VA HEALTH CARE Defining EXCELLENCE in the 21st Century

IntegratedEthics In Action

Promising Practices – Emerging Champions

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Strong Change Strategies:

Improving VISN-Wide Documentation of Oral Consent for HIV Screening

The VISN IntegratedEthics® (IE) advisory board is charged with "supporting each facility's efforts to achieve national and local program performance and quality improvement goals" and making recommendations on how to manage issues that affect more than one facility in the VISN (VHA Handbook 1004.06, *IntegratedEthics*). During fiscal year 2014, some VISNs acted on this responsibility by supporting facilities' efforts to improve documentation of oral consent for HIV screening. Every facility with less than 95 percent compliance with this ethics standard had to complete an ISSUES cycle on the topic. Ten networks submitted documentation on their cross-cutting efforts to support facilities and improve documentation of oral consent for HIV screening (Figure 1).

According to the summary reports, each network took a unique approach to supporting quality improvement. Many included strong change strategies such as forcing functions and standardization. Other approaches included strategies such as reminders or warnings, staff and patient education, software enhancements, and enhanced communication of performance results. (See Table 1 for a summary of change strategy strength.) Some of the strongest interventions included forcing functions or process standardization paired with regular feedback on performance.

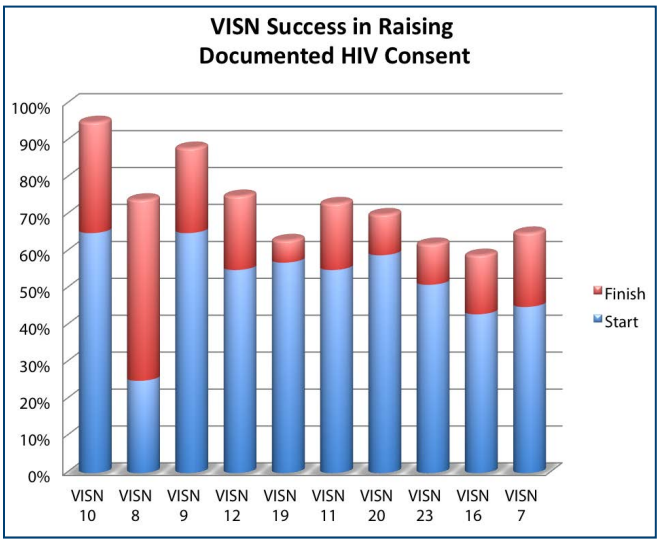

Figure 1. The graph shows the percentage of EHR records that contained documented consent for an HIV screening test in a sample of records in which a test was ordered. "Start" represents the percentage of records with documented consent from August 2012 to August 2013. "Finish" represents the percentage of records with documented consent from May 2014 to August 2014.

STRONGER	INTERMEDIATE	WEAKER
Architectural/plant changes	Checklist or cognitive aid	Policy development
New devices with usability testing	Enhanced communication	Education
Forcing functions	Redundancy	Double checks
Simplify the process	Reduce distractions	Warnings or warning labels
Standardize the process	Software enhancements and modifications	Additional study or analysis
Tangible involvement or action by leadership	Eliminate sameness (look alike, sound alike)	

Table 1. Source: Robin Cook, et al. Preventive Ethics: Addressing Ethics Quality Gaps on a Systems Level, second edition. U.S. Department of Veterans Affairs National Center for Ethics in Health Care. In press.

VISN 10 established a cross-facility team of clinical applications coordinators and clinicians, who developed and implemented a standardized message triggered by an attempt to place an order for an HIV screening test. The message (a) provided education to clinicians about the requirement for oral consent and documentation, and (b) directed clinicians to complete a progress note using a specific progress note template. The progress note template, in turn, included an embedded order for the HIV screening test, which could be completed and signed at the same time as the progress note. VISN 10 paired this strategy with a strong data collection and feedback mechanism, starting collection in December 2013 and sharing results monthly with facility leaders.

(Continued on page 2)

Strong Change Strategies

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VISN 9 hit upon the same solution as VISN 10 but arrived at the endpoint by a different means. VISN 9 initially supported two different electronic health record (EHR)-based solutions, but abandoned the second solution once data collection and reporting revealed that the first solution yielded superior results. The VISN expects to continue to see improved outcomes, because the last three facilities to adopt the preferred solution did so after July 1, 2014. A particularly innovative addition within the VISN 9 solution was the inclusion of links in the reminder dialogue to educational material that could be printed and given to patients.

VISN 8 posted significant gains by offering two solutions for ordering HIV screening tests from the EHR. One was a forced function solution like those used in VISNs 9 and 10. The other used a quick order function that included documentation of oral consent, making it very easy for clinicians to complete documentation as they ordered the screening tests.

VISN 12 made progress using a forced function solution together with regular data reporting and feedback. Similar to VISN 9, many VISN 12 facilities implemented this strong intervention late in the year. Following the good preventive ethics (PE) practice of conducting small-scale tests of interventions to refine and improve implementation strategies, VISN 12 began by implementing this strategy at only one facility. Once it was shown to be effective, it was rolled out across the VISN through the latter half of the year.

Forcing functions in the EHR and performance data reporting are two proven change strategies familiar to quality improvement practitioners in the Department of Veterans Affairs (VA). However, neither approach is without risk. Safety experts remind us, and clinicians often concur, that too much forced functionality can cause users to stop thinking about the situation before them (in this case, a patient) and just push buttons. VISN 20, perhaps recognizing this risk, took the opportunity to reduce the overall use of clinical reminders within the VISN even while introducing this new one. In a similarly cautious approach, VISN 23 offered a clinical reminder solution, but did not require its use, because clinical leaders raised concerns about such a requirement.

Whichever solution was adopted, national results of the HIV oral consent PE intervention have been impressive. On average across the country, nearly 70 percent of records examined now document appropriate ethics practice of oral consent for HIV screening tests, up from only 49 percent in FY2013. Over the next year, facilities will continue to work to bring practice above the 95 percent mark.

National Compliance and Ethics Week 2015 — More Important than Ever

National Compliance and Ethics Week (C&E Week) will be celebrated in VA from **April 27 - May 1, 2015**. This year's theme is "Excellence and Integrity." Co-sponsored by NCEHC and the Office of Compliance and Business Integrity, C&E Week is an opportunity for staff to reflect on the essential contributions made by ethics and business integrity in providing high-quality care and services to our nation's Veterans.

This year, VA Secretary Robert A. McDonald is supporting C&E Week with a video message about ethics and integrity. In addition, Interim Under Secretary of Health Carolyn M. Clancy, MD, will kick off the week by leading a C&E Week lunch-and-learn activity at VA Central Office on Monday, April 27, from noon to 1:00 PM.

Facility IE program officers and CBI officers are encouraged to lead local celebrations. Activity guides, communications tools and everything else you need for a great C&E Week are available from http://vaww.cbi.va.gov/ceweek.asp.

For more information, contact Steve Tokar: steve.tokar2@va.gov

IntegratedEthics Program Champion: Salt Lake City IE Team

Systems Design Coordinator and IEPO Dawn Hibl, RN, JD, VHA-CM; ECC Terri Forte; Chief of Psychology and PEC Patrick Miller, PhD; Facility Director and ELC Steve Young, MPS, FACHE

The IntegratedEthics team at Salt Lake City VAMC has been together for over six years. In that time, only one position has turned over. IE Program Officer Dawn Hibl spoke with *IE in Action* about the team's longevity and the success of IE.

Tell us about your IE team and how you have managed to stay together so long.
We have a good mix of professional backgrounds on the team. I am an attorney and registered nurse, and I have worked in quality improvement and focused on geriatric law for the last 20 years. The ethics consultation coordinator (ECC) is a LCSW and has been a member of the ethics consultation service for 13 years. The preventive ethics coordinator (PEC) is the chief of psychology and works in outpatient mental health as a supervisor of one of the mental health teams.

The team has been together for six-plus years. The only change has been with the retirement of our ECC last year, and she had a great succession plan for the new ECC (who had been an ethics consultant since 2008). As the IEPO, I provide mentoring and support to the core team, engaging directly with them on every aspect of their work whenever they ask for assistance. Our team enjoys their work, but only one member has protected time. The ECC has 0.5 FTE allocated to IE. This was requested and approved by the pentad a few years ago. The rest of us do our IE work as collateral duty.

What other external factors influenced the stability of the team?
I really think it is that leadership happened to choose individuals who have an interest in sustaining and participating in an ethical culture at our facility. As the IEPO, I have not placed a lot of requirements on my team members, and try to spread the workload among us evenly, so that no one gets burned out — especially since we don't have allocated time. I also try to work collaboratively with other teams at the facility. For instance, we routinely have an ethics representative on other work groups, which can result in our using their improvement work to meet IE performance measures if the work has an ethics component.

Has the composition of any of your IE groups changed over the years?
We had the change to the ethics consultutation service that I mentioned, with the retirement of our ECC. We also changed the IE council from a council per se to the council being our executive board with the director as the chair. We include ethics as a regular agenda item on our weekly executive board meeting agenda, and additionally the IEPO provides a quarterly report to the board. But we don't hold a spate of IE council meetings with sparse attendance. We took the "integrated" part of IE seriously and made ethics a priority at all executive leadership meetings instead of having ethics in a silo by itself!

The Salt Lake City IE team. From left: PEC Patrick Miller, IEPO Dawn Hibl, ECC Terri Forte.

How have your team's efforts promoted an ethical environment at the facility over the years?
Continuity has helped us to keep momentum going, and not to have gaps in long- term strategic planning related to ethics initiatives.

Ethics is considered whenever a decision is made, from a resource decision to a policy decision. We have included an ethics representative on all executive-level boards and committees, so that we always have that ethical discussion when decisions are made. We have a very transparent leadership team here and they welcome all inquiries, comments, or concerns when it comes to ethics, patient safety, or compliance. We try to focus on improving our processes and not blaming individuals for specific actions.

(*Continued on page 4*)

IntegratedEthics Program Champion

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What kind of advice would you give to other facilities looking to create a more stable IE team?
Our leadership team supports our work by providing us with the tools we need to make improvements and changes in the culture at our facility. They allow staff to exercise personal leadership, use the power of transparency, and they value and respect employees at all levels of the organization. They have created a common purpose among staff and have been an example to staff of good values and beliefs. Our leadership team invites us to have the hard conversations with them, and allows the IE team to influence policies, processes and decisions at all levels of the organization.

Finally, pick the right individuals at the beginning who have an interest in the "hat" you want to give them — then give them rewards and authority to wear it!

Informed Consent for Long-Term Opioid Therapy for Pain:

Manchester VAMC's Experience with Early Implementation of VHA Directive 1005

VHA Directive 1005, *Informed Consent for Long-Term Opioid Therapy for Pain*, was published May 6, 2014. It established requirements for signature informed consent for long-term opioid therapy for pain and prohibited the use of Opioid Pain Care Agreements (OPCAs). The goal for full implementation is May 6, 2015.

VA facilities across the country are at different stages of implementing this new informed consent process. Some began early, while others may only now be starting (see Figure 2). Manchester VA Medical Center in New Hampshire is committed to early implementation, which is being led by the facility's Pain Management Committee. *IE in Action* interviewed the committee's co-chairs, Chief of Primary Care Richard Siemens, JD, MD, MPH, and Clinical Pharmacy Specialist Anita Wallace, PharmD, CGP.

Why did your facility decide to move forward with early implementation of the new informed consent process?
There has been a strong focus on opioid prescribing practices at our facility over the past three or four years. Since implementation of the Opioid Safety Initiative (OSI), we significantly reduced the number of opioid prescriptions we write and increased our focus on providing Veterans with alternatives to opioid therapy. When VHA Directive 1005 was published, it came into waiting arms, both at the facility and VISN 1, as we were already focusing heavily on this topic. The new informed consent process is consistent with the OSI; it helps us to provide patient-centered care and ensure that practitioners have conversations with our Veterans about the risks and benefits of, and alternatives to, long-term opioid therapy.

How has collaboration between services, committees, and/or leadership played a role in early implementation?
The Pain Management Committee has played an important role in implementing the directive, updating staff on the new process and providing staff with educational material, including the FAQ developed by NCEHC. Our local pain policy identifies which services should be on the committee, and so we have a multidisciplinary group of people. This is great because not only can we easily get new information out to multiple services, we can get feedback from each of these services, which makes implementing new processes easier.

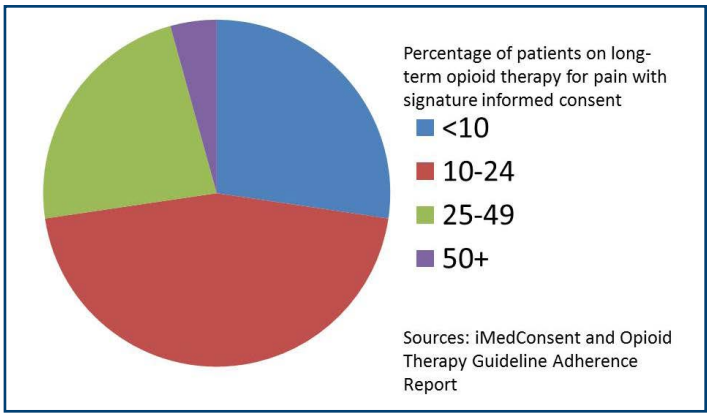

Figure 2. By the end of the first quarter of fiscal year 2015, six VA facilities (4.3 percent) had obtained signature informed consent for more than half of their patients on long-term opioid therapy for pain.

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Informed Consent for Long-Term Opioid Therapy for Pain

(*Continued from page 4*)

Historically, signature informed consent has not been a part of the primary care workflow. How have you integrated the new process into primary care?
First, the clinical applications coordinators deactivated the VISN 1 OPCA. Second, we made sure that staff was trained in the new processes. We provided education in our Friday morning primary care meetings. Also, we tried to create a culture in our facility in which staff is open and ready for change, including change mandated by new national policies.

Primary care practitioners have come to realize that this new process doesn't just mean more work. When Veterans sense that we care about them, that helps them therapeutically; when practitioners see that the care they are providing is helping Veterans, they understand the importance of implementing new patient-centered processes. Also, safe, patient-centered opioid prescribing practices have helped reduce hospitalizations and prescriptions, which, in turn, reduces some of the work for our practitioners.

> ***"When Veterans sense that we care about them, that helps them therapeutically; when practitioners see that the care they are providing is helping Veterans, they understand the importance of implementing new patient-centered processes."***

How do team members support primary care practitioners in the informed consent process?
Although the informed consent process is completed by the practitioner and the patient, PACT RNs can play an important role. For example, when a patient at our CBOC requests an opioid prescription refill and the informed consent for long-term opioid therapy has not been completed, the RN contacts the patient to explain the new process. The patient is then scheduled to see the RN, who provides the patient with, and reviews, an unsigned copy of the consent form and a copy of "Taking Opioids Responsibly." Patients then have time to review the material and think of any questions they may have for the practitioner. If they do have questions, an appointment is scheduled with the practitioner. Once the patient has all of their questions answered, the patient and practitioner sign the consent form.

How have you been able to streamline moving from OPCAs to robust informed consent?
When the directive came out, we made lists of patients on long-term opioid therapy available to all practitioners, and we continued to update these lists for our practitioners throughout implementation. Also, there are a couple of processes that we already had in place that helped us make the transition.

First, as part of a practice we had in place for 15 years, we conducted Opioid Safety Reviews on all patients on long-term opioids for pain. The goal of this process is to ensure patient safety by reviewing charts and providing information back to primary care practitioners about additional treatment options. During the chart review, we now look to ensure that the informed consent process has been completed and, if not, we let the practitioner know. The Opioid Safety Review process is really important for patient safety, but it is also resource-intensive. Other facilities may have their own established processes that could help with implementation of the informed consent process.

Second, we have a telephone triage service that patients use to request refills on opioid prescriptions. During this process, the triage staff assists with documenting whether the consent form is in place.

Were there any barriers to your implementation initiative?
We are striving to ensure that 100 percent of our Veterans on long-term opioid therapy complete the new informed consent process by the implementation date in May. It may be hard to get to 100 percent, though, because some of our patients, for example the "snowbirds," use multiple facilities, and this makes completing the process more complex.

Do you have any advice for facilities that may not have gotten as far in their implementation?
We know that appointment access is a big concern for VA right now, and many practitioners may be wondering how they can fit this new process into their already busy schedules. At first there was a little pushback from primary care practitioners at our facility as their schedules are very busy, but once they adjusted to it, they were able to see that it doesn't really take that much time, and more importantly, they were able to see the benefit that it provides to our Veterans.

Government Ethics Corner

By the Office of General Counsel Ethics Specialty Team

In 2006, the Ethics Resource Center published a report by the Ethics & Compliance Officer Association Foundation entitled *Ethical Culture Building: A Modern Business Imperative*. The report suggested that no organization is without values, but unless the organization actively fosters a positive ethical culture, a more negative culture, focused on self-interest, will arise. Because most employees want to fit in with their organization's culture, employees will tend to behave ethically if the organization's ethical culture is positive and active. This positive ethical culture will thus reinforce itself.

> ***"No organization is without values, but unless the organization actively fosters a positive ethical culture, a more negative culture, focused on self-interest, will arise."***

The report also links a strong ethical culture to lower rates of observed misconduct, reduced pressure to compromise standards, increased reporting of misconduct to leadership, and greater satisfaction with management's response to misconduct. The underlying message of this report is that all VA employees have a role in establishing and maintaining VA's ethical culture. Acting ethically must be the norm at VA. Both Government ethics and ethics in health care — IntegratedEthics (IE) — are integral to maintaining a positive ethical culture at VA. All VA employees are subject to the Government ethics laws and rules applicable to them as federal employees. At the same time, VHA employees may also need to adhere to ethical standards dictated by their profession, policy implemented by VHA, or specialized standards such as those supporting the ethical conduct of research. When considering the right action to take, all of these ethics laws, rules and standards must be applied together as appropriate to a particular situation.

The need to apply more than one set of rules is best illustrated in an area where Government ethics and IE often overlap: VA research. It is not uncommon for a VA researcher to be an employee of, or paid consultant for, an outside company. The researcher might serve as a member of the company's speaker's bureau, or on its scientific advisory board or steering committee. In this example, the researcher secures company funding for a research study to be conducted at VA, and submits the study proposal to VA for review. The proposal includes a required financial disclosure that is intended to identify any conflicts of interest. Reviewing the financial disclosure, the R&D subcommittee at the VA medical center identifies a conflict of interest that is resolved when the researcher discloses her relationship with the company to the prospective study subjects.

The OGC Ethics Specialty Team is available to assist you with your Government ethics questions. To contact an OGC ethics official:

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The DAEO, ADAEO, and other deputy ethics officials at VA Central Office may be contacted at GovernmentEthics@va.gov or (202) 461-7694 or (202) 461-1600.

To contact a deputy ethics official outside VA Central Office:

OGCNorthEastEthics@va.gov for ME, NH, VT, MA, RI, CT, NY, NJ, DE, PA, OH, WV, MI, WI.

OGCSouthEastEthics@va.gov for VA, NC, SC, GA, FL, MI, AL, LA, southern TX, Puerto Rico.

OGCMidwestEthics@va.gov for DC, MD, IN, KY, TN, AR, MO, IL, IA, MN, ND, SD, NE, KS.

OGCWestEthics@va.gov for northern TX, OK, NM, AZ, CO, UT, WY, MT, ID, NV, CA, OR, WA, HI, AK, Guam, Philippines.

However, as a Government employee, the researcher is also subject to Government ethics. When an Office of General Counsel (OGC) ethics attorney reviews the same financial disclosure report and applies Government ethics laws and rules to the facts, an unmanageable conflict of interest is likely to be found, and the researcher will be unable to conduct the research at VA. The conflict is this: federal criminal ethics law prohibits employees' participation in official matters affecting their personal financial interest or any financial interest imputed to them (18 USC § 208). This law imputes, or ascribes, an outside employer's financial interests to the employee. Thus, the researcher could not participate in a VA research study funded by the researcher's outside employer, because the researcher would be participating in an official matter affecting a financial interest that is imputed to the researcher.

(*Continued on page 7*)

Government Ethics Corner

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Even when the researcher is not an employee of the outside company, but is instead a paid consultant or independent contractor, this same statute prohibits the researcher from participating in the research if such participation has a direct and predictable effect on the ability or willingness of the company to continue paying the researcher's consulting fees.

Further, even if the researcher gave up her compensated position with the company, she would nevertheless, under the Executive Branch Standards of Conduct, continue to have a "covered relationship" with the company for one year (5 CFR 2635.502). Therefore, without an authorization by a VA agency designee such as the medical center director, the researcher would be unable to participate in the study for one year after giving up the compensated position, if a reasonable person with knowledge of the facts would question the researcher's impartiality. In this case, the appearance of an ethical conflict — which can be probed by asking the hypothetical question, "Taking the facts as a whole, how they would appear if published on the front page of the *Washington Post*?" — does not favor the medical center director granting an authorization under these facts. Ultimately, the goal of an ethical culture is to maintain the public's trust in VA. Appearances do matter.

Together, Government ethics rules, IntegratedEthics, research ethics and VHA policies form the foundation for Integrity, the first of VA's Core Values, codified in the Federal Regulations as I CARE. The regulation states, "VA's Core Values define VA employees. They describe the organization's culture and character, and serve as the foundation for the way VA employees should interact with each other, as well as with people outside the organization. They also serve as a common bond between all employees regardless of their grade, specialty area, or location" (38 CFR 0.601). An active ethics program helps to ensure that the department will earn the trust of those it serves through the daily actions of its employees who provide care, benefits, and services with compassion, dependability, effectiveness, and integrity.

Around IntegratedEthics . . .
ANNOUNCEMENTS

VHA Publishes Revised Ethics Policies

VHA published revised and updated versions of two ethics policy handbooks.

The updated VHA Handbook 1004.07, *Financial Relationships Between VHA Health Care Professionals and Industry*, was issued November 24, 2014 and is available at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3059.

The updated VHA Handbook 1004.05, *iMedConsent* was released December 10, 2014, and is available at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3064.

What We're Reading:

Here are some articles that were of recent interest to our NCEHC IE staff. Articles can be used to spark engagement in your local IE program or to discuss in local journal clubs. To access, click on the links below, or consult your facility's librarian.

Ethics Resource Center. "Ethical Leadership: Every Leader Sets a Tone." Available at http://www.ethics.org/nbes/leadership/ethical-leadership-download/; accessed March 4, 2015.

Wong, Leonard and Stephen J. Gerras, "Lying to Ourselves: Dishonesty in the Army Profession." Available at http://www.strategicstudiesinstitute.army.mil/pdffiles/PUB1250.pdf; accessed March 4, 2015. Coming soon: A discussion guide featuring this article.

Presidential Commission for the Study of Bioethics. *Ethics and Ebola: Public Health Planning and Response.* Available at http://bioethics.gov/sites/default/files/Ethics-and-Ebola_PCSBI_fnl.pdf; accessed March 5, 2015.

National Center for ETHICS in Health Care

Developed by the IntegratedEthics team at the National Center for Ethics in Health Care, *IntegratedEthics in Action* is published on the IE website vaww.ethics.va.gov/integratedethics/IEaction.asp, listserv, and via other IE venues. Its purpose is to rapidly disseminate promising practices and feature emerging IE champions to help facilities and VISNs in implementing IE. We welcome your comments and suggestions for topics to: vhaethics@va.gov.