HSR&D
Health Services Research & Development Service

FORUM
Translating research into quality health care for Veterans

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Commentary

Change in Health Care

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Contents

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The opinions expressed in this article are those of the author and not necessarily official policy of the Department of Veterans Affairs.

The Imperative

"If you don't like change, you're going to like irrelevance even less."

The Honorable Eric K. Shinseki, Secretary, Department of Veterans Affairs

The national consensus for change in health care comes from increasing awareness of inadequate access, variable quality, high costs, and mediocre outcomes, as well as the realization that economic stability requires we address these shortcomings. While VA may have demonstrated superior performance in access, quality, and outcomes, we are not exempt from this imperative. In areas such as polytrauma, advanced prosthetics, and comprehensive mental health services, the pace of change in VA has been significant. Yet, in January 2009 testimony to the Senate Veterans Affairs Committee, Secretary of Veterans Affairs, Eric Shinseki emphasized the need, not simply for more of the same, but instead for fundamental transformation into a "21st Century Organization." He characterizes this as:

- Centering on Veterans as clients, not simply users. We design, implement, and evolve our services to meet the changing needs of Veterans through an engaged, inspired, and empowered workforce.
- Focusing on results, particularly the timeliness, quality, and consistency of our services. We set and meet objectives for improved access, high-quality care, and exceptional client relationships, using world-class technology and business processes, leadership, accountability, and attention to effectiveness.
- Forward looking. We anticipate Veteran needs and are proactive in meeting them, through an innovative, Veteran-focused culture, effective communication, and systematic outreach and collaboration.

As Army Chief of Staff from June 1999 through June 2003, General Shinseki transformed a high fixed-cost, Cold-War legacy into an agile, versatile, and flexible fighting force able to respond rapidly to emerging threats. Many parallels to health care can be drawn from the Army's transformation.[1]

A Compelling Vision

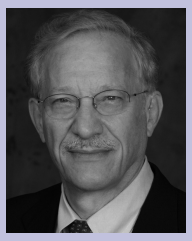
"…the core of the matter is always about changing the behavior of people, and behavior change happens in highly successful situations mostly by speaking to people's feelings."

John P. Kotter[2]

Those that study organizations closely have observed that change is less about data, analysis, and strategic planning than about a compelling truth that shapes feeling and motivates action. We appreciate as much in clinical practice—the smoker won't quit by being presented statistics, but only after seeing the benefit that quitting produces.

Within VA, the vision for change takes the

Director's Letter



Given the national focus and debate about health care reform, it seems very timely that this issue of FORUM focuses on the topic of change. As both Drs. Francis and Atkins note in the opening Commentary and Response articles, VA has made tremendous progress in organizing to improve health care for Veterans, but many challenges remain. Specifically, how do we best implement changes that will improve the VA health care system now and for the future, enabling us to provide consistent, accessible, high-quality, cost-efficient care for all Veterans? Health services researchers can play an integral role in assisting the organization to meet such challenges. For example, much has been learned about implementing cost-effective, evidence-based interventions into routine clinical practice from VA's Quality Enhancement Research Initiative (QUERI). In addition, there are many other health services research efforts that already have or will add to our knowledge about achieving and sustaining health care systems change. In this issue's Research Highlight articles, Drs. Charns and VanDeusen Lukas describe critical drivers of systems change and Drs. Hartmann and Berlowitz discuss challenges associated with changing the culture of nursing home care to one that is more resident centered.

In other news, HSR&D will hold its Scientific Merit Review Board (SMRB) meeting in August. The SMRB consists of a multidisciplinary group of VA and non-VA experts who rigorously review VA health services research proposals covering an array of health care issues that affect Veterans' health and care. The August SMRB will review 113 research project proposals (an increase of 10 percent over the August 2008 review) and 82 pilot project proposals. HSR&D looks forward to supporting innovative, Veteran-centric research projects. Keep your proposals coming!

Seth A. Eisen, M.D., M.Sc.
Director, HSR&D

form of *Veteran Centered Care*. This involves anticipating patient needs by defining the delivery system and aligning our services around mutually negotiated needs and goals. The care we provide, whether local or regionalized, in-house or purchased, will reflect the longitudinal needs of patients rather than the expertise of specialized clinicians. As a result, VA will increasingly orient care around interdisciplinary teams that share decision-making with patients and families. Among the key principles of such care are:[3]

- Honoring the Veteran's expectations of safe, high quality, accessible care.
- Enhancing the quality of human interactions and therapeutic alliances.
- Soliciting and respecting the Veteran's values, preferences, and needs.
- Systematizing the coordination, continuity, and integration of care.
- Empowering the Veteran through information and education.
- Incorporating the nutritional, cultural, and nurturing aspects of food.
- Providing for physical comfort and pain management.
- Ensuring emotional and spiritual support.
- Encouraging the involvement of family and friends.
- Providing architectural layout and design conducive to health and healing.
- Introducing creative arts into the healing process.
- Supporting and sustaining an engaged workforce.

The success of this vision will require exceptional attention to *coordination of care*. In health care, coordination means connections among interdependent people who transfer information toward the goal of advising and enabling the patient and organizing care for the purpose of optimizing the patient's health status. Despite many strengths (including computerized health records and primary care teams), coordination of care remains imperfectly realized within VHA. Key challenges include strengthening primary care teams, establishing new systems for information exchange for Veterans that get part of their care in the private sector, assigning care coordinators for high risk Veterans, and fully leveraging information technology to enhance communication.

This vision also involves significant rethinking of *access to care*. Veterans deserve timely access to quality health care which meets or exceeds internal and community standards and is measured by their expectations. Such access should not depend on proximity of fixed infrastructure such as hospitals, but rather utilize new modes of care delivery supported by technology.

Inquiry and Learning

"In the beginner's mind there are many possibilities; in the expert's mind there are few."

Shunryu Suzuki[4]

The weight of experience makes it harder to change. This includes past VA transformations. Lifelong learning demands we shed old habits and question our assumptions. For the health services research community, old patterns include the three to five year duration of projects (the window for transformation will be shorter than 36 months), the selection of "safe" hypotheses and methods (peer review may need to be recalibrated toward risk-taking and speed), and a predilection for analyzing the past rather than creating the future (rapid cycle, action-oriented research is more needed than ever). Shedding these old habits will require unprecedented speed and agility as well as the

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Response to Commentary

Transformation and QUERI

David Atkins, M.D., M.P.H., QUERI Director, Office of Research and Development

The fundamental question at the heart of the debate over health care reform is how to redesign a dysfunctional health care system so that it promotes quality and value. Watching this debate, it can be tempting to congratulate ourselves for the many ways that VA is ahead of the private market—for example, in our ability to measure and reward performance, our primary-care-based outpatient system, and our electronic health record. But as Joe Francis reminds us in his commentary, the challenges facing VA are no less daunting. We need to adapt to meet the needs and preferences of a new generation of young Veterans while maintaining our commitment to aging Veterans from earlier wars. To do this, VA needs to transform itself to become a high-quality, efficient, patient-centered system. For those of us involved in the QUERI program, which was designed to speed the uptake of better practices in VA, the call for such a transformation poses two questions. How can QUERI help facilitate that transformation, and how might this transformation require changes to QUERI itself?

Change Lessons from the First Ten Years of QUERI

The first ten years of QUERI taught us many of the lessons about change observed by Dr. Francis. Change depends on people and relationships; it cannot be achieved simply by disseminating data or directives; success often depends on facilitation and on the local conditions; and it usually takes longer and costs more than we hope.[1] Three factors, however, create new opportunities for change in VA and for QUERI. The first is the new leadership under Secretary Shinseki, since commitment of leadership is one of the essential factors in any successful change.[2] The second is consensus on a direction for change. The Universal Services Task Force recommendations provide a road map of what specific changes are needed, and many of these involve areas studied by QUERI—implementing new models of care, expanding telehealth and Web-based interventions, and improving coordination across providers. Finally, the expanding work of the Systems Redesign initiative has created opportunities to partner with a VA-wide effort working at the network and facility level to address high priority process improvements for VA.

Systems Redesign and QUERI offer complementary approaches for how to speed change in the health care system. In Systems Redesign, engineering approaches such as process mapping, making small tests of change, applying "lean" principles to eliminate waste, and collaborative learning have succeeded in improving access and reducing waiting times and they are expanding to address new administrative and clinical issues. Elements of the QUERI approach, however, are essential to tackle the complex processes of improving care in chronic disease. The clinical and research expertise within QUERI is needed to decide which changes are most important. For example, the work of the Diabetes QUERI identified "improvements" that provide little benefit (tight glucose control in older patients) and those that are clinically most important (improving poorly controlled blood pressure). Implementation science can help understand the barriers and facilitators at the patient, clinician, practice, and system level that go beyond simple process improvement. The QUERI program can more easily support solutions that would be hard to develop through incremental changes and rapid process improvement—for example, the multi-year projects to develop the infrastructure for the TIDES depression care management model or to design the CART-CL catheterization registry. Finally, the research expertise within QUERI has been essential for refining clinical databases so we can tell whether our efforts are succeeding.

Key Learnings from Systems Redesign

There are important opportunities, however, for QUERI to learn from Systems Redesign to develop interventions that are more responsive to the needs of our stakeholders and more sustainable. Attention to engineering principles and efficiency can identify improvements that do not require new resources. Second, letting stakeholders determine their own priorities for change produces more effective engagement than when a "solution" appears to have been developed at a distance by researchers. Finally, learning from best performers within the system may help convince others that the solutions are feasible and sustainable. Several QUERI Centers, including Stroke and Chronic Heart Failure, have begun to collaborate on systems redesign projects to bring the strengths of both approaches together and to foster cross-program learning. The four new Veterans Engineering Resource Centers (VERCs), funded under the Systems Redesign initiative, will provide new avenues for collaboration between research and operations. QUERI will focus on additional ways to foster closer and more transparent collaboration with all of our health system partners, such as Office of Quality and Performance and Office of Patient Care Services.

A popular Dilbert cartoon notes, "Change is great—you go first." It is to the credit of VA that so many parties are "going first," readily embracing the call to improve the care we deliver and the systems in which we work. It will be our challenge to see that we are all pulling together toward the common vision of a Veteran-centered, forward-looking, high-quality health care system.

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Research Highlight

The Challenges of Achieving Sustained System Change

Martin P. Charns, D.B.A., and Carol VanDeusen Lukas, Ed.D.,
Center for Organization, Leadership, & Management Research, VA Boston Healthcare System

How can health care systems transform to provide consistently safe, high-quality care for patients as envisioned by the 2001 Institute of Medicine's (IOM) report, *Crossing the Quality Chasm*? From our research in both VA and non-VA health care organizations, we have identified five critical drivers of change that distinguish organizations that have reached sustained system change—meaning higher levels of reliability in their care processes and greater changes in their systems and cultures. These five critical elements are illustrated in the Figure below.

1) Impetus to transform often came from outside the organization in response to external pressures for change, but also came from within the organization, often stimulated by multiple factors. In successful transformations, organizations sustained impetus for change over time.

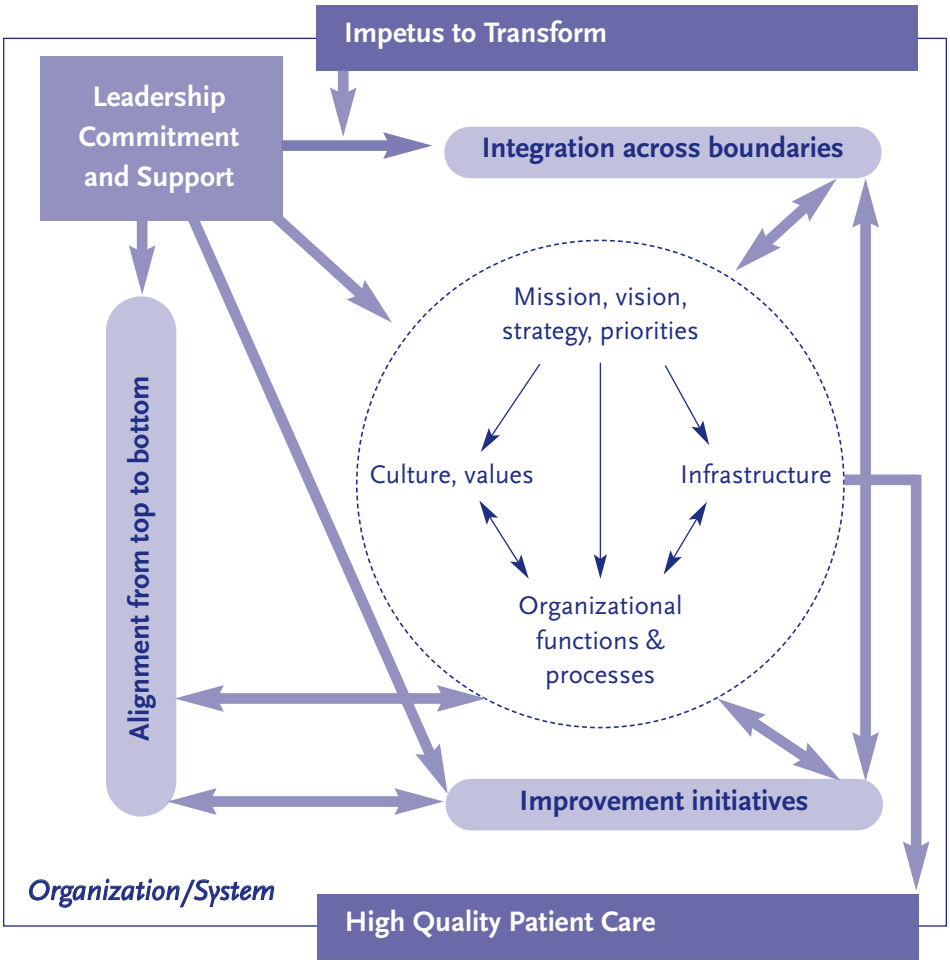
2) Leadership commitment to quality and change—beginning at the top of the organization but including all levels—proved a critical element for organizational transformation. Senior leaders drove change in two ways. First, they steered change through the organization's structures and processes to maintain urgency, set a consistent direction, and provided resources and accountability to support change. Second, to create momentum for dramatic improvement in patient care, leaders demonstrated authentic commitment to quality, by expending significant personal capital to motivate staff, often leading by example through personal involvement in improvement efforts.

3) Improvement initiatives that actively engaged staff in meaningful problem solving were central to change. Improvement initiatives contributed to transformation in at least three ways. First, initiatives such as clinical redesign improved operations. Second, initiatives actively engaged staff in problem solving around meaningful, urgent problems across disciplines and hierarchical levels. Third, successful initiatives built momentum for further improvement and contributed to culture change.

4) Alignment from top to bottom to achieve consistency of organization-wide goals with resource allocation and actions ensured that improvement efforts contributed to larger system change. Accountability was a key aspect of alignment, ensuring that behaviors, operations, and processes in practice supported organization-wide goals.

5) Integration to bridge traditional intra-organizational boundaries between individual components occurred at a later stage of transformation. Integration is a multi-faceted concept that applies to all organizational levels and is both an end state for a high-performing system and a strategy for transformation. Integration often began with multidisciplinary improvement teams that encouraged communication and prob-

Organizational Transformation Model



lem solving across work units. However, by themselves, improvement teams ran up against the limits of traditional organizational boundaries. To move beyond those limits, organizations needed integration at the systems or organizational level in the form of structures and processes that involved managers with decision-making authority and responsibilities spanning the organization. Integrating structures and processes also facilitated the spread of improved clinical practices and values for improvement across the organization.

These elements affected transformation by driving change in complex and dynamic health care organizations. As illustrated inside the dotted circle in the Figure, we define the organization—or network of organizations comprising the system—in terms of four basic components: 1) **mission, vision, and strategies** that set direction and priorities; 2) **culture** that reflects values and norms; 3) **operational functions and processes** that embody the work that is done in patient care; and 4) **infrastructure,** such as information technology and human resources, that support delivery of patient care.

Practice Implications

Transformation of health care systems is a complex and difficult undertaking that is achieved over a period of time. Each model element offers direct practice implications for managers seeking to change their systems to improve patient care. However, no single element is sufficient to achieve organizational transformation. Managers should recognize that all model elements are important, and that the challenge is to maximize the likelihood that the elements will interact with one another in complementary ways to maintain urgency to change and to move the organization forward. Full transformation may be attained only when multiple improvements are *spread* across the system and *sustained* over time.

Finally, successful transformation takes time. Transformation most likely unfolds over a decade or more. Although many of the systems we studied demonstrated considerable progress, they too described transformation as a continuing journey with no fixed endpoint. Persistence and constancy of purpose is required for this journey.

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HSR&D Investigators Honored at AcademyHealth 2009 Annual Research Meeting

VA researchers had a strong presence at AcademyHealth's Annual Research Meeting in June 2009. A number of VA researchers—whose submissions were competitively reviewed—presented papers, workshops, and posters at the meeting. In addition, several VA HSR&D researchers were honored with awards.

Dr. Seth Eisen with Article of the Year awardee, Dr. Amal Trivedi.

■ **HSR&D's Werner received Alice Hersh New Investigator Award.** HSR&D investigator Racher Werner, M.D., Ph.D., received the Alice S. Hersh New Investigator Award, which recognizes scholars that demonstrate exceptional promise for future contributions early in their health services research career. Dr. Werner is a Research Career Development Awardee with the VA HSR&D Center for Health Equity Research and Promotion and a primary care internist at the Veterans Affairs Medical Center in Philadelphia. Dr. Werner's research examines quality improvement initiatives—including pay for performance and public reporting—and how those initiatives change health care delivery, overall quality of care, and racial disparities.

■ **HSR&D Investigator Trivedi received AcademyHealth Article of the Year Award.** HSR&D investigator Amal Trivedi, M.D., M.P.H., received the 2009 Article of the Year Award for his article "Insurance Parity and the Use of Outpatient Mental Health Care Following a Psychiatric Hospitalization," which appeared in the Journal of the American Medical Association. The award recognizes the best scientific work in the fields of health services research and policy, produced and published during the previous year. Dr. Trivedi also received a Best Abstract award for his study "Unintended Consequences of Increased Ambulatory Copayments on Hospital Use in the Elderly." Dr. Trivedi is a Research Career Development Awardee with the Center for Systems, Outcomes and Quality in Chronic Disease & Rehabilitation at the Department of Veterans Affairs in Providence, RI.

■ **HSR&D Investigator Yano awarded Best Abstract.** HSR&D investigator Elizabeth Yano, Ph.D., M.S.P.H., received a Best Abstract award for her work, "Impact of Practice Structure on the Quality of Care for Women Veterans." The abstract examines the first attempt to evaluate systematically the quality of care experienced by women Veterans in VA settings. Yano's research provides a critical evidence base for VHA's ability to reduce gender disparities and improve outcomes and satisfaction of women Veterans.

Research Highlight

Nursing Home Culture Change

Christine W. Hartmann, Ph.D., Dan Berlowitz, M.D., HSR&D Center for Health Quality, Outcomes, and Economic Research, Bedford, Massachusetts

Long seen as places one would avoid living in if one had a choice, in the past decade nursing homes (NHs) have increasingly adopted more resident-centered care paradigms, under a rubric generally termed "culture change." Culture change means that residents' needs and preferences are of central importance in designing the structure of care, and that facility designs, routines, management, and care should be shaped by these needs and preferences. In reality, culture change spans a wide spectrum of potential modifications, including minor or major modifications to the physical environment (from decorating hallways and baking bread to removing nursing stations and remodeling residents' rooms), changes in staff roles (consistent assignment of staff to the same residents and increased autonomy of frontline staff), and changes in management styles (incorporating input from residents and staff into management decision-making). These changes should also include resident participation, for example allowing resident choice in a variety of areas and structuring life around resident needs and wishes.

Evidence Base

The implicit goal of culture change resonates strongly with many stakeholders, but on a day-to-day basis, culture change necessitates a fine balance between the multiple needs and wishes of residents and potential impacts on safety and quality of care. The financial implications of these changes are also a consideration. To date, relatively little research has been undertaken on culture change.[1] Some preliminary studies have shown elements of culture change to correlate favorably with resident, staff, and family outcomes, but not in all instances. For example, it has been shown that some promising changes—such as providing a more home-like environment and promoting freedom of movement for residents—may also have safety implications (e.g., possibility of increased falls).[2] In addition, while consistent assignment of staff (having the same individual work with the same residents for at least 80 percent of her/his shifts) is one hallmark of culture change, some evidence about the benefits of consistent assignment has been equivocal.[3]

The redistribution of staff and redefinition of staff jobs that culture change entails are the source of potential tensions too. Much of the current literature indicates that the majority of nursing homes are already understaffed, and specific methods of improving resident outcomes often take more time from staff (e.g., toilet training, walking improvement programs, and turning schedules to avoid pressure ulcers). Given these competing demands, it is unclear exactly how these changes will impact resident outcomes. Finally, with regard to cost, in a study of culture change in a for profit nursing home chain, the primary factor that prevented timely implementation of the more comprehensive elements of culture change at participating sites was expense.[4]

Since 2004, the VA Office of Geriatrics and Extended Care has spearheaded the movement to change NH care, focusing on four key elements:

1) transforming the current NH culture to a resident-centered approach;

2) empowering frontline team members to help address issues related to the delivery of customized, high quality care;

3) changing the environment to foster a homelike experience; and

4) linking transformation of the NH culture to quality indicators.

In 2008, the Deputy Under Secretary for Health for Operations and Management announced a name change that transformed "Nursing Home Care Units" into "Community Living Centers" (CLCs) to reflect this initiative. Also as of 2008, culture change has become a performance improvement measure. Twice yearly, all CLCs must complete a self-assessment using the Artifacts of Culture Change Tool first developed by the Centers for Medicare and Medicaid Services. However, despite this emphasis from top VA management, much remains unknown.

Research Challenges

While the changes being implemented are designed to affect residents and staff positively, they also have many as yet unknown implications. As noted, very little research exists on the impact of various aspects of culture change on resident and staff outcomes such as quality of care, safety, and satisfaction. Care must be taken, as we move forward, to capture impressions accurately (e.g., in the case of cognitively impaired residents) as well as in sufficient depth (e.g., including qualitative observations of resident-staff interactions). Both short- and long-term financial implications have to be investigated and weighed alongside the quantitative and qualitative impacts. It is imperative that as VA moves forward with culture change, clinicians, researchers, and leadership all work together in a collaborative partnership to continue to define and improve the safety and quality of care for Veterans living in CLCs.

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Organizational Profile

VA HSR&D Establishes New Resource Center to Support Implementation Research and Practice

Brian Mittman, Ph.D., Center for Implementation Practice and Research Support

VA's HSR&D and QUERI work to facilitate improvements in the quality, performance, and outcomes of the VA health care delivery system by applying health services research to significant problems and by creating and implementing evidence and evidence-based practices.

VA's efforts to apply research to improve quality were strengthened in October 2008 with the establishment of a new QUERI resource center, the VA Center for Implementation Practice and Research Support (CIPRS). CIPRS pursues a two-part mission, aiming to strengthen implementation research and to strengthen implementation and quality improvement practice within VA. This mission is accomplished via a portfolio of programs and services that include consultation, technical assistance, and education.

CIPRS is led by Brian Mittman, Ph.D., and is based at the VA Greater Los Angeles Healthcare System. Center co-directors are David Aron, M.D., M.S. (Louis Stokes Cleveland VA Medical Center), and Gary Rosenthal, M.D. (Iowa City VA Medical Center).

CIPRS aims to:

- Improve VA's implementation research capacity and performance; and
- Enhance quality improvement and implementation practice within the VA health care delivery system.

CIPRS Programs and Services

The CIPRS portfolio has been shaped by a series of needs assessment interviews and surveys designed to gather information regarding VA policy and practice leaders' and VA researchers' needs and preferences. The resulting portfolio is depicted in the accompanying figure, and described on the CIPRS website (www.queri.research.va.gov/ciprs).

The CIPRS Portfolio

Highlights of CIPRS programs include:

- A monthly **Implementation Practice Cyber Seminar Series** offering presentations on state-of-the-art topics in implementation practice, aimed at a clinical audience; and a monthly **Implementation Research Cyber Seminar Series** presenting topics of interest to implementation researchers.
- A **telephone and web-based helpline** offering one-on-one consultation to VA implementation researchers.
- Seminars, workshops, conference presentations, and research "clinic" sessions offering guidance and assistance to novice and experienced implementation researchers.
- A series of quality improvement, evaluation, and implementation **resource toolkits** under development that will offer guidance for VA clinical and quality improvement leaders who wish to use implementation and quality improvement research to improve quality and performance.
- An extensive web-based **Implementation Research Resource Clearinghouse** (under development) featuring an overview of the field and extensive tools and resources for planning, conducting, and reporting implementation and quality improvement projects. Resources will include evaluation tools, compendiums, or implementation theories and theoretical frameworks, annotated listings

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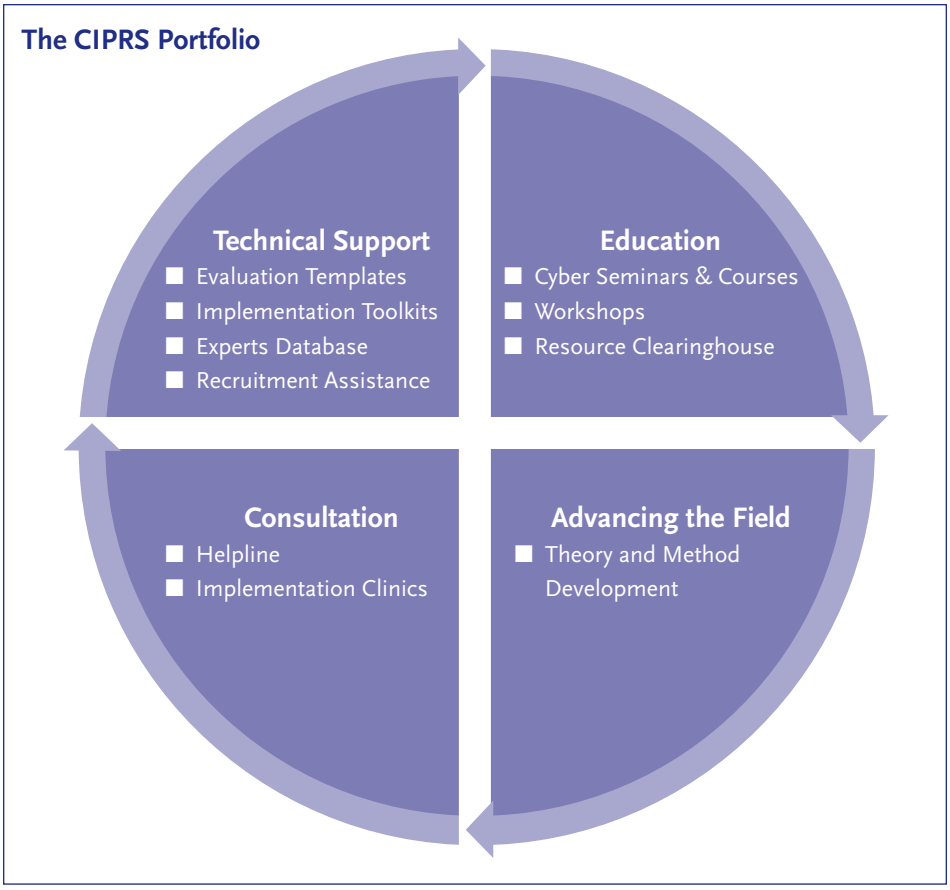

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willingness to roll up sleeves and learn through our actions, successes, and failures. This won't be easy for a number of reasons, yet our Veterans deserve nothing less.

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of funding programs, conferences, training resources, and more.

CIPRS also contributes to the continued development of the field of implementation science through "Theory and Methods Development" projects designed to develop, test, and refine new methods and measures, new theoretical frameworks, and approaches and other resources.

CIPRS contributes to improved quality and performance in VA through direct collaboration and support for specific VA quality improvement initiatives. For example, CIPRS is collaborating with VA's Office of Quality and Performance and Systems Redesign program in developing evaluation frameworks and tools for VA quality improvement staff. CIPRS will also evaluate national implementation of selected clinical programs and innovations.

Collaborations with Non-VA Entities

CIPRS seeks to contact and collaborate with like-minded researchers and research groups outside VA, to identify common interests and goals, and pursue opportunities for mutually beneficial interactions. CIPRS collaborations with non-VA implementation research programs will facilitate HSR&D and QUERI researchers' ability to follow and learn from advances in other sectors, and will help recruit outside collaborators in developing the Implementation Research Resource Clearinghouse.