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Commentary

Practicing, Teaching, and Researching in an Era of Transformational Change

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Since publication of the Institute of Medicine (IOM) report titled *Crossing the Quality Chasm*, much attention has focused on change within the culture of health care delivery systems. Within VHA, the culture shifts may be characterized as transformational. The shifts influence not only the larger VHA health care delivery system but also the changes required by individual providers in the delivery of health care, and in our medical education and research priorities. Importantly, our culture must also address the changes occurring to our Veterans themselves, both as individuals and as a population.

Transformational Systems Change

During the latter part of the 20th century, organizational change emerged as a science unto itself. Much has been written about the need to manage and lead change; this work has made clear the role of leaders in championing change and the need for proven methodologies in instituting change. During the same time, system management and change emerged as a core component of graduate medical education.

In 2007, VanDeusen Lukas et al published findings critical for success in health care system change within VHA.¹ Their work demonstrated not only consistency between change in VHA and other health care delivery change models but also highlighted the required components of effective organizational transformation. These components include communicating the need for change, aligning and integrating change activities across all levels of a health care organization, and pairing leadership engagement with process improvement activities.

The changes in the health care delivery system motivated by the Affordable Health Care Act, combined with the continued evolution of health care technologies such as e-connected medicine and the growth in patient engagement and expectations, have all contributed to a rapidly changing environment. In recent years, numerous initiatives have led to improvement and cultural change throughout VHA. As a result, VHA, in partnership with Veterans' families, our students, and our trainees, is now engaged in building a culture of data-based continuous improvement to meet the ever-evolving needs of our Veteran patients.

Transforming the Individual Practice of Medicine

Of equal importance to the system-wide and cultural changes occurring within VHA, changes are taking place in the individual- and population-based care of our Veteran patients. Dougherty and Conway outlined the 3T's of transformative change, providing insight into the characteristics of such change.² The practice of medicine continues to move toward biomedical research strongly linked to clinical efficacy research (T1), thereby better defining the knowledge used in individual care decisions. T1 is balanced by improved population health achieved through outcomes, comparative effectiveness, and health services research—and translation of research into evidence-based tools for both clinicians and patients (T2). These practices, accompanied by effective measurement systems based in the domains of health care value (technical quality, access, satisfaction, and efficiency), comprise



Director's Letter

The late Senator (and former sociologist) Daniel Patrick Moynihan famously said, “The central conservative truth is that it is culture, not politics, that determines the success of a society. The central liberal truth is that politics can change a culture...” Health care systems and researchers are increasingly paying attention to organizational culture in health care settings and how to improve it. Patient safety events often reveal local breakdowns

in communication, teamwork, and leadership that enable problematic practices to develop; positive culture as assessed by VA's All Employee Survey and other markers is correlated with better health care outcomes.

The role of health care culture is central to at least three important clinical initiatives in VA. First, team training developed by the SimLearn Center is targeting the critical role of team communication in reducing surgical errors. Second, the Patient Aligned Care Team (PACT) rollout is illustrating the importance and challenge of building functioning, collaborative teams that include physicians, nurses, and support staff. Finally, the Office of Patient Centered Care and Cultural Transformation is piloting programs to transform VA culture into one where patients, rather than providers, are at the center of care.

A 2003 review in the *International Journal for Quality in Health Care* identified key factors that impede culture change, including inadequate leadership; constraints imposed by external stakeholders and professional allegiances; perceived lack of ownership; and competing cultures within health care systems.¹

Health services research has contributed in various ways to our understanding of health care culture and culture change. Both HSR&D and QUERI benefit from the presence of anthropologists on various research teams. Research has contributed practical tools to measure culture and can illuminate those aspects of culture that may serve to either facilitate or impede efforts to improve care. A big challenge for research and health care systems is to develop and test effective programs that can either promote a healthy culture or improve a dysfunctional one.

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1. Scott, T. et al. “Implementing Culture Change in Health Care: Theory and Practice,” *International Journal for Quality in Health Care* 2003; 15(2):111-8.

the third component (T3) of a culture that is able to adapt to and satisfy the requirement for continuous improvement.

By applying the 3Ts across VHA practices, we can improve the care of our patients while aligning our research and educational missions. In fact, the 3Ts are reflected in our transformational initiatives around the Patient Aligned Care Team, Mental Health Integration, and E-Health initiatives—and through new sources of feedback, such as Patient Almanacs, Inpatient Evaluation Center, and Corporate Data Ware-

house reports. Creating a culture of patient care decisions at the individual level, or an N of one patient, supported by population analytics or an N of 1,000, defines the proactive, patient-centered culture envisioned by large integrated health care delivery systems.

Supporting an Engaged, Patient-Centered Culture

Change throughout the broader health care delivery system and research-driven individual patient care plans are necessary components

of a successful organizational culture. Changes in our Veteran patients' attitudes and expectations will more clearly refine both present and future culture changes. Enhanced engagement of patients in their care planning and self-management decisions will be central to reaching VA's goal of improved Veteran well-being and improved population health.

New educational methods and research efforts, such as those described by Dr. Weiner, are needed to understand this new dynamic and are important to effective organizational change. System and individual changes associated with an increased awareness of health care equity and literacy are key to achieving the desired care outcomes. Furthermore, these changes are necessary if VHA is to continue providing the high-quality medical education needed to develop the workforce to sustain a new culture. Through improved analytics, individualized care plans will change how we measure and achieve enhanced patient wellness, shifting from an absolute process-based outcome to an individually tailored outcome. “Patient centeredness” will redefine the journey of improvement from one that not only focuses on the application of evidence-based information but one that also addresses how such information is delivered and aligned with individual goals.

Culture change is complex, continuous, multivariate, and essential to the effective delivery of health care services within VHA. The continued evolution of culture and practice is the only component of our system and practice that will not change. New models, methods, measures, technologies, and expectations are constantly emerging. VHA welcomes innovations in a culture that values safety, understands risk, redesigns systems, improves care based on data, and engages patients while honoring their preferences. At the same time, VHA will integrate leading-edge research and effective medical education to ensure that future generations effectively serve those who have served.

References

1. VanDeusen Lukas, C. et al. “Transformational Change in Healthcare Systems: An Organizational Model,” *Health Care Management Review* 2007; 32(4):309-20.
2. Dougherty, D. and P. Conway. “The ‘3T’s’ Road Map to Transform U.S. Health Care. The How of High-Quality Care,” *Journal of the American Medical Association* 2008; 299(19):2319-21.

Response to Commentary

The Individual, Research, and Transformational Change

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When I was a first-year medical student in the late 1980s, I was assigned to shadow a family physician in a rural New Hampshire town where many patients were uninsured. The physician's receptionist knew everyone and made decisions about how much of patients' fees would be waived or whether patients would be turned away. The doctor said that he did not concern himself with financial matters and was there to care for the patients. Years later, I had an opportunity to explore the role of front desk clerks in rationing access to care across large health care systems. Most striking was the minimal guidance given to frontline bureaucrats in how to manage patients who could not afford prepayments and how—in the absence of guidance—they made *ad hoc* decisions based on their personal values. The strongest predictor of whether an indigent patient received care was which clerk signed him or her into the office.

Perhaps the most important message is that everyone in a health care organization is powerful and that, without a process for communicating its mission and obtaining everyone's buy-in, the results are potentially capricious and chaotic. This lesson is particularly applicable to periods of organizational change. Dr. Murawsky emphasizes the importance of "communicating the need for change, aligning and integrating change activities across all levels of a health care organization, and pairing leadership engagement with process improvement activities" as essential ingredients for creating an effective environment for change. In essence, any effort designed to ensure that systems function properly is about getting everyone on the same page. First and foremost, the effort requires an acknowledgment of the interdependence and equal importance of all individuals in contributing to the desired out-

come; other key elements include clear messaging, incentives, team building, leading by example, and an environment in which every individual is viewed—and views him- or herself—as a potential problem solver.

How does the researcher's perspective contribute to the organizational change process? From the researcher's perspective, the patient, physician, and, indeed, all health system employees are potential research subjects. Health services researchers examine the interactions of myriad variables at the level of the organization, provider, and patient as they facilitate or impede the search for solutions to patients' problems. Close partnership between research and operations assures that the right questions are being asked and that lessons learned inform decision making.

The changes occurring in VHA pose a specific challenge for systems leaders and researchers. Dr. Murawsky refers to this challenge as creating a "culture of patient care decisions at the individual level, or an N of one patient, supported by population analytics or an N of 1,000. . . ." For health care organizations to advance in both arenas, we need valid metrics for both adherence to evidence-based practices and adaptation to patient context. Tools for measuring the former are far more developed and widely used than those for measuring the latter.

Even as algorithms evolve toward sophisticated patient care management systems that permit us to tailor decisions based on risk levels, capture clinical actions, and incorporate patient preferences and goals, we still face the challenge of assessing whether care plans are adapted to patients' life circumstances and needs, or context. For instance, if a particular patient's blood pressure is poorly controlled

because his medication delivery packages are routinely stolen from his entryway, will the provider elicit such information and propose that the patient pick up his medication at the clinic pharmacy? Adapting care to patient context must be a part of the culture of patient care decisions at the N of one patient.

Challenges are opportunities to innovate. For instance, to assess clinician performance in contextualizing care, we both employ unannounced standardized patients and recruit real patients to audio-record their encounters. Our performance measure, Content Coding for Contextualization of Care, or 4C, is designed to answer four questions for each encounter. Were there clues—such as loss of control of a chronic condition—that a patient's life situation is interfering with the patient's care? If so, has the provider noticed and looked into the situation? If so, has the provider uncovered contextual factors—such as a Veteran's loss of social support—that can be addressed? And, finally, is the provider or Patient Aligned Care Team taking the steps needed to adapt the care to the patient's context? When care is adapted to the patient's context, evidence is that patients experience better health care outcomes. No doubt, we have scratched only the surface with our focus on clinicians, given the key roles that even clerks may play when, for instance, patients show up late because of contextual factors that may be central to their care.

This is, indeed, an exciting time as HSR&D researchers, focusing on evidence-based and patient-centered strategies, contribute innovative tools and new knowledge to support VHA's commitment to transformative change that advances the care and health of Veterans.

References

- Kerr, E.A. and R.A. Hayward. "Moving toward a Patient-Centered Performance Management System," *FORUM* October 2012.
- Weiner, S.J. et al. "Patient-Centered Decision Making and Health Care Outcomes: An Observational Study," *Annals of Internal Medicine* 2013; 158:573-9.
- Weiner, S.J. et al. "Rationing Access to Care to the Medically Uninsured: The Role of Bureaucratic Front Line Discretion at Large Healthcare Institutions," *Medical Care* 2004; 42(4):298-304.

Research Highlight

The Critical Role of Leadership in Creating a Culture of Improvement

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As VHA strives toward higher levels of Veteran-centered, data-driven, and team-based care, VA medical centers need to engage in continuous change and improvement. Recognizing that most medical centers have not yet fully developed a culture of improvement, the Office of Systems Redesign (OSR) initiated a program of Improvement Capability Grants (ICG) in 2009. OSR awarded grants to support local approaches to building improvement capability in five VISNs and 25 VA medical centers in FY2009 and FY2010. OSR commissioned the Center for Organization, Leadership, and Management Research (COLMR) to evaluate the experiences of the grantees over the course of the program.

One of the key findings that emerged from the evaluation is that strong senior executive support and engagement play critical roles in building a culture of improvement, consistent with the literature on the importance of senior leadership in organizational change (e.g., Beer, Eisenstat, & Spector, 1990; Lukas et al., 2007). While leadership at all levels is important, the drive for a sustained improvement culture must come from the top—in VA medical centers, leadership begins with the medical center director and the other members of the quadrad or pentad.

The experiences of the ICG sites offer lessons in four areas to build strong improvement capability, lessons that can help senior executives foster needed change.

Vision and alignment. *Senior executives develop, communicate, and translate a vision for continuous improvement that supports the medical center's strategic and operational priorities.* Senior executives create a motivating vision for improving the organization by focusing on the organization's long-term goals. They see a clear direction for the organization's future and have identified the path that will enable them

to fulfill their vision. Senior executives align and integrate their vision with organizational priorities, structures, processes, and local context. In addition, they clearly communicate their vision for performance improvement to middle managers and staff. Leaders also acknowledge and reinforce positive behaviors that support their goals and encourage staff to take initiative in improving their work.

Personal expertise. *Senior executives have deep knowledge about performance improvement principles and incorporate them in their management behavior.* Senior executives are well-trained in advanced improvement methods so they can lead in a strong improvement culture and guide other staff in improvement management approaches. They serve as executive sponsors or coaches of improvement initiatives, and facilitate change by addressing barriers encountered in the improvement process. Senior executives actively participate in setting the performance improvement agenda by contributing to the identification, prioritization, adoption, implementation, and monitoring of improvement initiatives. They ensure that these initiatives support the facility's overall strategic and operational priorities. Importantly, senior executives apply systems redesign tools and principles to respond to crises rather than using them only when time allows.

Infrastructure. *Senior executives understand what is required in order for performance improvement projects and training to succeed, and they develop systems, processes, and structures to support success.* To develop a sustained culture of improvement, medical centers need both key staff with improvement expertise (i.e., system redesign coordinators and quality managers) and a larger group of trained staff versed in supporting improvement teams and helping spread improvement efforts on a daily basis across the medical center. Senior executives provide staff with the time and other

resources required to engage in performance improvement and succeed in their work. They also hold staff accountable for applying their training, hold managers accountable for facilitating improvement, and implement reward systems to spur change efforts. Senior executives play a key role in supporting the development of data systems that track measures and monitor improvement progress. Finally, they develop structures and processes to elicit information about successful projects in order to acknowledge and promote accomplishments—and share lessons about factors that contributed to success; they also elicit information to learn from projects that failed.

Staff engagement. *Senior executives foster active collaboration and engagement in performance improvement efforts by establishing a psychologically safe environment.* Senior executives show respect for their staff and recognize their considerable technical skills, tacit knowledge, and practical experience. They teach, coach, and monitor improvement work on the frontlines of care delivery. They manage by asking questions that stimulate staff to develop their own solutions. They encourage innovation by fostering an environment in which staff feel secure in taking risks and by accepting that failures may occur. Senior executives are also careful to demonstrate their support for improvement without dominating, thereby encouraging others to lead improvement efforts.

Active engagement of senior executives is critical to implementing strategies that build solid knowledge, skills, and commitment to systems redesign among senior leaders and middle managers; establish an infrastructure of improvement expertise; align improvement efforts with organizational priorities; and engage staff across the organization in routinely improving their work. Leadership at all levels of the organization is important, but the drive for a sustained improvement culture must come from the top.

References

- Beer, M., Eisenstat, R. A., and Spector, B. "Why Change Programs Don't Produce Change," *Harvard Business Review* 1990; 68(6):158-66.
- Lukas, C.V. et al. "Transformational Change in Health Care Systems: An Organizational Model," *Health Care Management Review* 2007; 32(4):309-20.

Research Highlight

Patient Engagement and Diabetes Self-Management

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At any given time, over 1 million Veterans receive health care services for diabetes, and many suffer adverse vascular outcomes, such as myocardial infarction, blindness, and peripheral artery disease. Glycemic control, as measured by hemoglobin (Hb) A1c, is associated with lower morbidity and mortality. Given that diabetes is a self-managed condition, achieving diabetes control requires patient involvement in most aspects of treatment planning and management.

Personalized Diabetes Care Using Patient-Reported Measures

Patient-reported measures, such as functional health literacy (FHL) and patient activation, play critical roles in achieving diabetes control through enhanced diabetes self-management.^{1,2} Thus, identifying these characteristics and incorporating information on these characteristics into routine self-management and collaborative goal setting may lead to better patient outcomes. The ability to integrate information about FHL and patient activation into the context of traditional primary care encounters is, however, limited. Nonetheless, VA's transition to Patient Aligned Care Teams (PACT) provides an opportunity for developing and implementing patient-centered, personalized approaches to diabetes care that are aligned with patient preferences.

While the independent effects of FHL and patient activation on diabetes control are well documented, their combined effect is less clear. Using brief, validated screening measures, we explored the relationship between/among FHL, patient activation, and glycemic control in a cohort of multimorbid, diabetic Veterans receiving care within VA PACTs.

Brief Measures of Functional Health Literacy and Patient Activation

Using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes and relevant ICD-9-CM and Current Procedural Terminology procedure codes, we identified Veterans who had coexisting hypertension, diabetes, and ischemic heart disease and were receiving primary care between November and December 2010. We excluded patients with limited life expectancy and those who died during the study period. We mailed to eligible participants a self-administered questionnaire with brief measures of FHL and patient activation and then collected laboratory, demographic, and clinical data from the medical records of the patients who returned surveys. Using validated scoring for the Single Item Literacy Screener and the Patient Activation Measure, we classified patients based on their level of health literacy and patient activation into four categories.³ We based these categories on combined high versus low levels of FHL and patient activation, e.g. high FHL/high activation. Subsequently, we examined the relationship between/among patients' self-reported FHL, patient activation, and mean HbA1c levels.

We received surveys from 195 individuals (50 percent response rate). Of those, we studied 183 individuals (94 percent) with complete data for all variables in the analyses. The mean age of the study cohort was 68 years. We found a normal distribution for FHL and patient activation, with approximately 50 percent of participants reporting high FHL and 45 percent reporting high patient activation. Patients identified with both high FHL and patient activation (i.e., high FHL/high activation) had significantly lower HbA1c levels compared to those with low levels of both FHL and patient activation.

Bringing Personalized Diabetes Care to the Clinical Encounter

Providing high-quality care to patients with diabetes can pose significant challenges. However, VA's transformation to the PACT model of care offers the ideal setting in which to meet these challenges. One approach to providing more personalized care is to incorporate into routine PACT care patient self-reported measures (e.g., FHL and patient activation) that have been shown to influence diabetes outcomes. We demonstrated that brief, validated measures of FHL and patient activation may be feasibly obtained among multimorbid Veterans within the context of primary care encounters. Further, we found that the combined effects of FHL and patient activation are associated with better glycemic levels. Thus, understanding patients' FHL and activation levels may result in more personalized care and a greater likelihood of diabetes control.

Future research is needed to inform how measures of FHL and patient activation can be efficiently integrated into routine discussions between patients and their clinicians. Interventions that incorporate information about patients' FHL and activation levels hold promise for providing collaborative care that is personalized to patients' desired level of engagement and understanding of diabetes self-management.

References

- Schillinger, D. et al. "Association of Health Literacy with Diabetes Outcomes," *The Journal of the American Medical Association* 2002; 288:475-82.
- Remmers, C. et al. "Is Patient Activation Associated with Future Health Outcomes and Healthcare Utilization among Patients with Diabetes?" *The Journal of Ambulatory Care Management* 2009; 32:320-7.
- Morris, N.S. et al. "The Single Item Literacy Screener: Evaluation of a Brief Instrument to Identify Limited Reading Ability," *BMC Family Practice* 2006; 7:21.

Research Highlight

Progress Toward Recovery Transformation in Mental Health

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A decade ago, the President's New Freedom Commission outlined a vision of recovery-oriented mental health services. As part of the "recovery transformation," the commission foresaw a future in which "everyone of all ages with a mental illness would have access to effective treatments and supports—the essentials for living, working, learning and participating fully in the community."¹ Although VA is a national leader for many indicators of care quality, improving mental health care has proven challenging. To determine whether patients are receiving appropriate mental health treatment, it is often necessary to know patients' preferences, outcomes, and history of psychosocial services. Given that such information is often not documented in medical records, policymakers have struggled to identify gaps in mental health service provision and to tailor the delivery of needed services. One approach to implementing recovery-oriented care calls for informing patients of potentially beneficial services, educating clinicians about new evidence-based practices, and monitoring implementation to ensure the delivery of services that improve outcomes.

Implementing Recovery

Recovery transformation includes returning Veterans to mainstream jobs, also known as "competitive employment." VA has a national program of individual placement and support, an evidence-based approach to supported employment (SE) for individuals with serious mental illness. This SE model has the singular goal of competitive employment and is characterized by rapid job search, an alliance between an SE specialist and the Veteran's treatment team, and ongoing support of the individual during

employment. Eligibility for SE is based only on an individual's expressed interest in returning to work; there are no requirements regarding the presence of symptoms, for example. Evidence shows that SE helps about 60 percent of enrollees secure competitive employment while traditional rehabilitation programs help approximately 10 to 20 percent of enrollees find employment. In fact, receipt of SE is the single best predictor of employment among individuals with serious mental illness. Employment can improve symptoms and social skills, increase self-efficacy, and reduce costs.

Despite evidence of its effectiveness, SE has been vastly underused. A 2009 SAMHSA survey indicated that only 2 percent of individuals with serious mental illness nationally receive SE services. Several factors may contribute to underuse of SE services, including: (1) in usual mental health care settings, individuals are not routinely asked if they would like to return to work; (2) many individuals with serious mental illness are not strong advocates for themselves; (3) many clinicians are not knowledgeable about the eligibility requirements for SE; and (4) caseloads for SE specialists are typically full, with a waiting list for enrollment.

Transforming Care Practices

The overarching aim of the VA HSR&D QUERI project, "Enhancing Quality of Care in Psychosis (EQUIP)," was to improve the use of evidence-based recovery-oriented services by Veterans with schizophrenia. This 15-month, clinic-level, controlled trial engaged four VISNs and enrolled 801 adults with schizophrenia and 171 clinicians across eight specialty mental

health clinics. Each VISN selected two services to be targeted, and each VISN selected SE as one of the services.

Each site used evidence-based quality improvement tools to determine why eligible Veterans were not using SE. Researchers partnered with leaders at each site to identify gaps in care processes and to address deficiencies in knowledge. Sites installed patient-facing kiosks that permitted patients to self-report their clinical status, preferences, and treatment use. The kiosks queried patients about their interest in returning to work, whether they had received a referral to SE, and, if yes, how many SE appointments they had attended in the previous month. The kiosk printed reports for patients on the spot. If appropriate, the patient-level report provided either "talking points" that patients could use with their clinicians to discuss an SE referral or written encouragement for beginning or sustaining the use of SE services. The study also generated reports for clinicians with names and dates of their patients who reported interest in returning to work or who were previously referred, along with their attendance rate.

Study results indicated that Veterans at intervention sites were twice as likely to use SE services during the study compared to Veterans at control sites. A formative evaluation indicated an increase in SE capacity at intervention sites, including the addition of an SE worker, SE training for additional clinicians, and adjustments to SE caseloads to allow for new patients. Employment differences, a more distal outcome, were evident when examining site-level differences; an intervention site with good fidelity to the SE model showed significant increases in employment.

References

1. President's New Freedom Commission on Mental Health (2004). *Achieving the Promise: Transforming Mental Health Care in America*. Final Report.
2. Drake, R.E., Bond, G.R., Becker, D.R. et al. (2012). *Individual Placement and Support: An Evidence-Based Approach to Supported Employment*. New York: Oxford University Press.
3. Hamilton, A.B. et al. "Implementation of Evidence-Based Employment Services in Specialty Mental Health: Mixed Methods Research," *Health Services Research*. In press.

Dialogue

A Conversation with VHA National Center for Organization Development's Linda Belton

FORUM recently sat down with Linda Belton, Director, Organizational Health, VHA National Center for Organization Development, to discuss her views on culture change and organizational transformation in VHA.

Would you briefly describe the mission of VHA's National Center for Organization Development (NCOD) with respect to VHA's organizational culture?

NCOD is an internal consulting service to VA leaders and staff in support of workforce engagement and satisfaction to enhance Veteran outcomes. Practitioners in organizational development integrate service, training, and research in ways that positively affect culture. The mission of Organizational Health is to help create an environment *where employees want to work and Veterans want to receive care*. If we had a motto it would be “All Things Connected.” Acting as conveners, we bring together diverse programmatic efforts within VA under the organizational health umbrella.

What strategies does the NCOD use to address organizational culture and change in VHA—across the patient, organization/system, and provider levels?

A primary strategy is data-driven assessment through on-site consultation or online tools, including the All Employee Survey (AES), 360/180 degree, change management, and team and Servant Leadership assessments. With that information in hand, NCOD staff help individuals and work groups fashion practical plans. We then support those plans through executive coaching, leadership development, team building, facilitation, transition briefings, change management, enhancement

of psychological safety, and AES action planning. (Psychological safety is the ability to give input, feedback, disagree, etc., without fear of reprisal.)

Can you provide an example or two of recent successes with regard to organizational culture and change?

NCOD's Civility, Respect and Engagement in the Workplace (CREW) program offers an excellent example of the significant impact that culture change can have in VHA. As we know, patient-centered care is best delivered by an engaged, empowered workforce. With that in mind, NCOD launched CREW in 2005 to address AES findings of low civility, which appeared to affect outcomes adversely. NCOD's data provide a business case for civility: less sick leave, fewer Equal Employment Opportunity complaints and grievances; lower ICU mortality rates and lengths of stay; higher patient and employee satisfaction; enhanced psychological safety; and reductions in work-related injuries.¹ CREW is rooted in relationship and team building via regular, facilitated work group meetings. Post-CREW data demonstrate statistically significant improvement in civility scores. More than 1,200 work groups have now participated in CREW. In 2011, The Joint Commission recognized CREW as a best practice.

Another excellent example is Organizational Health's endorsement of “Servant Leadership” as a framework for achieving transformational change. Leadership is critical to shaping and sustaining culture. In fact, NCOD data illustrate a spillover effect from leaders' behaviors to employees' perceptions of their workplace and Veterans' perceptions of their care.²

Servant Leadership is a philosophy that distinguishes “serving to lead” from “leading to serve.” It values characteristics such as putting people first, integrity, humility, building teams and communities, leading change effectively, exercising stewardship, sharing power, and establishing a culture of accountability.

To help VA leaders grow as Servant Leaders, NCOD designed a 360-degree assessment to gauge Servant Leader skills. The VA Servant Leader 360 is behaviorally based, developmental, and action-oriented. Participants receive an electronic report and a consultation session with NCOD. Interested readers may contact Jaimee.Robinson@va.gov.

What do you see as the biggest challenges in the next one to three years in terms of culture and change in VHA? Any words of wisdom or opportunities you see for our readers regarding organizational culture and change?

Over the next several years, we can expect a “permanent whitewater” of change, reflecting shifts in legislative direction, Veteran demand, and culture. NCOD will continue to support change efforts in VA. Perhaps the biggest challenge is not any one event or issue but rather the way in which we approach change itself. Culture change doesn't happen by caveat, policy, or training; it happens in the “interstitial spaces.” I believe the real challenge of managing culture change (and where NCOD can be most helpful) lies in the following:

- **Patience.** Culture change won't be accomplished by next quarter or next year. It takes time to assimilate change into all levels of the organization. True culture change is woven into the fabric of the organization.
- **Persistence and focus.** Avoid the “flavor of the month” phenomenon. Juggling too many culture change efforts risks diluting the change that's really important. Set the direction and maintain “true north.”

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FORUM

Translating research into quality health care for Veterans

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- **Draw the connections.** We sometimes see conflicting priorities that, if understood in the larger systems context, may not be conflicting at all. Helping employees connect the dots between programs and initiatives, between culture change and VA's mission, brings us back to the common denominator: the Veteran.
- **Leadership.** Culture change cannot be delegated; it must be led. Alignment, consistent messaging, and authentic modeling are all key components of culture change.
- **Make it real.** How can change be made meaningful to every employee? Does every employee know what he or she will do differently to support the change?

If we help employees find their own answers to these questions, we create a personal connection to change and the organization's mission. That's when change becomes transformation and transformation becomes culture.

References

1. VHA Office of Public Health, Occupational Health Division (2012).
2. National Center for Organization Development: Executive Teams Assessments and AES, 2011; AES and SHEP 2008–2012.

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