,000 physicians registered as volunteers across the United States in less than one year. This was the result of an extensive communication campaign that leveraged the VA's Office of Public and Intergovernmental Affairs (OPIA) and press releases to the public, a public-facing website that was launched, and effective external partnerships such as the one with the ARC.

QUALITY STANDARDS AND PROGRAMS

External Accreditation Services and Programs

Developed and Implemented the New National Naloxone Administration for Opioid Overdose

Accreditation worked in concert with the Boston Patient Safety Managers, the National Center for Patient Safety (NCPS) and Diffusion of Excellence Shark Tank groups to assess The Joint Commission standards compliance and approval for use of the new system throughout VHA. Automated External Defibulators are now stocked with naloxone for immediate opioid overdose reversals in non-clinical care areas of VHA facilities.

Access to naloxone has been proven to provide life-saving successes when overdoses are immediately reversed with intranasal administration of naloxone. This benefits all VHA patients, staff and visitors where this process is implemented. Many VHA facilities are beginning programs to replicate the Boston VAMC.

For more information, visit vaww.ncps.med.va.gov/tools.html

Evidence-Based Clinical Practice Guidelines

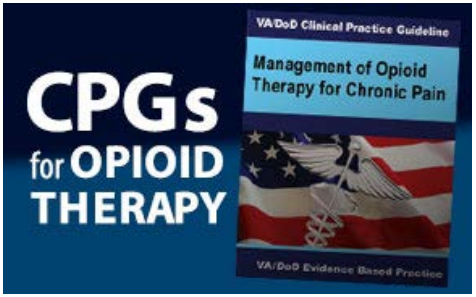
Completed Five Clinical Practice Guidelines

QSV supported development of evidence-based clinical practice guidelines in joint development with DoD. Guidelines were established for opioid therapy, PTSD, diabetes mellitus, lower limb amputation and low back pain, including a high-profile set of guidelines on opioid use for pain control in concert with the Department of Defense (DoD).

In addition, this effort was integrated into the Electronic Health Record Management (EHRM) strategy to ensure Cerner includes these guidelines in workflow solutions that will allow for enhanced standardization and a better approach to quality improvement. This union also represents a contribution to the Cerner effort, building coalitions to ensure sustainment of care delivery to Veterans in the years to come.

QSV ensured that jointly-developed VA-DoD guidelines are populating purchased workflows as part of contract negotiations, ensuring that order sets and clinical decision support reflect the hard work of developing the guidelines, operationalizing them and tracking reasonable levels of adherence for the first time in VA history. This contributes to quality improvement of care delivery to Veterans and allows for robust assessment and research into efficacy for the general population in health care.

Released VA/DoD Management of Opioid Therapy for Chronic Pain Clinical Practice Guideline



This initiative produced a provider summary, a patient summary, an educational video for an hour-long continuing medical education credit and a variety of presentations for the Specialty Care Access Network-Extension for Community Healthcare Outcomes, the Defense Center of Excellence (DCoE) and the International Opioid Conference. All materials were developed in coordination with VA/DoD Pain Groups, Centers for Disease Control and Prevention/U.S. Health and Human Services, the VA Employee Education System and DCoE.

This program is directly oriented to patients, families and health care providers to improve care, coordination and quality standards for active duty military, dependent families and Veterans. It provides guidance on starting/stopping opiates, risk mitigation, safe tapering, Substance Use Disorder monitoring and referral, effective alternative therapies and self-care.

For more information, visit vaww.oqsv.med.va.gov/functions/integrity/cpg/cpgCOT.aspx

Collaborated with ePocrates to Post VA/DoD Clinical Practice Guidelines on Their Platform

EPocrates is a popular mobile clinical reference platform and is free to use for VA and DoD health care providers. Evidence-based CPGs will be posted on their platform under the VA/CPG category.

All CPG content was reviewed and approved by VA/DoD subject matter experts for adherence to VA/DoD CPG. This initiative increases ready access at bed/chairside by VA providers improving real-time, updated, evidence-based practice, quality care, efficiency and potential improved access at no cost to VA. It also increases positive visibility of quality VHA evidence-based practice efforts. Clinical practice guidelines for Substance Use Disorder/Alcohol Use Disorder were the first to be posted on the platform.

For more information, visit www.epocrates.com

Collaborated with Annals of Internal Medicine to publish VA/DoD Clinical Practice Guidelines

Evidence-based Practice program staff assisted and supported VA CPG subject matter experts in writing and submitting articles for review and acceptance in *Annals of Internal Medicine*. The senior editor of the publication has also assigned a member of her staff to assist.

Annals of Internal Medicine is among the most highly-cited and respected medical journals in the world with a worldwide distribution of over 100,000 readers. Significantly increasing availability of VA/DoD evidence-based CPGs to our internal medical providers and external community health care partners improves adherence to our high quality standards.

For more information, visit http://annals.org/aim and search for Department of Veterans Affairs.

Systems Efficiency and Improvement for Utilization Management

Optimized Patient Flow and Utilization Management Support Efforts for the Field

Metrics for performance around transitions of care and bed management were used to assess endpoint effects. Several conferences and targeted engagements took place, led by QSV's Utilization Management (UM) and Systems Redesign offices.

QSV submitted advanced platforms to the Healthcare Improvement Center for ongoing analyses of low-performing facilities' performance with inpatient access and bed flow.

Resources Sharepoint Refinement

The UM Resources Sharepoint is an internal resource site for educating and guiding staff regarding UM processes and data interpretation and analysis. This was a collaborative effort with Health Systems Innovation Planning and Coordination.

Standardizing UM processes benefited facilities by improving flow and efficiency. Veterans benefit from receiving more efficient and effective care.

Enhanced Reports

Data analysis drilldown reports (e.g. Full Facility Comparison by Complexity and Major Service) aid in data interpretations and quickly identifying specific improvement opportunity areas. Subscription capability affords autogenerated reports.

These reports benefit facilities with timely identification of barriers to flow. Veterans benefit with improved efficiency.

National Utilization Management Integration Software

National Utilization Management Integration (NUMI) 1.1.15, the newest release of the software, received much-needed security enhancements, enhancements to clinical information, and improved system speed in FY17. This was a collaborative effort between Utilization and Efficiency Management, Health Systems Innovation Planning and Coordination, and VA's Office of Information and Technology.

Utilization Management (UM) Staff and Facility Staff benefit from having a standard, enterprise-wide system that supports UM review of inpatient care through application of evidence-based practice criteria. This results in identification of avoidable bed days of care and system inefficiencies, prompting system improvements. Veterans benefit from optimized utilization and efficiency by receiving the right care in the right place at the right time for the right reason.

SYSTEMS RELIABILITY AND CONSULTATION

QMS Consultative Division

Office of Emergency Management ISO 9001-2008 Certification

This initiative allows for a cradle-to-grave quality management system build for the major VA Central Office-level program office. The Office of Emergency Management (OEM) is compliant with all ISO 9001-2008 standard requirements, earning its external certification in 2017. OEM became only the second VA program to achieve internationally recognized ISO 9001-2008 certification. We are currently assisting them with the transition to ISO 9001-2015.

Improved governance tools ensure effective and efficient administrative systems, providing reliable processes and consistent outcomes. Improved training and competency tracking programs lead to confident staff. This initiative is a proven morale booster, leading to improved access to quality care and continuous readiness for internal and external reviews.

Improved Sterile Processing Service and Standardized the Specific Purpose Funding Program

This initiative provided $53 million to support Sterile Processing Service (SPS) improvements and standardization and provided funds to support human factors workplace improvements, automated processes, equipment upgrades and modernization and improved sterilization practices.

SPS is the front line in the war against hospital-acquired infections. Improved processes and "right-sized" instrument inventories resulted in Improved access to safe care. Improvements in workplace environment and automated processes resulted in higher employee satisfaction and increased employee retention and morale.

QCD Governance Tools

Quality Management Systems were internally developed and installed in 11 program offices and facilities, including a document control system, an education management system, corrective action/preventive action tracking, operating room workflow scheduling and Performance Measurement Dashboards.

Improved governance tools ensure effective and efficient administrative systems, providing reliable processes and consistent outcomes. Improved training and competency tracking programs lead to confident staff.

PRODUCT EFFECTIVENESS

Product Effectiveness and Pharmacy Baseline Assessment

Product Effectiveness delivered the Clinical Pharmacy Baseline Executive Summary Report to Pharmacy Benefits Management (PBM). PE provided a detailed, rigorous and comprehensive measurement methodology of supporting business functions and accountability measurement, maintaining VHA's status as a national leader in provision of comprehensive pharmacy services.

VHA Clinical Pharmacy Services are national leaders and front-runners in the provision of care to Veterans that is unsurpassed by non-VHA pharmacy service providers. VHA pharmacy service consistently out-performs non-VHA pharmacy service providers in accountability, quality of care, patient safety, value and access to care for Veterans. PE offered its expertise to conduct a comprehensive baseline review of VHA pharmacy services including development of a measurement framework and comprehensive measurement plan to showcase the pharmacy services VHA provides and prove that VHA is the unprecedented national leader in providing expert, high quality and safe medication management. VHA Clinical Pharmacy has a positive impact on Veterans health experience throughout VHA.

VetLink Queuing Baseline Assessment

Product Effectiveness and Veterans Point of Service (VPS) partnered to conduct a joint evaluation of the VetLink VPS technology. The primary focus of the evaluation was identifying how capabilities of patient queuing could help track provider utilization. The scope of the engagement was to assess the end-to-end workflows of the VetLink queuing processes within Primary Care, Specialty Care and Mental Health clinics.

The evaluation provided several key findings shared with VA and VPS leaders. Specifically, the evaluation emphasized the effectiveness of VPS queuing as a tool that leaders can use for practice management.

The following are benefits of VetLink queuing: the ability to track patient movement within the facility, better understanding of the patient experience, improved health care team communication, improved clinic operation efficiencies if used for improvement and reinforced concierge-level service offering.

Pharmacy Clinical Decision Support Baseline Assessment

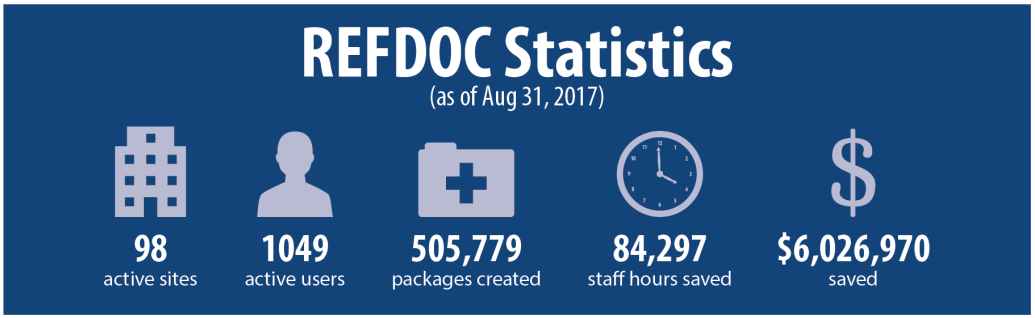
The Kansas City Veterans Affairs Medical Center is developing an integrated medication management platform to seamlessly integrate VA's multiple pharmacy systems (e.g., IV smart pumps, automated storage cabinets and pharmacy dispensing technology) and Electronic Health Records (for example, VistA). The goal of this effort is to better support the full range of clinical (e.g., prescribing and administration) and pharmacy medication-related activities (for example, procurement, dispensing, etc.).

This platform includes BD CareFusion's MedMined technology, a clinical surveillance software application that continuously scans and aggregates clinical data from multiple source systems and presents this information to the user in an actionable format. MedMined has the potential to improve quality by enabling health care providers and pharmacists to have real-time access to critical patient data. This results in improved clinical decision-making and, subsequently, improved patient outcomes by providing enhanced monitoring, prioritized alerting and tailored patient profiles which will support the increased identification and prevention of Adverse Drug Events. The impact of this technology has the potential to positively impact Veterans seeking pharmacy services.

REFDOC Assessment

Product Effectiveness completed an evaluation of REFDOC, a web-based tool that automatically retrieves, consolidates and organizes a Veteran's medical information into an authorization packet.

Findings from the most current assessment indicate that REFDOC is providing operational efficiencies compared to previous processes. Due to variations in VAMCs legacy processes, a conservative estimate of 10 minutes per staff hour savings was used in calculating estimated time savings in preparing Choice Program referral packages. This tool positively impacts all Veterans utilizing VHA Community Care services by providing timely efficient access to care.



Key Performance Indicators Framework

Product Effectiveness developed the Key Performance Indicators (KPI) measurement approach as a standardized mechanism for monitoring leading indicators of the measurable drivers of performance. Indicators are the application of a specific threshold for a performance metric or combination of metrics to provide a signal for an element of program health. KPIs, indicators for the most elements, provide a tool to help local facilities manage risks before they become issues and to support reporting and escalation of issues that require assistance or resources from VISN or national offices. Product Effectiveness is working with the Office of Veteran Access to Care to develop access-specific KPIs.

The KPI approach provides visibility at local, VISN, and national levels, and a tailorable means of escalating access issues that are outside the ability of the local facility or service to address. Leadership establishes the thresholds, triggers and actions based on unique facility characteristics and acceptable levels of risk. If one of the indicators highlights problems with space or equipment that may affect access, a facility may not have the funds to address that problem and would need to escalate the issue for action. The KPI framework will provide VISNs and national leadership visibility into potential enterprise-

level access issues, such as policy or processes that should be revised across the VISN or VA to address enterprise access problems. Implementation of these concepts drives a new method of managing risk for the enterprise, resulting in leading change for the organization.

PATIENT SAFETY AND RISK AWARENESS

National Center for Patient Safety

National Communications on Clinical System Vulnerabilities

The core function of the National Center for Patient Safety (NCPS) is to investigate issues that VA patient safety professionals see as a Veterans Health Administration (VHA) risk.

In FY17, over 350 issues were brought to NCPS as vulnerabilities or issues that could potentially be larger than what was seen in the reporting facility. NCPS published seven patient safety communications, directing VHA action to reduce the risk of patient harm. Key Device manufacturers changed product design due to NCPS and VHA CO demonstration of system vulnerability. NCPS also introduced CareShareDare as a framework where PSO/PSM can capture their work and articulate questions on system limits-of-use.

National Products Recall

Another core function of NCPS is to centrally collect and determine applicability of the Food and Drug Administration (FDA) and manufacturer recalls, and to ensure through closed-loop communication that a tainted product is removed from shelves.

In 2017, NCPS posted more than 700 recalls for devices, drugs, food, software and other goods, directing impacted facilities to take required action. Able to confirm message received, action taken by each facility, and running VHA compliance of greater than 98 percent. Affected products removed from VHA facilities: 3,040,763.

NCPS has expanded so different VHA central office chiefs can post notices to act and get confirmation action has been taken. Healthcare Talent Management and Pharmacy Benefits Management are included; Prosthetics and SPS both are requesting to be hosted as well.

Development of Clinical Limits of Use Tool

Developed CLOUT for wheeled mobility device evaluation, with VA Human Engineering Research Laboratories (HERL). NCPS funded VA HERL to implement the creation of the Clinical Limits of Use tool, which will guide the IPTs and purchase teams to confirm safe product design and performance.

Those entrusted to evaluate and purchase complex devices/products for VHA may or may not have the experience or incentive to confirm actual in-use performance. Along with striving to bring the summary of in-use performance issues reported through patient safety to the purchasing teams and IPTs, we'd like to capture the best practices for ensuring device performance over the range of environments and with the range of end-users experienced in VHA. This will help the industry define and communicate the "limits of use," as opposed to assuming the end user will follow whatever IFU is provided.

Often, the instructions for use do not speak to how a product should be stored, the assumed climate/environment, the assumed strength, or the assumed size of the end user. We strive to better document the performance envelope so that we can maximize the chances of safe care.

Pressure Injury Prevention Breakthrough Series Launched

VHA teams from around the country apply and participate in a year-long program to reduce pressure injury occurrences and improve injury care on their unit.

Thirty teams participate, each with two coaches: a clinical coach and an implementation coach. This program is geared at making changes locally, allowing hundreds of patients to benefit over time.

Patient Safety Centers of Inquiry

Patient Safety Centers of Inquiry (PSCIs) are expected to develop, disseminate, and most importantly implement clinically relevant innovations that improve patient safety in VHA facilities. Successful PSCIs provide specific tools for the field that can help to improve patient safety.

- Improve interventions, such as safety planning, to reduce suicide rates among Veterans.
- Inspire studies around Veteran suicide to develop improved interventions that reduce suicide among Veterans.
- Develop methods to reduce the use of opioid medication after orthopedic surgery and reduce the chance that Veterans will become addicted to opioid medications.
- Improve electronic communication and alerts so that critical test results for Veterans with cancer are not lost to follow-up.

- Breakthrough series collaborative was designed to reduce patient falls.
- Improved patient safety in the use of the electronic medical record.

Chief Resident in Quality and Safety

Improving overall quality and patient safety is at the core of VA's mission to provide the best care possible for Veterans. Reducing and preventing accidental harm has significant impact on improving safety, and VA's NCPS leads the effort to disseminate key practices throughout the Nation.

Establishing an environment of quality and safety throughout VA needs to start from the earliest stages of a physician's career. Too often, new physicians do not understand the systems of care, such as institutional culture and electronic health records, that work together to ensure quality and safety are just as important as a physician's commitment, hard work and attention to detail.

The Chief Resident in Quality and Patient Safety (CRQS) program provides an opportunity for recently graduated medical residents to learn about quality and patient safety while engaging in improvement activities at their home facility. During the year-long program, residents participate in a curriculum led by NCPS that includes a week-long, in-person meeting as well as monthly virtual sessions. Residents gain knowledge on improving processes related to everything from electronic health records to their home facility's environment.

The CRQS program now includes over 80 chief resident positions in specialties including internal medicine, radiology, psychiatry and surgery at over 50 VA medical centers. Approximately 60 percent of CRQS graduates stay within the VA health care system, which helps improve access to care for Veterans. Graduates teach their quality and safety skills to others within VA, which helps improve the overall quality of care that VA provides.

Advanced Fellowship in Patient Safety

NCPS led the training, including boot camps, weekly calls and mentoring independent patient safety projects for seven fellowship sites with one to three fellows at each site.

Fellows work as part of an interdisciplinary team at VA host facilities to conduct important patient safety and quality improvement projects that are aligned with the Secretary of Veterans Affairs Dr. David J. Shulkin's five priorities. NCPS has fellows working to enhance the reporting and investigation of adverse events and close calls in outpatient clinics so that, as an organization, we can learn and improve; implementing the Daily Plan on VA inpatient units, empowering Veterans to participate in their care; and working to enhance the joy of work for Patient Safety Managers across the VA nation that help ensure safe care for Veterans.

Public Health Surveillance and Research

System-Wide Public Health Surveillance

One of the missions of OE's Public Health Surveillance and Research Program (PHSR), part of the Office of Quality, Safety and Value, is to provide public health surveillance throughout the VA health care system. Public health surveillance is a tool to collect data to estimate the health status and behavior of different populations—in VA's case, America's Veterans. In support of the VHA referral laboratory project (reducing commercial laboratory test costs to VA), our public health reference laboratory (PHRL) performed over 7,000 clinical tests from over 90 VAMCs in FY17 resulting in a cost-savings to VA of $2 million.

Veterans and their families benefit from the work of the Public Health Surveillance and Research Program by being fully considered in nationwide statistics related to health emergencies, which helps VA obtain the resources needed to prepare to serve and care for them properly. They are also helped by the critical situational awareness public health surveillance provides VA leadership and clinicians, allowing them to meet Veterans' needs and find ways to protect them from infectious disease outbreaks.

Zika Surveillance

Two recent surveillance projects conducted by PHSR are extremely important—surveillance for Zika virus within the VA and the health effects caused by Hurricane Maria. As of October 2016, of the 1,477 unique patients from 80 VA medical centers tested for Zika virus at PHSR's Public Health Reference Laboratory, 712 Veterans were found to have been infected with the virus. Veterans residing in Puerto Rico and the Virgin Islands represented 93 percent of cases (660/712); the remaining 52 cases were Veterans who had traveled to areas where Zika transmission was occurring.

Because of PHSR's weekly surveillance reports, Veterans and VA employees at various locations throughout the nation were provided with critical information to reinforce educational services and preventive measures to help protect against possible Zika infection. This was especially helpful to state and local health departments and to Veterans residing in areas where Zika transmission was occurring (Puerto Rico and the Virgin Islands), and where frequent sporadic cases occurred (Florida).

PHSR provided syndrome-based surveillance, looking for diagnoses that might indicate infectious diseases potentially resulting from the storm. These include conjunctivitis (an eye infection that sometimes occurs when people do not have access to clean water), influenza outbreaks and outbreaks of leptospirosis, a serious illness associated with exposure to contaminated water.

During both the Zika and Hurricane Maria events, PHSR partnered with the Centers for Disease Control (CDC), making certain that data CDC collected included accurate information about Veterans (who are

sometimes hit harder by hurricanes and infectious diseases because many are older, sicker, and poorer than others in the general population).

Systems Redesign and Improvement

Improvement Advisor Academy

Systems Redesign and Improvement launched a 12-month program to train and develop change agents within VHA.

The program supports 40 participants in learning multiple improvement methods and leadership skills to develop students into strong advocates of improvement, which supports strategically aligned improvement work. Through this program, 120 improvement projects focused on reducing wait times, waste and costs.

Inpatient Flow Academy

Completed a program to train and develop inpatient flow operations and improvement experts across VHA. The program supported 30 participants in gaining knowledge of inpatient flow operations methods and tools, as well as leadership engagement and communication methods (among other skills), with a requirement to complete a hospital flow improvement project for graduation.

Through this program, Inpatient Flow Academy expects to support future national improvement collaboratives, providing coaching, development of and showcase improvements to spread across VHA, thereby contributing to VHA's overall improvement capability.

Disaster Response and Relief: Events in Houston, Florida and Puerto Rico

The Bed Management System and the Emergency Department Information System (emergency room flow systems) are managed out of Health Systems Innovation Planning and Coordination with staff working diligently to ensure that these systems were used to manage capacity as VA took on the health care burdens of the public during these disasters. Despite the strains placed on the systems, staff worked to ensure they were functional and appropriately used by staff across VA to make critical decisions. In addition, the National Office of Credentialing worked overtime to ensure that care providers being sent from across VA had their credentials appropriately transferred for the legal authority to work in these areas for all three natural disasters.

VHA Transitions Collaborative Optimizing Patient Flow

Systems Redesign and Improvement completed a national inpatient flow improvement initiative to demonstrate improvement in transitions of care within facilities across VHA.

The initiative supported 30 VAMC-based teams in developing and executing improvement plans to improve patient flow processes, which centered around transitions of care from higher to lower acuity levels. It consisted of three learning sessions, national coaching, monthly all-team calls and instructions on flow/process improvement methods and tools, leadership engagement and communication methods (among other focus areas). Based on past successful Institute for Healthcare Improvement modeled collaboratives of this type, a strong initiative-wide return on investment is expected.

OFFICE OF REPORTING, ANALYTICS, PERFORMANCE, IMPROVEMENT AND DEPLOYMENT

The Office of Reporting, Analytics, Performance, Improvement and Deployment (RAPID) provides VHA leaders and field facilities with the analytics they need to assess how well VHA is performing as an organization.

These tools help VA, at all levels, to rapidly identify concerns about the performance of individual VA health care facilities or the system as a whole.

RAPID also helps VA leaders prioritize significant care issues and respond to them; engages VA facilities and network leadership in monitoring issues in their areas of responsibility; coordinates with other organizations within VHA on issues involving quality of care; and works to monitor, sustain, and spread quality measures (tools that help health care organizations measure or quantify health care processes, outcomes, and patient perceptions) and their use throughout the entire VA health care system.

RAPID Accomplishments

RAPID impacted at-risk facilities by developing applications for use in the Healthcare Improvement Center (HIC) to package relevant content needed to evaluate facilities, integrate the various early warning systems and trigger systems with a geospatial map and project the content across the 12 to 16 high-definition screens on the wall in the HIC. Improvement plans were executed for all one-star, high-risk, otherwise vulnerable hospitals with continued virtual follow-up monitoring and ongoing consultations. A Strategic Analytics for Improvement and Learning consultation application that uses three modules to track various consultative activities was developed to achieve standardization across Veterans Health Administration (VHA) facilities.

RAPID puts Veterans first by transparently sharing results on the quality and timeliness of Veteran care, which improves the public's trust in our services. Internal and public reporting tools were constructed to compare VA care with the community along access, experience, quality and safety dimensions.

VA medical centers' (VAMC) patient safety metrics were also released. U.S. and local benchmarks and

community partner performance is unparalleled, making VA the first nationwide health system to provide this level of comprehensive monitoring and reporting.

New Approach to Assist Struggling Facilities with STAT

Strategic Action for Transformation (STAT) is a more aggressive and proactive approach to identifying VA medical centers struggling to meet the needs of Veterans using sophisticated statistical methods tracking to identify VA medical centers at risk of low performance.

OFFICE OF CLINICAL SYSTEMS DEVELOPMENT AND EVALUATION

The Office of Clinical Systems Development and Evaluation (CSDE) works toward the development of clinical systems that integrate quality and decision support into workflow and analytical programs. Products prepared by CSDE help VA facilities with patient care plan management, identification and evaluation of high risk patients, biosurveillance, infection control and optimized assessment and tracking for cardiovascular procedures.

CSDE oversees the National VA Cardiovascular Assessment, Reporting, and Tracking program, which monitors and enhances the quality and safety of invasive cardiac procedures for Veterans through clinical analytics and information technology.

Using predictive analytics, CSDE staff use context-sensitive and relevant information to identify unrecognized relationships and develop sophisticated analytic models that predict important clinical outcomes, including the Care Assessment Needs (CAN) score, which helps primary care providers identify patients at risk of hospital admission or death.

The office's Patient Care Assessment Systems (PCAS) program is a web-based clinical application which provides risk-based patient filters and team-based tasking and care planning for front-line providers.

The CSDE Bio-Surveillance Anti-Microbial Stewardship and Infection Control (BASIC) tool provides near-real-time reporting of health care-associated infections at all VA locations.

Accomplishments

Clinical Assessment Reporting and Tracking Program

Safety - National Center for Patient Safety

The Clinical Assessment Reporting and Tracking Program (CART) has forged a collaboration with the National Center for Patient Safety, with plans to coordinate recall notifications for cardiac devices during the first quarter of 2018.

The organization will be able to provide for a single, unified source for device recall information for all interventional cardiologists or cardiac electrophysiologists in the VA system.

Safety – Device Surveillance

The program continues to work with the Food and Drug Administration (FDA) to monitor and report issues with devices. In the past year, CART has reviewed and reported 138 unexpected problems with devices and 30 device failures.

The organization has already identified several cardiac device failures that have been reported to the FDA, reducing the chances that similar device failures can lead to patient harm. This is an ongoing process that will continue through 2018.

Quality – Patient Reported Outcomes

Patient-recorded outcomes have been incorporated into the Clinical Assessment Reporting and Tracking System for Cardiac Catheterization Laboratories pre-procedural report, allowing providers to refer to a quantitative measure of patient symptom burden prior to completing an elective invasive cardiac procedure.

This will allow cardiology providers a quantitative assessment of symptom burden prior to coronary revascularization. Subsequent measurement of symptoms could elucidate the potential benefit of invasive cardiovascular procedures.

Quality – Analytics

The program has developed predictive analytic programs for post-intervention mortality, bleeding and contrast-induced nephropathy.

These predictive analytics will ultimately be implemented into the CART application, allowing individual

providers to determine the periprocedural risks of the patient they are about to treat, and use this information to mitigate some of the risk.

Reporting – Risk Adjustment

The program has developed a risk adjustment algorithm so that risk adjusted outcomes could be reported for each individual VA cardiac catheterization laboratory.

Reporting or periprocedural outcomes was previously performed using raw data, without reference to the risk faced by the patient undergoing the procedure. Going forward, the CART program will report risk adjusted outcomes to give a better understanding of interventional quality at all VA cardiac catheterization laboratories.

Patient Care Assessment System

PCAS is a national, web-based application designed to optimize the health care that VA's Patient-Aligned Care Teams (PACT) provides to patients—especially those who are high-risk. Specifically, PCAS helps PACT care managers and teams identify patients who require focused attention based on risk characteristics, and improve coordination of the services and care that the patients receive. The National Center for Ethics in Health Care has developed a Goals of Care Conversations (GoCC) tool within PCAS to help PACT teams identify manage, and track completion of GoCC with their high-risk patients.

The GoCC tool within PCAS includes the following features:

- An automatically-generated list of Veterans on the team panel who are at highest risk of hospitalization or death based on a Care Assessment Need (CAN) score of 95 or greater, and who may be appropriate for GoCC.
- The ability to manually add to the list other Veterans whom the team, based on clinical judgment, considers at high risk for a life-threatening clinical event in the next one to two years.
- A table that provides a snapshot of high-risk Veterans' status with respect to GoCC, along with information about upcoming appointments.
- The ability to assign, schedule and manage tasks associated with a GoCC across the team.
- Tool Tips to guide appropriate use.

This program impacts all VHA primary care patients who require end-of-life decision making.

Care Assessment Needs Score Production Improvements

The CAN scores are predictive models developed in 2013 that provide PACT with the ability to locate patients who are statistically at the highest risk of hospitalization or mortality. The models are run weekly and provide risk assessment scores and associated probabilities for hospitalization in 90 days or one year, or a combined risk of hospitalization or mortality within 90 days or one year. CAN 2.0 was released in 2015. Several important improvements were made to the production process for CAN in 2017, which improved the general validity and reliability of the data and improved the efficiency of the overall process by nearly 25 percent.

The CAN scores impact VHA Clinical, Operational and Research users.

Intra-Agency Agreement with the Department of Energy's Oak Ridge National Labs

CSDE (with support from Vista Evolution) led an intra-agency agreement to leverage Oak Ridge National Lab subject matter expertise for defining business and related acquisition requirements and performance criteria for a Department of Veterans Affairs (VA) advanced analytics system implementation. The results of this intra-agency agreement created a design plan and architectural roadmap to integrate advanced analytics into health care operations related to the VA and existing Cerner analytics platforms. The redesigned analytics architecture and infrastructure included the capability to accommodate high throughput analytics, diverse and growing data sources, and knowledge and metadata management systems that evince reusable, modular workflows for reporting and discovery.

The following products were prepared in 2017, which will guide prototyping of clinical use case-based advanced analytic products in 2018:

- Environmental scan of current VA analytics and data infrastructure capabilities
- Robust and diverse user interviews, which included informaticists, leadership and end-users of analytic products to create a summary entitled "Cohort Management User Stories"
- Software requirement specifications for cohorts and workflow application enhancements for electronic health records modernization

- Advanced analytics reference architecture which addresses mutable and immutable data stores from VHA (including Connected Health) and ILER data from the Department of Defense
- Analysis of consult-specific clinical and technical workflows and user "stories" as a use case to direct analytics planning
- Gap analysis between the current VA analytic state and requirements for future capabilities for advanced analytics, which encompass traditional business intelligence analytics and extends to model-based and deep-learning analytics and in-workflow cohort management
- Technical design specifications for the envisioned Advanced Analytics Environment
- A technical roadmap for the Advanced Analytics Platform
- Installations of the VA CDW and eHMP Sandbox both completed at ORNL

The potential impact will include all VHA users of the electronic records systems (e.g. CPRS, with future impacts to Cerner), operational leadership and research users.

Bio-Surveillance Anti-Microbial Stewardship and Infection Control (BASIC) Tool: Infection Control

Preparing for National rollout in Nov. 2017

Rollout of the Bio-Surveillance Anti-Microbial Stewardship and Infection Control (BASIC) tool for infection control pilot users working with Inpatient Evaluation Center implementation team. Version 1.8 published to IPEC Production site. Customized default reports for typical infection control workup of patients requiring precautions and of patients with a possible healthcare associated infection. As of September 2017, approximately 40 pilot users across 27 sites have used the BASIC tools; preparing for national rollout as of November 2017.

Several versions published over the year with the latest update on September 9, 2017.

User Audit Report

Prepared a user audit report to evaluate usage by station and report.

Created a user audit report so BASIC and IPEC teams can see which users/sites are accessing the system and how frequently. This can assist with following up after trainings and tracking adoption of tools.

OFFICE OF HEALTH EQUITY

The Office of Equity (OHE) helps VHA leaders develop effective management tools, systems and studies that optimize the productivity of the department's clinical staff. This support helps the department make informed decisions on how VHA facilities, networks, and other offices should be optimally staffed in order to provide Veterans with safe, efficient, effective and compassionate care in a timely manner.

The office also produces a variety of studies, products and tools to measure the productivity of VA's physicians, rehabilitation specialists and other health care providers. It also helps to unify the work of VA managers and clinicians by creating an annual contract between VA Central Office and Veteran Integrated Service Network directors, called the Executive Career Field plan. Finally, the office develops products to help VA offer world-class health care to its growing population of enrolled Veterans, without having to increase the funding taxpayers provide for that care.

Accomplishments

Focus on Health Equity and Action Cyberseminar

In 2017, the Office of Health Equity continued to leverage online outreach by working with VA Health Services Research and Development to launch a series of cyberseminars for Veterans, VHA leadership, clinicians and non-clinicians, stakeholders and researchers focused on health equity and action.

These monthly seminars highlighted activities that promote implementation of VHA's Health Equity Action Plan as well as health concerns important to Veterans. There were 2,347 registrants and 746 attendees to the seminars. Additionally, the seminars were archived on the OHE website.

Journeys with High Blood Pressure Videos

With the assistance of a VA research team, OHE created a series of videos showing Veterans discussing their experiences with high blood pressure and offering tips to take medications, talk with health care providers and make other lifestyle changes. These videos are being viewed by Veterans and other medical center staff in patient waiting rooms in medical centers nationwide. Viewing the hypertension videos has helped Veterans and other medical center staff to better identify, understand and tackle health disparities through education. It has translated medical research into action, promoting change within the organization.

National Veteran Health Equity Report

OHE finalized the National Veteran Health Equity Report (NVHER), which is also available for download on mobile devices in an ePUB or PDF format. The NVHER provides detailed data on the disparities in health care and health outcomes among Veteran subgroups.

The report allows VA, Veterans and stakeholders to monitor the care vulnerable Veterans receive and set goals for improving their care. The NVHER includes a foreword from the Association of American Medical Colleges' CEO, Darrell G. Kirch, MD. A data story and visualization tool has also been created from the NVHER. There have been 5,695 pageviews on the NVHER webpage.

Transgender Veterans Protocol Main Paper

The purpose of this research protocol and related research is to examine medical and mental health outcomes among transgender Veterans and identify disparities these Veterans face when seeking VHA care.

According to the journal *LGBT Health*, the main paper from the protocol was the third-most downloaded article as of March 27, 2017. The study, *Mental Health and Medical Health Disparities in 5,135 Transgender Veterans Receiving Healthcare in the Veterans Health Administration: A Case-Control Study*, was first published online in December 2015. The study examines psychiatric and mental health outcomes in clinically-diagnosed transgender Veterans receiving VHA care from 1996 to 2013.

Virtual Patient Training Modules

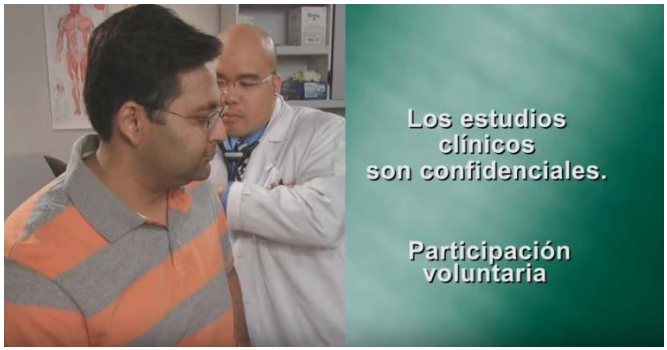
OHE now offers Virtual Training Modules in VA's Talent Management System (TMS) and VHA TRAIN for both VA employees and the public. The Virtual Patient Training Modules were created by OHE to assist clinicians, non-clinicians, Veterans and stakeholders in understanding the importance of assessing and increasing competency of health equity issues for Veterans of all races and ethnicities.

Training scenarios for each module are based on health care experiences of Veterans collected by OHE over the years. The intent is for users to hear the voices of vulnerable Veterans, learn about their experiences and use this knowledge to reflect on everyday interactions between staff and vulnerable patients. The training modules were highlighted by MedEDPortal in February 2017.

Food and Drug Administration Clinical Trial Diversity Educational Series – 2017

The Food and Drug Administration (FDA) Clinical Trials Initiative involves launching a series of educational videos and materials to raise awareness about the importance of minorities participating in clinical trials. OHE partnered with the FDA's Office of Minority Health to amplify these videos among Veterans and stakeholders.

These videos stress the importance of why diversity is needed to ensure medical products are safe and effective for everyone, particularly minority Veterans.



DIFFUSION OF EXCELLENCE INITIATIVE

Borrowing from start-up and entrepreneurial ventures, the VA launched The Diffusion of Excellence Initiative in 2015 to engage, encourage, and support employees to solve VA's most pressing challenges. The Diffusion of Excellence Initiative helps to identify and disseminate clinical and administrative best practices through a learning environment that empowers its top performers to apply their innovative ideas throughout the system – further establishing VA as a leader in health care. Through Diffusion of Excellence, dedicated frontline employees are influencing outcomes far beyond their individual workplaces. Those facilities that shine have a way to spread their excellence and help their peers reach their potential. The diffusion process helps identify and disseminate clinical and administrative best practices, and standardize those that promote positive outcomes for Veterans across the entire VA system.

Accomplishments

Executed Two Shark Tank Events in 2017

The Diffusion of Excellence Initiative continued to contribute best practices to the highest-priority initiatives in VA through a "Shark Tank"-like virtual competition program. The program was made more sustainable by recruiting a full time Diffusion Lead, Dr. Ryan Vega. Evidence of success includes Diffusion Hub documentation of best practice uptake. Best practices surrounding suicide prevention, prosthetics device delivery and other key priorities of the Secretary of Veterans Affairs Dr. David J. Shulkin were emphasized in recent rounds and have been scaling efficiently.

Currently, there are 664 replications of the initiative in place, exceeding the 2017 goal of 450 replications. Additionally, four best practices have scaled nationally in the same fiscal year, exceeding the goal of three best practices.

GOLD STATUS PRACTICES

FLOW3 System

The FLOW3 System is a workflow management system developed by the VA Puget Sound Health Care System in Seattle that incorporates custom-designed features to address the process for authorizing artificial limbs. The system includes an artificial limb consult template, a consult comment tool and a web-based dashboard with custom screens for staff members' workflow management. Using FLOW3 has reduced wait time variability and led to a more predictable process to help Veterans get their artificial limbs more quickly, thereby improving the overall experience.

Pain University

The Tomah, Wisconsin VA Medical Center puts Veterans in charge of their pain through Pain University. The program allows them to learn about the factors that impact their pain and helps them choose a treatment path. Research has shown that those with better knowledge of their pain and treatment strategies have significantly greater success in managing their pain than those who do not. VA medical centers around the Nation have expressed interested in launching Pain University at their facility, reinforcing the initiative as a top model for improving the VA experience for Veterans.

My Life, My Story

The William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin is also committed to improving the overall Veteran experience through My Life, My Story. The initiative encourages staff and trained VA volunteers to conduct interviews with Veteran patients and write brief stories about their lives. The program helps Veterans share their compelling and deeply moving stories with others; honors their voices and lived experiences; and can support more effective patient-centered care by providing VA health care providers with insights and information they might not otherwise have obtained in single visits. At least 16 other VA medical centers are now using the program, and it is in the process of being implemented nationwide by the Veterans Experience Office.

SharePoint Construction Safety Tool

The SharePoint Construction Safety Tool from VA's Palo Alto Health Care System developed a web tool that provides an electronic method to document construction safety inspections using SharePoint. The tool tracks deficiencies from identification to corrective action; ensures compliance with federal

regulations; and documents inspection information, deficiencies and emails to the contractor. The standard tool is helping to improve the overall quality of the VA health care experience.

Substance Use and Suicide Prevention Group Therapy Module

The Louis Stokes Cleveland VA Medical Center, located in Ohio, developed a Substance Use and Suicide Prevention Group Therapy Module, which includes a one-hour psychoeducational group therapy session for Veterans. In the session, a Substance Use Disorder (SUD) treatment specialist and suicide prevention coordinator facilitate group sessions covering the prevalence of suicide in SUD treatment populations. It also explores risk factors and warning signs for suicide, provides information on the Veterans Crisis Line and local resources, and teaches Veterans to create personalized safety plans. In addition to creating a safe environment for Veterans, the module also focuses on suicide prevention, another core goal of VA.

Prevent Non-Ventilator Associated Hospital Acquired Pneumonia (NV-HAP)

Quality and safety is also at the forefront of the Salem VA Medical Center's initiative to prevent non-ventilator associated hospital acquired pneumonia (NV-HAP). The program encourages clinicians to collaborate with dental services to improve oral care for hospitalized Veterans, addressing the association between the oral microbiome and development of pneumonia. By improving teeth brushing among hospitalized Veterans, the team reduced the number of cases of NV-HAP in their facility by 70 percent, greatly improving the safety of Veterans.