Performance Yearbook 2011

Harry S. Truman Memorial Veterans' Hospital
Columbia, Missouri

Truman VA
the pulse of Veteran health care in the heart of Missouri

The Harry S. Truman Memorial Veterans' Hospital, located in the center of Missouri on the University of Missouri campus, provides care and treatment to eligible Veterans from throughout Missouri and is a part of the VA Heartland Network. A full continuum of care is provided in both inpatient and outpatient settings. During FY 2011, Truman VA provided care to more than 34,000 Veterans at our main medical center and our seven Community Based Outpatient Clinics (CBOCs). The operation of our seven CBOCSs (Waynesville, Kirksville, Mexico, Osage Beach, St. James, Sedalia and Jefferson City) allows us to improve access to primary care and behavioral health services for Veterans.

In FY 2011, the Fort Leonard Wood CBOC was moved to a new location in Waynesville, which allowed for increased space and expansion of services. The medical center opened a new blood draw area as part of a complete renovation of our laboratory as well as a newly renovated Imaging (Radiology) suite. Construction and planning activities were in full gear for improvements to come in FY 2012 and beyond.

Mission Statement is "To improve the health of the Veterans we serve by providing primary care, specialty care, extended care and related social support services in an integrated health care delivery system." To that end, the hospital staff is committed to outstanding health care delivery and to continuous performance improvement and patient satisfaction. We are proud to share some of our initiatives from the past year through our Performance Yearbook.

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Decreasing the Use of Foley Catheters on the CLC

Team:

Back Row L to R: Eva Santoyo, RN, Nurse Manager; Penny Woods, LPN; Dr. Frederick Wilson, Physician; Kathy Kormann, RN, Infection Control Practitioner; Shirley Blair, RN; Reng Winters, Nurse Practitioner; Jean Jackson, LPN; Charlene Abrams, Nursing Assistant; Vickie Robinson Purdy, Nurse Practitioner; Patty Martinez, LPN; Vicky Rivera, RN

Objective:

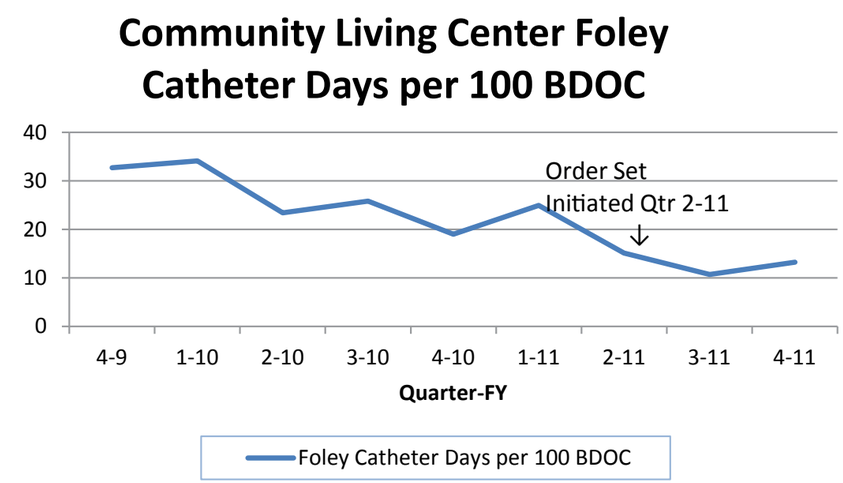
- Objectives: Per the Centers for Disease Control and Prevention, "the most important risk factor for developing a catheter-associated UTI (CAUTI) is prolonged use of the urinary catheter. Therefore, catheters should only be used for appropriate indications and should be removed as soon as they are no longer needed." The objective of this project was to decrease the number of residents having foley catheters on the Community Living Center (CLC), thereby decreasing infection risk.

Methodology:

- In July 2009, data collection on the total number of foley catheter days was initiated on the CLC.
- Appropriate indications for foley catheter use were agreed upon by the team based upon the 2009 CDC Guidelines for Prevention of Catheter-Associated Urinary Tract Infections.
- Appropriate indications for foley catheter use were entered into all admission order sets for the CLC in March 2010.
- Staff ordering a foley catheter were required to justify its use by checking one of the indications in the order set.

Outcomes:

- Foley catheter days per 100 Bed Days of Care (BDOC) were reduced from 26.6 in the 6 quarters before implementation of the order sets to 13.0 in the 4 quarters following implementation.



Healing Internal Wounds Evidence Based Psychotherapy for PTSD

Team:

L to R: Dr. Scott Sandstedt, Psychologist; Dr. Janet Johnson, Psychologist
Not Pictured: Dr. Cheryl Hemme, Chief Behavioral Health Service

Objective:

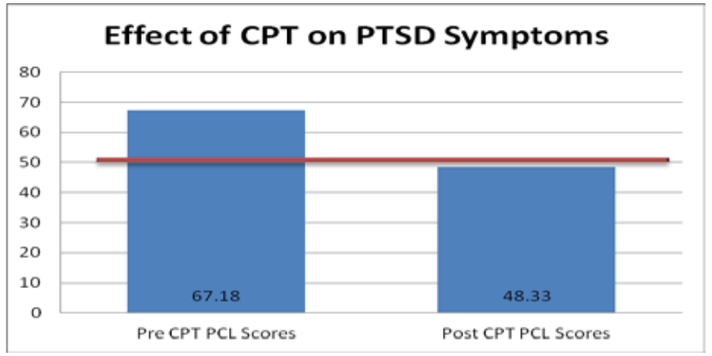
- Research suggests certain methods of psychotherapy are effective in helping Veterans overcome and decrease symptoms of PTSD. Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) are two types of evidenced based psychotherapies (EBPs) for PTSD.
- The goal was to increase the number of providers trained and certified in these EBPs, as well as increase the amount of these therapies provided by Behavioral Health Service. These EBPs would be provided to Veterans with PTSD who would like to participate and who are good candidates for therapy.
- The effectiveness of these therapies on the PTSD symptoms in the Veterans we serve would be measured.

Methodology:

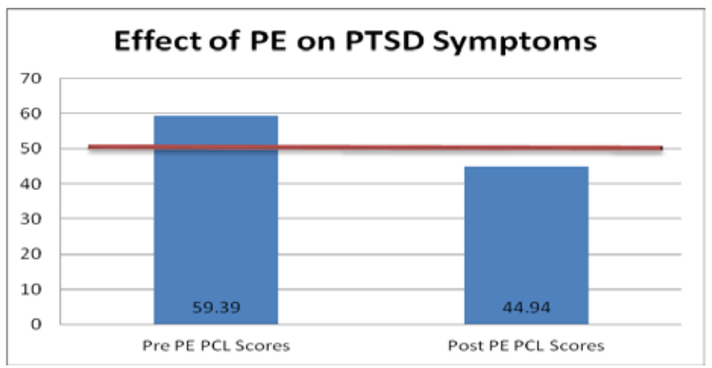
- The team determined relevant staff to participate in the EBP trainings.
- The team maintained a staff database on training attendance, certification and staff progress.
- The team completed chart reviews to track the number of Veterans receiving EBPs for PTSD and PTSD symptoms through the use of a standardized clinical measure, the PTSD Checklist (PCL). PCLs are routinely given throughout PTSD therapy to track progress.

Outcomes:

- Cognitive Processing Therapy
  - ♦ Since May 2008, 12 providers have been trained in CPT and 6 providers have achieved certification.
  - ♦ As of June 2011, 86 Veterans had begun participation in and/or completed CPT.
  - ♦ Average PCL scores decreased from 67.18 to 48.33 among Veterans completing CPT. (A PCL score of 50 is suggestive of PTSD. Thus, the average post-treatment scores fell below the PTSD threshold.)



- Prolonged Exposure Therapy
  - ♦ Since September 2009, 8 providers have been trained in PE therapy and 5 providers have achieved certification.
  - ♦ As of June 2011, 44 Veterans had begun participation in and/or completed PE.
  - ♦ Average PCL scores decreased from 59.39 to 44.94 among Veterans completing PE therapy. (A PCL score of 50 is suggestive of PTSD. Thus, the average post-treatment scores fell below the PTSD threshold.)



Electronic Clinic Request Form

Team:

Seated: Mark Roland, IT Specialist; Standing: Cheryl Meisinger, Program Analyst

Objective:

- Develop a more efficient and user friendly clinic request process. The previous system had numerous obstacles such as a long approval process, no consistency in request format and requiring one request per email. That process, at times, could take up to two weeks for a clinic to be approved and established.

Methodology:

- The team identified the use of an electronic Permission Access System (ePAS) as a solution to simplifying the clinic request form and providing a more efficient approval and communication route.
- The team developed a template of required information needed for a clinic request.
- The team incorporated the template into a program that includes several prompts with pull-down choices to make completing the request form easier.

Outcomes:

- The process of requesting a clinic via email, which took approximately 15-30 minutes, can now be completed in less than 5 minutes.
- Approval for clinic requests can be given by a designee, which eliminates the need to wait on personnel.
- ePAS allows for the creation of templates, which can be used to create multiple clinics. This has eliminated the need for "cutting and pasting," which often led to confusion and/or omitting vital information.
- ePAS has reporting capabilities that allow us to monitor the document request process and its timeliness. This, in turn, opens the door for additional improvement opportunities.

Health Care for Homeless Veterans (HCHV) Program Expansion

Team:

Seated: Katie Burnham Wilkins, LCSW, Social Worker; Standing: Jessica Holdinghaus, LMSW, Social Worker

Objective:

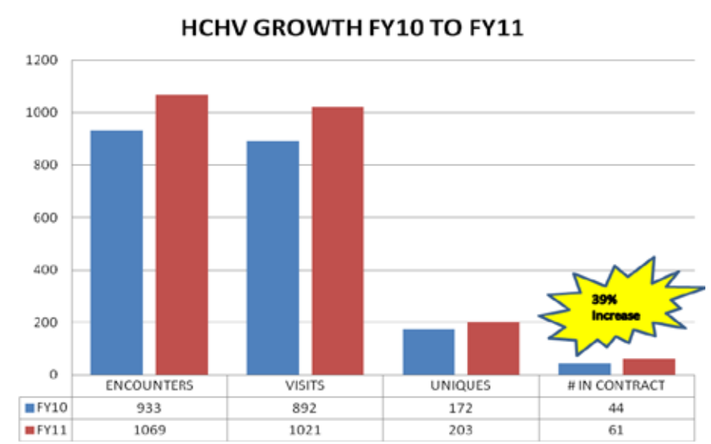
- Create more emergency and transitional housing beds for Veterans experiencing homelessness.
- Create a more streamlined and efficient way to meet the needs of homeless Veterans who present to the Green Team clinic as walk-ins.
- Provide education on VA programs and services and outreach to VA staff, community partners and Veterans who are experiencing homelessness or who are at risk for homelessness.

Methodology:

- Implement a triage pager and response system for walk-ins to the Green Team clinic.
- Provide education/training to Community Based Outpatient Clinic (CBOC) staff.
- Increase participation in Project Homeless Connect events.
- Increase participation in the annual Point in Time (PIT) count, which is required by the Department of Housing and Urban Development (HUD) to capture data on the sheltered and unsheltered homeless population. These data are used by VA Central Office for funding consideration.
- Participate in state wide and local homeless coalitions or Continuums of Care.

Outcomes:

- Increased utilization of current HCHV contracts and creation of new HCHV contracts.
- The homeless triage pager for walk-ins was created:
  - ♦ HCHV staff now share responsibility with Psychosocial Rehabilitation Team staff for the volume of Veterans who present as a "walk-in" to the Green Team clinic;
  - ♦ More efficient system to ensure that staff is able to fully respond to immediate needs and there is a decreased wait time for Veterans who present to the clinic;
  - ♦ Easier process for Green Team clinic clerks and other VA staff, as there is always an available staff person to answer the pager.
- Increased outreach and education
  - ♦ HCHV program staff provided site visits and education/training to CBOC staff
  - ♦ HCHV staff increased participation in all PHC events in our catchment area, which provides direct outreach to homeless Veterans.
- Increased participation in local and statewide homeless coalitions:
  - ♦ Katie Burnham Wilkins was elected President of the Basic Needs Coalition (local homeless coalition) for the 2011 term;
  - ♦ Katie Burnham Wilkins is a member of the Governor's Committee to End Homelessness (statewide homeless coalition) and was elected to serve on two committees that advocated for the unique needs of the homeless Veteran population.



Imaging Relocation Project

Team:

Front Row from L to R: Joan Hollensteiner, Diagnostic Radiologic Tech; Lance Lochmann, Supr. Diagnostic Radiologic Tech; Cathy Beamer, RN; Lesley Smith, Medical Instrument Tech; Susan Knisely, Medical Support Assistant; Dr. Marta Lemmon, Radiologist; Lanny Barber, Medical Instrument Tech; also pictured: Imaging staff
Not Pictured: Patty Drury, Diagnostic Radiologic Tech; Clay Atherton, Engineer Supervisor

Objective:

- A LEAN consultant worked with Imaging staff for eight months beginning in September 2008 to develop the design for the new department that would improve patient privacy, satisfaction and efficiency.

Methodology:

- Several LEAN tests and projects were implemented to reduce waste and inefficient processes.
- Input was received from physicians, clinical and administrative staffs from other sections on what improvements were desired.
- Weekly briefings were provided to hospital administration and Imaging staff on developments.
- Several design proposals were developed before the final design was approved.
- Improvements obtained from the Imaging project were:
  - ♦ Additional ultrasound and general radiology imaging rooms;
  - ♦ Larger outpatient waiting area and waiting area for inpatients;
  - ♦ Four holding bays for the recovery of patients;
  - ♦ Three dedicated check-in stations for outpatients;
  - ♦ Private patient consent room;
  - ♦ Four dressing rooms for patients;
  - ♦ Improved security of the department after normal working hours;
  - ♦ Additional bathrooms for patients and staff.

Improving Safety on Behavioral Health Unit

Team:

L to R: Tim Anderson, Patient Safety Manager; Dr. Jeff Thiele, Psychiatrist; Wayne Hogan, Plant Manager; Maya Warren, RN; Matt Stewart, Safety Specialist

Objective:

- Leadership was committed to environmental safety on the locked behavioral health unit. Healthcare Failure Mode Effects Analysis, Root Cause Analysis following Sentinel Event and a checklist team was empowered to recommend changes.

Methodology:

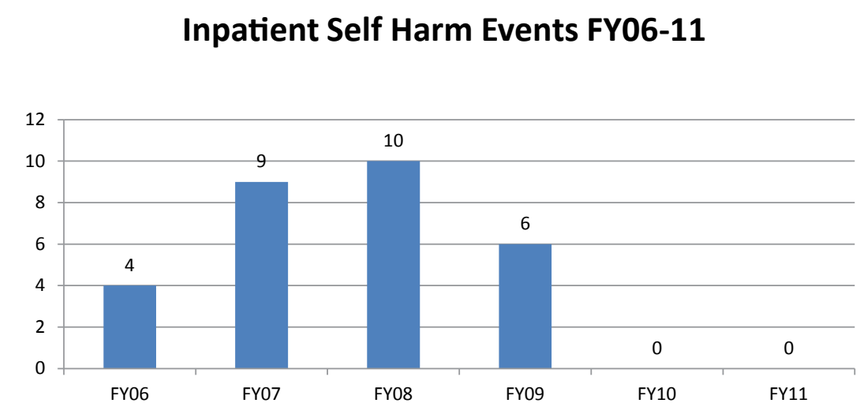
- Utilized Mental Health Checklist by the Mental Health Safety Inspection Team and leadership support for recommended changes by the team.
- Eliminated self harm events on the behavioral health unit through environmental design and controls.
- Conducted Root cause analysis (RCA).
- Medical center leadership provided support and financial resources.
- A series of projects were designed and completed including construction projects
- Cultural improvements were seen with reduction of fall related injuries and medication administration.

Actions implemented:

- Solid ceiling and corner protectors throughout the unit;
- Angle down fixtures, door hardware, hinges, and picture frames;
- Integrated sink fixtures with minimal anchor points;
- Anti-suicide bathroom stall doors;
- Wicket bedroom doors (door within a door);
- Furniture replacement including beds, chairs, and tables;
- Purchased bendable utensils, combs, and toothbrushes;
- Purchased suicide blankets;
- Stainless steel grille covers for HVAC grilles;
- Enclosed television viewing boxes, coffee dispensing, and telephone.

Outcomes:

- There have been no self harm events involving inpatients since July 2009.



Medication Take Back Collaboration

Team:

Seated: Stephen Gaither, Public Affairs Officer
Standing L to R: Tim Anderson, Patient Safety Manager; Crystal Aholt, Performance Improvement Manager; Kevin Harris, Public Affairs Intern
Not Pictured: Radhika Poreddy, Health Systems Specialist

Objective:

- A Rapid Response Team (RRT) was chartered to develop a permanent medication take back process. Outdated or unusable drugs that are disposed of improperly by flushing or pouring down a sink enter the environment. Because wastewater treatment facilities are not designed to remove them, studies have shown that pharmaceuticals and over the counter drugs are present in our nation's water bodies and certain drugs may cause ecological harm.

Methodology:

- Partnered with the Columbia Youth Collation and the Boone County Sheriff's Department.
- Truman VA staff volunteered and collected the medications.

Outcomes:

- Truman VA hosted three collaborative Medication Take Back events.
- In October 2011, approximately 33,707 unneeded prescription drugs were properly disposed due to this effort.
- In April 2011, more than 16,000 unneeded drugs were properly disposed.
- In November 2010, more than 8,000 unneeded drugs were properly disposed.

Drug-Take Back volunteers pictured(left to right): Radhika Poreddy, Health Systems Specialist; Jennifer Lynch, Crime Prevention Officer with MU Police; Steven Starks, VA Police; Tim Anderson, Patient Safety Manager; Angie Erdel, PharmD, Staff Pharmacist; and Karen Iadanza, Program Assistant in Research

Prevention of Healthcare Acquired Infections due to MRSA

Team:

L to R: Allison Mitchell, Medical Technician; Phil Wilkinson, Housekeeping Aid; Kathy Kormann, RN, Infection Control Practitioner; Jimmie Higgins, RT; Kate Randerson, RN; Roxanne Slates, RN

Objective:

- Decrease the rate of Hospital Acquired Infections due to MRSA.

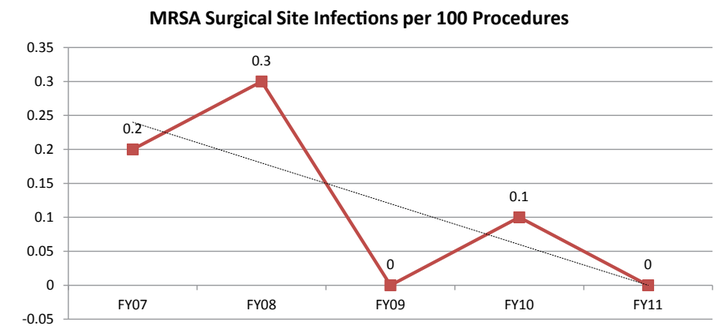
Methodology:

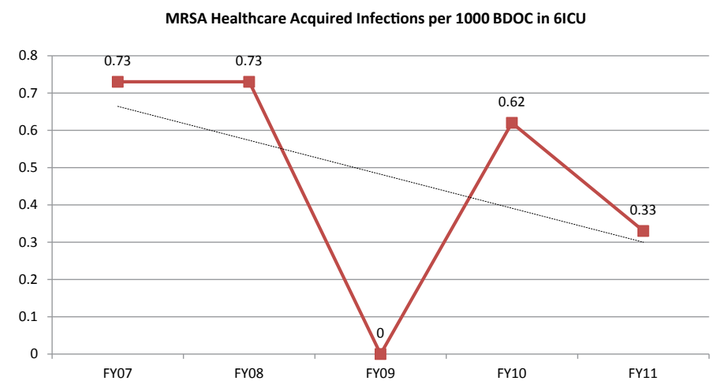
A program to prevent healthcare acquired infections due to MRSA was initiated in all acute care hospital units in January 2008. This included implementation of the following:

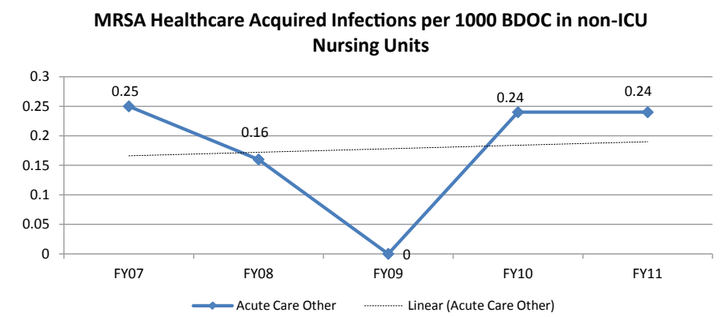
- A MRSA screening program to identify all positive patients upon admission, transfer between units and at discharge.
- Monitoring of screening compliance rates and initiation of interventions to achieve a goal of screening 90 percent of patients.
- Initiation of contact isolation of all patients positive for MRSA.
- Monitoring isolation for compliance and providing just-in-time training.
- Increased emphasis on hand hygiene. This included education, surveillance for compliance and just-in-time training.
- Encouraging staff to be active participants in preventing infection.

Outcomes:

- The rate of MRSA infections in clean and clean-contaminated surgeries was 0.3 per 100 procedures the first year of the program. Infection rates have declined since then with no surgical site infections due to MRSA in 2 of the 3 subsequent years.
- The rate for healthcare acquired MRSA infections in 6ICU was 0.73 per 1000 Bed Days of Care (BDOC) the year the program was initiated. Infection rates have decreased in each of the three years since then.
- Rates of MRSA infection in acute care non-ICU units have remained essentially unchanged. This rate equates to approximately 1 healthcare acquired MRSA infection per unit per year.







Outreach Video Creation

Team:

L to R: Jamil Powell, Supply Technician; Nathan Witt, Chief, Volunteer Service; Sarah Froese, Social Worker; Stephen Gaither, Public Affairs Officer; Andrea Wiggins, Communication Specialist; Heather Paxton, Supervisory PSA
Not Pictured: Amanda Culler, MSA; Robert Cundiff; HR Assistant; Dr. Kevin Gunter, Physician; Lisa Hall, RN Coordinator; Dr. Grant Oneal, Psychologist; Paula Williams, RN Manager HBPC; Dr. Lana Zerrer, Chief of Staff

Objective:

- The team was assembled to create an outreach video to highlight VA services and feature local Veterans in order to reach new enrollees and deliver Truman VA's core message to all stakeholders.

Methodology:

- Established initial team as subgroup of the Veterans Outreach Committee and contacted VHA Employee Education Service (EES) to complete needs assessment in November 2010.
- Collaborated with EES to brainstorm core message, video plot and Veterans to feature in December 2010.
- Contacted four local Veterans, confirmed participation and drafted script January-February 2011.
- Identified staff members to be featured in February-March 2011.
- Filmed feature interviews and "b-roll" at Truman VA and local landmarks in March 2011.
- Reviewed video draft in April 2011.
- Received final videos in May 2011.
- Posted videos on local website in June 2011.

Outcomes:

- The final product included two versions of the videos- local and network.
- Each video was dual purposed as a full 13 minute video to be shown to a live audience and a series of 2-3 minute video clips.
- The video has been used on the local social media and websites, network intranet and SharePoint, new employee orientation and a number of outreach events.

Pathology Relocation Project

Team:

L to R: Harriett Browning, Medical Technologist; Kristy Kruse, Medical Technologist; Linda Green, Medical Technologist; Allene Norman, Medical Technologist; Dawn Brooks, Medical Technologist ; also pictured: Pathology staff

Objective:

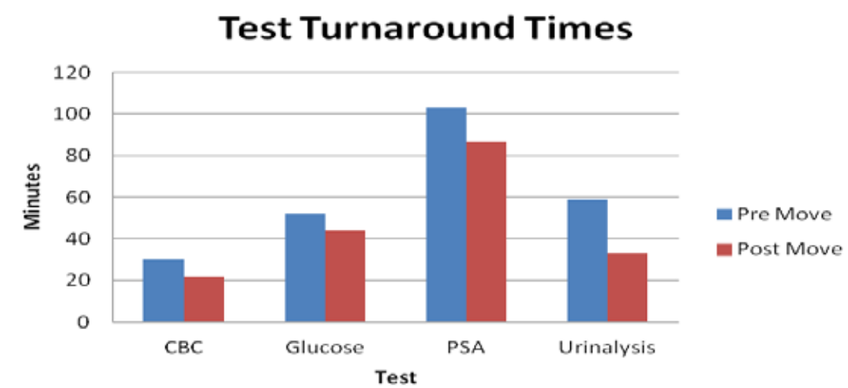
- The objective of the Pathology redesign was to improve efficiency and patient privacy in the Pathology clinical laboratory and blood draw area by January 2011.

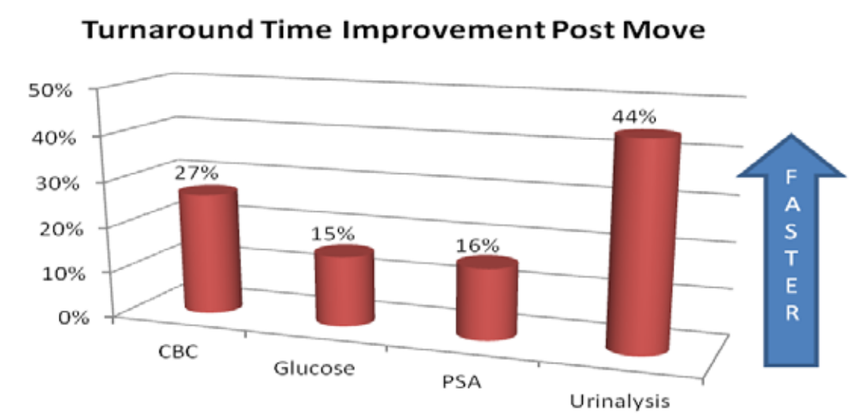
Methodology:

- Pathology employees worked with a systems redesign specialist to reconfigure the layout of the laboratory using Lean and Six Sigma principles to promote efficiency, reduce variation and reduce waste.
- The team participated in three days of training to learn basic principles of Lean and Six Sigma.
- The team constructed value stream maps and spaghetti diagrams to determine the best layout of the laboratory departments.

Outcomes:

- The blood draw area was enlarged to handle six patients at a time to improve efficiency.
- Blood draw cubicles improve patient privacy during the phlebotomy process. A stretcher can now be accommodated in a double cubicle area.
- A coaster pager system was implemented to improve patient privacy and reduce environmental noise.
- The clinical laboratory instituted a kanban, or pull system, for laboratory supplies that reduced the number of emergency orders.
- The "5S" process (Sort, Straighten, Scrub, Standardize and Sustain) was instituted to reduce clutter and standardize workstations for improved efficiency.
- A core laboratory (Chemistry, Hematology, Coagulation and Urinalysis) was developed to improve laboratory specimen flow and reduce staff travel time. Cross-training for all Core laboratory staff has allowed for maximum flexibility in staffing.
- An automated analyzer for urinalysis was put into use in June 2011 and has resulted in a 44 percent improvement in test turnaround time.





Patient Flow Systems Redesign

Team:

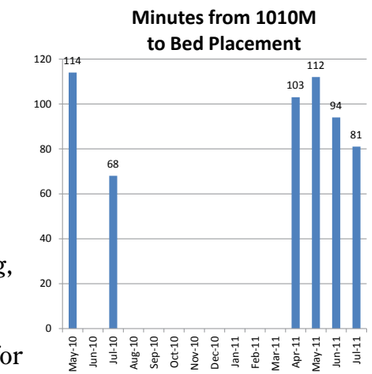
L to R: Donita Hensley, RN, Admission Advisor; Ed Allen, RN; Denise Schehl-Geiger, IT Specialist; Tanya Lee, Systems Redesign Coordinator; Kay Strom, RN, Informatics Nurse; Julie Fairchild, RN, Palliative Care Coordinator; Peggy Wilburn, Supr. WAS; Veronica Ramnarine, Chief Social Work Service; Woody Fountain, Asst. Chief HAS
Not Pictured: Dr. Aaron Zuidema, Chief Primary Care; Staci Findley, PSA; Nikki Harper, RN Manager; Lula Johnson, RN Manager; Jason Jones, RN; Stephen Keene, Housekeeping Aid Supr.; Roxanne Slates, RN; Mary Wideman, ADIR/PS

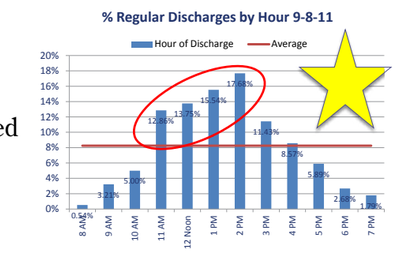
Objective:

- Decrease the time from 1010m to bed placement by 25 percent by September 30, 2011.
- Decrease percentage of continued stays that do not meet National Utilization Management Integration (NUMI) criteria by 25 percent by September 30, 2011.
- Fully implement BMS including housekeeping, diversion and patients waiting in community by September 30, 2011.

Methodology:

- Flow mapped admission process from all sources including clinics, Emergency Department (ED), Operating Room (OR), and Same Day Surgery (SDS).
- Identified huge bottleneck where ED called floor to give report.
- Revised process to include paging Nurse Manager or NOD if report was not taken in 20 minutes.
- Pager groups were established for 4 MED Admits and 6 Surg Admits to notify charge nurse, ward clerk, nurse manager, and clerk's supervisor of admissions with text page of basic information. Expanded the Admit pager groups to include SDU and ICU.
- Utilization Review (UR) was actively involved with providers about admissions and continued stays that do not meet criteria.
- UR nurse met with Core Team and reviewed provider reasons for stays not meeting criteria.
- Identified potential interventions for CHF and AMI patients.
- Improved consistent participation in IDT Rounds – UR, providers, nursing, SW, OT, Nutrition, and Pharmacy. Utilization Review nurses led the meetings and utilized opportunities for teaching NUMI requirements
- Used EDIS and BMS to track patients.
- Identified issue with transportation home when patients were transferred from another VA.
- Shifted discharges from 3 pm to 11 am to allow earlier placement of admissions.
- Standardized document-ation for short stay recovery patients to use CO-PHASE II RECOVERY NOTE. Modified note to include type of procedure, location of recovery and length of recovery. Developed menu option to search for note.
- Pulled Health Factor data on 20 recoveries.
- Revised policy to codify BMS and admission process.





Outcomes:

- Time from 1010M being entered until patient was admitted to the floor: 103min — 81 min
- Reasons for admissions/continued stays that do not meet Interqual criteria: Reasons reviewed with UR = Best for patient
- Percentage of housekeepers correctly using BMS. Day shift-100 percent Evenings-60 percent
- Percentage of scheduled admissions listed waiting for beds. 100 percent listed daily on BMS

PRRC Program CARF Accreditation

Team:

L to R: Dr. Joseph Hinkebein, Psychologist; Sammye Ward, RN; John Dunham, RN; Dr. Janet Johnson; Psychologist; Dr. Jocelyn Abanes, Psychologist
Not Pictured: Dr. Cheryl Hemme, Chief Behavioral Health Service; Dr. Scott Sandstedt, Psychologist

Objective:

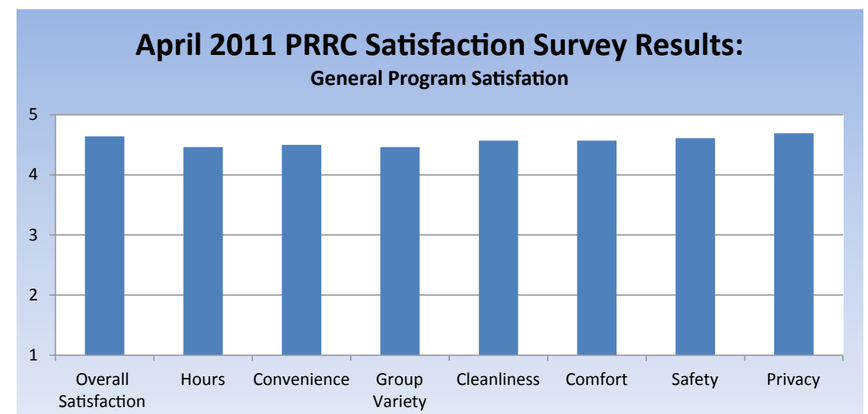
- We sought to transform the existing Day Hospital program into a Psychosocial Rehabilitation and Recovery Center (PRRC), accredited by the Commission on the Accreditation of Rehabilitation Facilities (CARF). The PRRC is an outpatient program that provides recovery-based mental health services to Veterans experiencing serious mental health challenges that interfere with quality of life and the ability to function in the community. CARF International is a private, nonprofit organization that promotes the quality, value and optimal outcomes of services through a consultative accreditation process centered on enhancing the lives of the persons served.

Methodology:

- Development of the PRRC: In response to the VHA Mental Health Strategic Plan, the Behavioral Health Service Line began the process of transforming existing Day Hospital services into a PRRC in 2009. Stakeholder meetings were held to determine ideas for programming. New recovery-based group curricula were developed and implemented. A consult and intake process was developed.
- CARF Accreditation: In August 2010, in collaboration with a facility wide CARF team, the PRRC team began to prepare the program to meet the exacting CARF standards for successful accreditation. "Intent to Survey" was prepared and submitted to CARF in December 2010. In May 2011, PRRC staff participated in a two-day accreditation survey of the PRRC.

Outcomes:

- Formal recognition of the PRRC was received by VA Central Office in October 2010.
- The PRRC received a three-year CARF accreditation, the highest level of accreditation offered by CARF.
- Surveyor comments highlighted numerous program strengths, including "the staff member of HSTMVH are committed, are compassionate, and have a passion that is palpable throughout the program. The health and well-being of Veterans are the utmost priority of the organization."
- Only 5 recommendations were offered by the CARF surveyors, all of which were addressed by a quality improvement process initiated by the PRRC team.
- The outcome of the CARF survey complements the feedback provided by Veterans served in the PRRC.



Reducing Verbal Physician Orders for Medications

Team:

L to R: Tim Anderson, Patient Safety Manager; Denise Schehl-Geiger, IT Specialist; Kay Strom, RN, Informatics Nurse
Not Pictured: Gary Morrison, RPh; Carrie Lawrence, LPN; Mavis Tripoli, RN; Brian Mayfield, LPN

Objective:

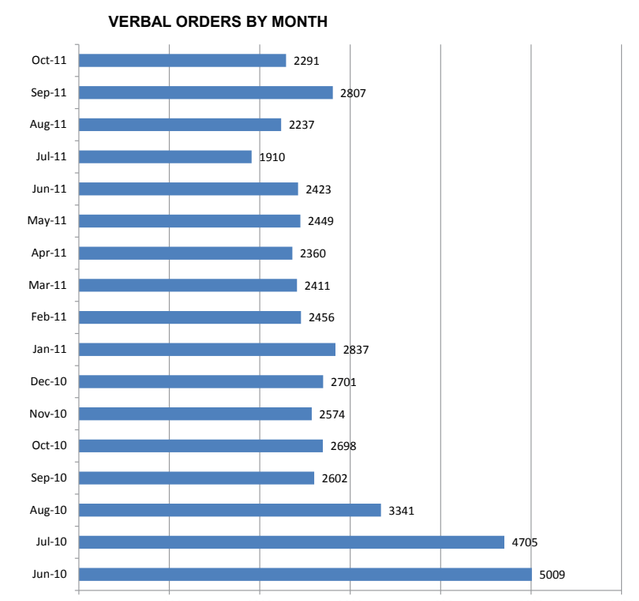
- A Root Cause Analysis of medication errors in May 2010 looked at 114 medication events dating from 10/1/2009. The team elected to focus on reducing verbal and telephone orders with the objective to see if the number of orders for medications could be reduced.

Methodology:

- A report was developed that identified physician verbal/telephone orders. The team discovered a culture of verbal order acceptance has permeated the facility, which led to more than 6,000 verbal/telephone orders every month in FY09.
- Computerized Physician Order Entry (CPOE) and BCMA are technology-based tools that can impact the goal to decrease verbal and telephone orders errors and improve patient safety.
- Actions implemented included:
  - Provided education at monthly new resident orientation and with each New Employee Orientation (NEO) session.
  - The team established a written plan that contains a timeline and milestones to monitor on a monthly basis.
  - A subgroup was appointed to assess where additional quick orders could decrease the amount of VO that are required. Examples include ordering nicotine replacement for patients who smoke and are admitted to BH; diet orders following procedures, and ward collect vs. laboratory collect on laboratory orders timed within 30 minutes of a laboratory collect time.
  - Many procedures were found to have a standardized set of drugs and activities that could be ordered before the procedure and this helped reduce number of verbal orders.
  - Quick orders were identified, presented at the Patient Safety Committee, the P&T committee and implemented by the Clinical Executive Board.
  - Patient Services established a write down, read back form to be used when verbal orders were taken. This form was used during the process and turned in to the manager to monitor the types and numbers of verbal orders being given and by whom. This tool helped empower the nurses to ask providers to enter orders and not take verbal and telephone orders. There were 36,000 forms printed and distributed to nursing staff.
  - Pulmonary worked with OI&T and Respiratory Therapy to develop an appropriate order set (parameter/ quick order) for management of ventilators by RT staff.

Outcomes:

The Verbal/telephone order report shows reduction of more than 30 percent (sustained).



Scanning Systems Redesign

Team:

L to R: Jim Orourke, Medical Records Tech; Tanya Lee, Systems Redesign Coordinator; Denise Schehl-Geiger, IT Specialist; Ann Richmond, Privacy Officer; Paula Clark, Operations Manager; Tammy Scott, Medical Records Tech; Sara Hake, EEO Program Manager; Peggy Wilburn, Supr. WAS
Not Pictured: Amanda Barnes, Supr. PSA; Mark Goldsmith, PSA; Paul Kurzejeski, Operations Manager; Woody Fountain, Asst. Chief HAS

Objective:

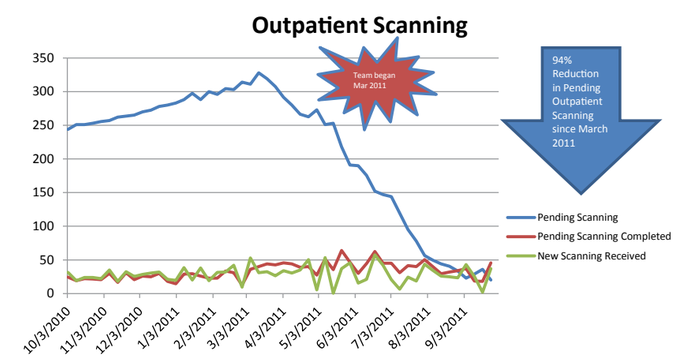
- Decrease the amount of pending outpatient and fee scanning, which had reached a level of 311 inches and 99.5 inches, respectively. Update the scanning policy to include a monitoring mechanism for pending scanning to reduce likelihood of backlog.

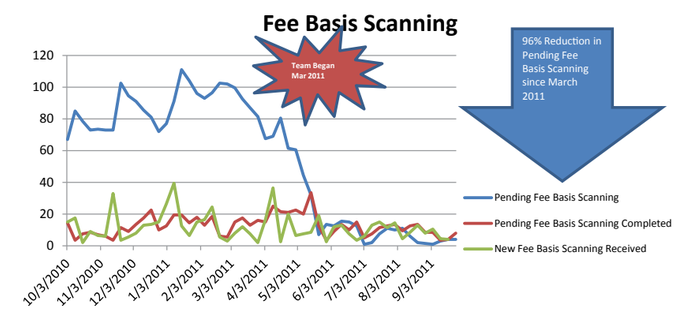
Methodology:

- 1.0 inch of scanning is equal to approximately 175 pages.
- 1.0 FTE scanning clerk can scan an average of 1.2 inches per day or 6.0 inches per week.
- A matrix for weekly monitoring of pending scanning, amount of scanning received and amount of scanning completed was developed and disseminated weekly to the team.
- Members of the team met with scanning staff for an "innovative think session" to elicit from the staff doing the work ways to improve efficiency.
- Ward Administration was provided with additional high speed scanners and assisted with nursing home scanning.
- Scanning team members met on a voluntary basis after hours on two occasions to sort, alphabetize and search for duplicates in pending scanning.

Outcomes:

- Scanning backlog was reduced by 94 percent for pending outpatient scanning and 96 percent for pending fee scanning.
- Reduction in the backlog led to:
  - ♦ Decreased phone calls to scanning staff by providers looking for documentation, which allowed for more time spent on Veteran care.
  - ♦ Decreased amount of time scanning staff spent "hunting" for documentation requested by providers.
  - ♦ Documents are scanned in a timely manner. Providers have the necessary information when needed, which results in Veterans receiving the care and treatment they need, when they need it.
  - ♦ Decreased number of duplications received, which means a reduction in waste (paper, resources, and rework).
- Accomplishments by the Scanning Systems Redesign Team were made without any additional staff allocation.
- The monitoring of pending scanning has been assigned to the Health Information Committee.





Secure Messaging Implementation

Team:

L to R: Kathy Lee, RN Coordinator; Cheryl Meisinger, Program Analyst; Sarah Fehling, IT Specialist; Felicia Casady, Supr. MSA; Gary Scott, Operations Manager; Andrea Wiggins, Communication Specialist; Becky Rahmoeller, RN Manager; Dr. Richard Burns, Physician
Not Pictured: Greg Bergman, Social Worker; Richard Chirnside, Lead Medical Records Tech; Nancy Dietz, Pharmacist; Mark Fleetwood, Medical Librarian; Tony Fuchs, IT Specialist; Steve Koeppel, Clinical Nurse Specialist

Objective:

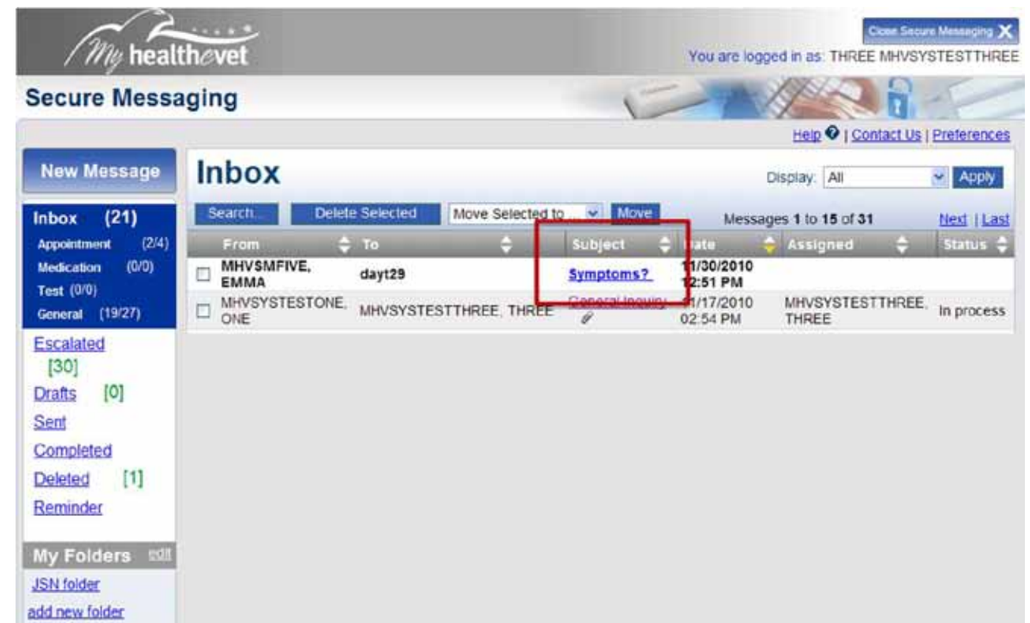
- The team was charged to generate Secure Messaging awareness within the facility, recruit Secure Messaging early adopters and implement Secure Messaging with pilot teams by December 30, 2010.

Methodology:

- Assembled team, identified objectives, and discussed implementation timeline in September 2010.
- Identified pilot teams, reviewed existing clinical communication workflows and selected patient recruitment methods in October 2010.
- Discussed local system requirements, activation of staff members and message triage process in November 2010.
- Activated pilot teams and mailed invitation to participate to eligible patients in December 2010 and January 2011.
- Reviewed feedback from initial implementation and developed roll-out schedule February 2011.
- Facilitated implementation, training and message monitoring March-September 2011.

Outcomes:

- Reached 93 percent Primary Care adoption with Secure Messaging by the end of FY2011.
- Implemented Secure Messaging with three additional clinics: MOVE, Smoking Cessation and Diabetic Clinic.
- 1,017 total messages completed (85 percent within three business days).



Social Media Launch

Team:

Back Row L to R: Nathan Witt, Chief Volunteer Service; Stephen Gaither, Public Affairs Officer; Kevin Harris, Public Affairs Intern; Cindy Stivers, Women Veterans Program Manager; Melissa Mertensmeyer, LCSW, Social Worker
Front Row L to R: Andrea Wiggins, Communication Specialist; Heather Paxton, Supr. PSA; Paula Williams, RN Manager; Dr. Autumn Keefer, Psychologist
Not Pictured: Stacey Dennis, Social Worker; Kristina Gaddy, HR Assistant; Mark Roland, IT Specialist

Objective:

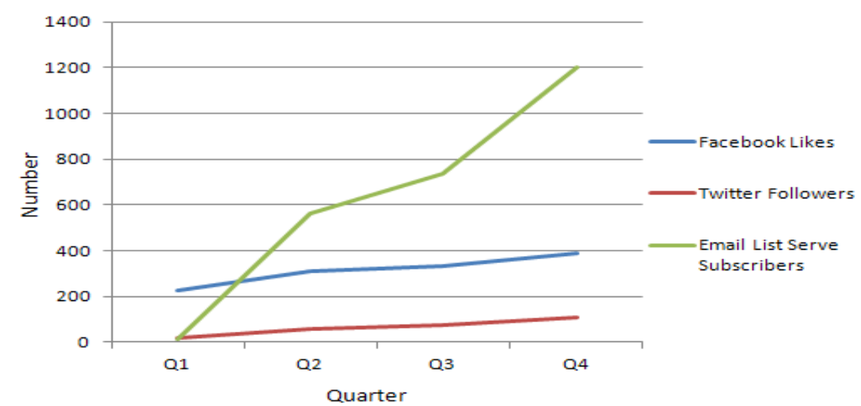
- Develop a social media presence and engage in informal two-way communication with Truman VA stakeholders.

Methodology:

- Launched Truman VA's Facebook and Twitter sites in concert with the Internet Homepage Refresh in October 2010.
- Held Social Media Lunch and Learn session for staff in December 2010.
- Incorporated messaging for events and programs such as Health Promotion Disease Prevention messaging and local articles.
- The team met quarterly to review use, reach, voice, access, mentions.

Outcomes:

- Completed 151 Facebook posts and 191 tweets in FY11 to extend our social media presence and reach.



Expanding Efforts for Veteran Justice Outreach (VJO)

Team:

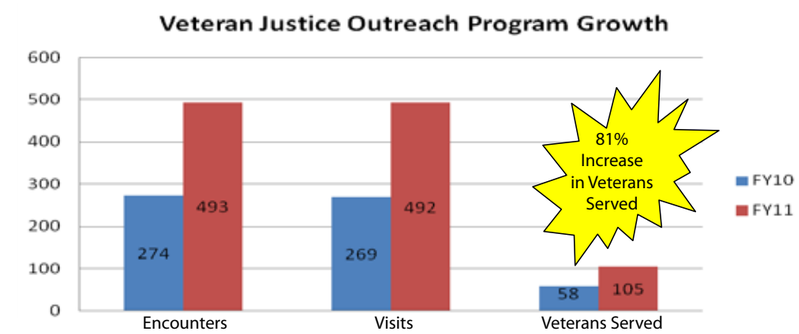
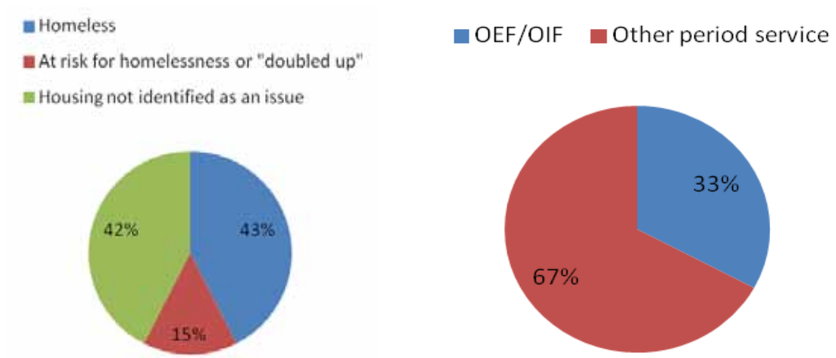
Danielle Easter, LCSW, Social Worker
Not Pictured: Dr. Cheryl Hemme, Chief Behavioral Health Service; Dr. Scott Sandstedt, Psychologist

Objective:

- The Veteran Justice Outreach (VJO) initiative ensures access to services for the justice-involved Veterans at risk for homelessness, substance abuse, mental illness, and physical health problems. With the appointment of a full time VJO Specialist in FY 11, the program was expanded via networking, outreach and education to reach a greater number of justice-involved Veterans and community providers.

Methodology:

- Worked with Boone County Jail and the Cole County Sheriff's Department to add a question to their booking paperwork that identifies if an offender served in the military. In Boone County, once identified, those individuals are eligible to attend the monthly information group facilitated by the VJO Specialist at the jail.
- Continued participation in the local Crisis Intervention Team, which includes: University of Missouri Campus Police, City of Columbia Police Department and the Boone County Sheriff's Department to provide education and resources to better serve Veterans.
- Provided presentations to Federal Court Attorneys for Continuing Education Credits, the Missouri Bar Association's Military Law Committee and the Missouri Drug Court Commission during their quarterly meeting.
- Met with members of the State of Missouri House of Representatives and Office of State Courts regarding legislation for Veteran Treatment Courts in Missouri.
- Presented at the Boone County Judicial Task Force about the benefits of a Veterans Treatment Court.
- Participated in a one week Veteran Treatment Court Planning Initiative Training with court teams from Pulaski County and Texas County.
- Met with Boone County Judge and Court Administrator about development of a Veteran Treatment Court in Boone County.

Outcomes:

- In addition to VJO Specialist participation in weekly staffings for the mental health court, drug court and DWI court teams in Boone County, VJO Specialist now participates in drug court and DWI court in Cole County.
- In FY11, VJO Specialist conducted 531 encounters with 114 Veterans.
- Of the 114 Veterans served in FY11, 73 participated in case management services that involved more than one visit.
- Agencies such as the Missouri State Public Defender System, Federal Public Defender for the Western District of Missouri, Alternative Sentencing Courts, and Probation and Parole continue to refer Veterans to the VJO program upon screening.