

# Performance Yearbook

2010



**Harry S. Truman Memorial  
Veterans' Hospital  
Columbia, Missouri**



Part of VA Heartland Network, the Harry S. Truman Memorial Veterans' Hospital, located in the center of Missouri near the University of Missouri-Columbia campus, provides care and treatment to eligible veterans from throughout Missouri. A full continuum of care is provided in both inpatient and outpatient settings. During FY 2010, the medical center provided care to more than 33,000 Veterans.

During FY 2010, a new Community Based Outpatient Clinic (CBOC) was established in Sedalia. The Lake of the Ozarks CBOC moved from Camdenton to Osage Beach. The operation of our seven CBOCSs (Fort Leonard Wood, Kirksville, Mexico, Osage Beach, St. James, Sedalia and Jefferson City) continues to improve access to primary care and behavioral health services for Veterans.

Our 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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# Interdisciplinary Discharge Plann

## Team:



Back: G. Jones, Supv. Physical Therapist; C. Sulltrop, Community Health Nurse Coordinator; M. Taylor, Supv. Occupational Therapist; S. Fehling, IT Specialist; P. Wilburn, Supervisor WAS; Front: V. Ramnarine, Chief, SW Service; A. Roark, Occupational Therapist; D. Keisker, SW; M. Nelson, Clinical Reviewer; M. Herndon, Clinical Reviewer; Not Pictured: Dr. A. Zuidema, Director Primary Care; M. Warren, Nurse Manager BH; J. Bechtel, Nurse Manager OR; M. Bell-Tyler, Dietitian; B. Dickinson, Pharmacist; M. Thomas, Program Specialist, PI; Dr. L. Zerrer, Chief of Staff.

## Objective:

This team reviewed current approaches to performing and documenting interdisciplinary discharge planning to ensure that a process was in place that was interdisciplinary, timely, coordinated, efficient and addressed the continuum of care and needs of the patient.

## Methodology:

- A 4 Medicine Team was established to meet daily with all disciplines to discuss challenges and discharge appointment time for each patient from Medicine. A *CO-Medicine Interdisciplinary Note* was developed for documentation. Discharge times were monitored and smoothing effects trended. After the two month trial period, it was noted that 100% of patients in 4 Medicine were reviewed with documentation.
- An Orthopedics team was established to follow the Interdisciplinary Discharge planning process for that service. The patient population type prompted the team to meet three times a week. A *CO-Surgery Interdisciplinary Note* was developed for documentation. This Orthopedics team has set the standard for the entry of both Specialty Care and Cardiothoracic Surgery into this process of Interdisciplinary Discharge Planning Team.

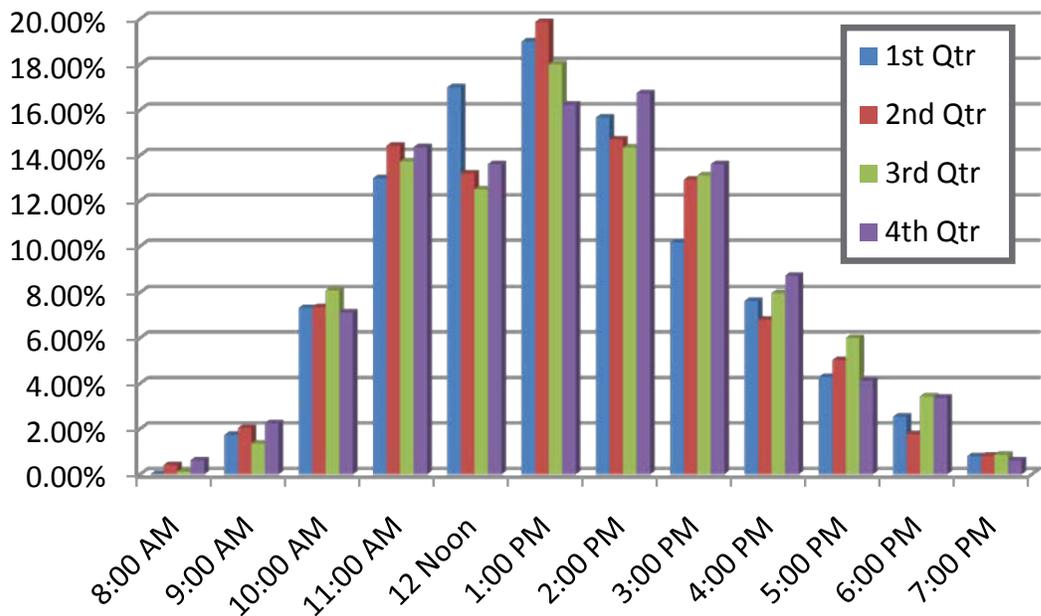
- Being a teaching hospital, a laminated note card was created as a reference tool for all disciplines. It provides rotating physicians information needed to plan for a discharge and designates what each discipline team member needs to contribute toward this plan. The note card is titled INTERDISCIPLINARY ROUNDS ARE PATIENT CENTERED FOR DISCHARGE PLANNING.

**Outcomes:**

What started as a Rapid Response Team (RRT) in September 2009 was subsequently determined to be a Systems Redesign Process.

- Inter-D team process was established on 4 Medicine and Orthopedics, ensuring the patient a smooth transition from admission through discharge.
- The performance monitor, “Smoothing Discharges within the Day,” was met with discharges at any particular hour of the day consistently below 20%.
- A more Patient Centric interdisciplinary process is in place, which allows staff members to more effectively support patient needs.

**% of Discharges by Hour**



# Recall Reminder System

## Team:



Back: H. Paxton, Supv. PSA; M. Magill, A/DIR; W. Park, AA/COS; M. Kruse, IT Specialist; S. Sandstedt, Psychologist; P. Clark, OM/Specialty Care Svc; Front: L. Duffen, Systems Redesign Coordinator; M. Thomas, Program Specialist, PI; M. Adams, Inventory Mgt Specialist; B. Carter, Health Systems Specialist, PC; Not Pictured: S. Koeppel, CNS, BH; L. Jacobs, Chief, Audiology and Speech Pathology; F. Casady, Supv. Medical Support Asst.

## Objective:

This Systems Redesign Team was assembled to facilitate the exploration and implementation of the roll out of the Class 1 Recall Reminder software. This software is designed to enable clinic teams to efficiently track and schedule Veterans who need appointments to be scheduled beyond 90 days. The primary desired outcome of the software implementation was a reduction of appointment no-shows. The software prompts scheduling clerks to issue letters to Veterans to remind them when it is time to schedule a future appointment. By waiting to schedule an appointment closer to the desired appointment date rather than the typical practice where Veterans are asked to agree to a future appointment date at the time of their last visit, it was presumed that the Veteran would have a greater likelihood of attending the appointment.

## Methodology:

- A Clinic Profile Management Team was established to ensure that clinic profiles were maintained and accurately reflected the true availability of each clinic.
- By January 31, 2010, clinics were identified to pilot the recall software. Primary Care (PC) clinics for Dr. Z and Dr. W were identified as pilot clinics. The first recall letters for the two Primary Care clinics were being mailed as the Systems Redesign Team was approaching its end of service time; therefore, no data could be collected to assess the impact of software on clinic no-shows. However, initial feedback suggested that patients seemed more satisfied than when we previously tried to implement recall.
- In an effort to reduce no-shows in selected clinics by 10%, flyers were

posted in the Silver Clinic and information on no-shows was displayed on the digital signage screens throughout the facility.

## Outcomes:

- Inactivation of 168 clinics.
- An 87% reduction in unused slots.
- Increase in clinic utilization from 15% to 73%.
- The dramatic progress made by the Clinic Profile Management Team will be continued through FY 11 by the Automated Data Processing Applications Coordinator in each service. The MyHealthVet Coordinator will continue to make certain that clinic titles are appropriate and that phone numbers are correct.
- Primary Care plans to roll recall out to all of the PC Silver teams this fiscal year.
- No-show signage will be distributed to additional Primary Care, Surgical, Specialty Care, Physical Medical and Rehabilitation clinics as well as ancillary clinics.
- The inserts to the appointment letters will be expanded to additional clinics.
- A teamlet in Primary Care is piloting Patient Aligned Care Team (PACT) in the Red PC clinics. As part of this pilot, patients are called two days ahead of their appointment to help reduce no-shows.



**THANK YOU VETERANS**

**Please help decrease the number of  
"No Show" appointments.**

**Help us serve you better by always  
calling at least 24 hours in advance to  
cancel your appointment if you know  
you cannot keep it. Canceling your  
appointment will allow us the  
opportunity to schedule another  
Veteran at that time.**

For 1st Quarter (Oct, Nov, Dec) there were 4,044 no shows  
For 2nd Quarter (Jan, Feb, Mar) there were 4,282 no shows  
For 3rd Quarter (Apr, May, Jun) there were 4,486 no shows  
For 4th Quarter (Jul, Aug, Sept) there were 4,404 no shows

# Improving Non-VA Care For Our

## Team:



Back: A. Westlund, Health Systems Specialist; W. Park, AA/COS; T. Haney, Asst. Financial Officer; S. Richardson, Program Analyst, FIN; P. Clark, OM Specialty Care Service; Front: L. Duffen, Systems Redesign Coordinator; M. Chandler, Program Support Asst.; M. Nelson, Clinical Reviewer; Sallie Houser-Hanfelder, Director; Not Pictured: J. Bechtel, Nurse Manager OR; T. Carter, RN; H. Shryock, Fee Basis Supervisor; A. Villiers, Program Analyst, PI.

## Objective:

This team took a detailed look at fee basis services for Orthopedics, Physical Medicine and Rehabilitation (PM&R), Neurosurgery and Vascular Surgery with the goals of decreasing fee basis costs, increasing quality assurance and increasing access to medical services through the following:

- Identify and analyze where fee dollars are being spent
- Decrease fee dollars spent in the community
- Cost benefit analysis of build vs. buy for these fee services
- Decrease reliance on the community to provide care to Veteran population
- Better utilization of VISN medical services
- Ensure patients receive timely access to health care services
- Ensure patients receive quality health care services.

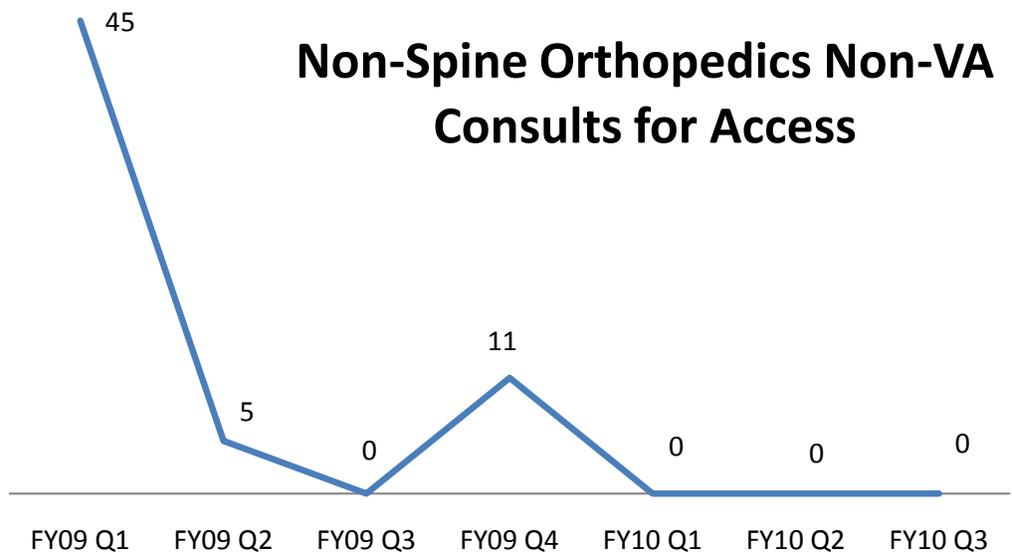
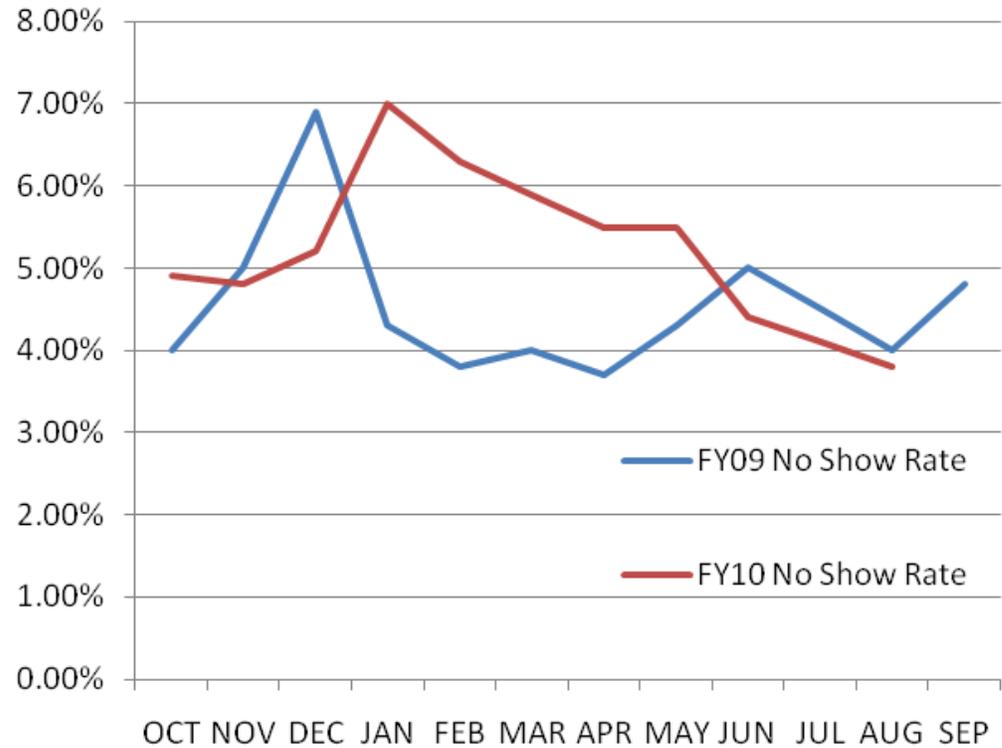
## Methodology:

- Collected data regarding the number of no-shows for PM&R and Orthopedics
- Implemented trial of Neurology after hours clinic with 48 Veterans seen, 28 cancellations and 1 no-show
- Collected information on the usage of non-VA care for Orthopedic patients
- Developed no-show inserts to be included in appointment letters.

# Veterans

## Outcomes:

- No-show rate dropped since June 2010 implementation of no-show appointment letter insert. As of August 2010, the rate decreased to 3.8%.
- Dramatic sustained decrease in the use of non-VA care for non-spine Orthopedics consults from 61 initiated in FY09 to 0 for all of FY10.
- Physical therapy services were initiated at Fort Leonard Wood CBOC.



# Bed Management Solution (BMS)

## Team:



Back: C. Meisinger, Program Analyst, HAS; S. Fehling, IT Specialist; P. Wilburn, Supervisor, WAS; P. Williams, Nurse Manager, HBPC; Front: D. Hensley, Admissions Advisor; V. Ramnarine, Chief, Social Work Service; M. Dykstra, Secretary/Assoc Dir/Pt Care Svc; K. Strom, Informatics Nurse; Not Pictured: M. Wideman, ADIR/Patient Services; L. Duffen, Systems Redesign Coordinator; W. Hogan, Plant Manager, FM, C. Kelly, ADIR/PS; H. Williams, Housekeeping Supervisor.

## Objective:

- The first aim was to facilitate more efficient patient flow, as evidenced by decreasing the time from admission order to bed placement by 10% by September 30, 2010, through implementation of the Bed Management Solution by June 30, 2010.
- The second aim was to complete a capacity/demand study, using queuing theory, of the Intensive Care Unit (ICU) and Step-Down Unit (SDU) by June 30, 2010 to assure that the facility had the correct number of beds.
- The third aim was to improve patient placement in the appropriate level of care, as demonstrated by decreasing the number of discharges to home from ICU and SDU by 10% by September 30, 2010.

## Methodology:

The Patient Flow Collaborative team vision was to work as one team, treating every patient with dignity and respect, assuring them they had been placed in the right bed, at the right time, and for the right reason, every time. Analysis showed that improvement was needed to facilitate more efficient patient flow from admission through discharge, especially in discharging patients directly to home from the ICU and SDU. Truman VA currently reviews 100% of inpatients every day for appropriate level of care.

Bed Management Solution (BMS) is software displayed through a link on the Home Page on nurses' personal computers and on a 40 inch monitor on the nursing units. It provides dynamic management of bed capacity and patient flow. BMS allows real-time tracking of patients and bed status, proactive management

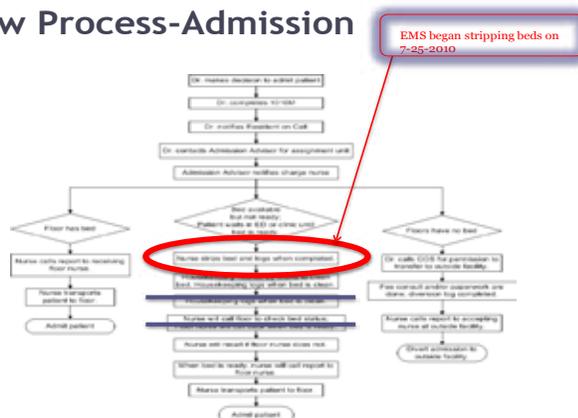
of demand and capacity and augments the emergency management system. The admission advisor uses BMS to do real-time bed assignments and proactive management of fee basis and other transfer patients.

This systems redesign project looked at the admission and bed placement process and identified barriers and strategies to correct them. Plan-Do-Study-Act (PDSA) cycles were used to plan, train staff and implement BMS. Predictive models were used to determine capacity levels. BMS benefits include the ability to: efficiently plan, prepare and manage patient flow; improve efficiency of communications by reducing the number of phone calls required for bed placement; minimize “fee basis” days and costs; track current and pending bed availability; identify and anticipate peak demands; maximize use of hospital capacity; decrease hospital diversions; and provide visibility into bed availability across the network of VA medical centers.

## Outcomes:

- Bed Management Solution was implemented facility wide by June 30, 2010.
- Two steps were deleted from the admission to bed placement process by using BMS.
- The average time from admission request (1010M) to floor placement decreased from one hour fifty-four minutes to one hour eight minutes.
- Responsibility for stripping the bed after discharge was reassigned from nursing to housekeeping to decrease the bed turn-around time.
- Erlang’s law was utilized to identify optimal ICU and SDU bed capacity. This demonstrated the need for two additional beds in ICU and two additional beds in SDU. Approval has been received for both expansions.
- The length of stay in SDU was shortened from Medicine-2.6 days and Surgery-2.9 days in April 2010 to Medicine-2.5 days and Surgery 2.1 days in July.

## Flow Process-Admission



# Decreasing Verbal Orders

## Team:



Back: N. Bates, RN; M. Kruse, IT Specialist; K. Strom, Informatics Nurse; Not Pictured: D. Tomasini, LPN; D. Stafford, RN; L. Dodds, RN; Dr. Kul Aggarwal.

## Objective:

The objective of this project was to decrease verbal orders by 50% by April 1, 2011. A culture of verbal order acceptance had permeated throughout Truman VA, which led to more than 6,000 verbal/telephone orders per month in FY09.

## Methodology:

Following in-depth analysis of the verbal orders that occurred during June 2010, the team identified a series of strategies. These included:

- **Re-establish a culture that supports computerized provider order entry (CPOE) and empowers staff to request the provider to put in the order.** This required tangible support of leadership and an ongoing training program for staff. It is estimated that it will take approximately two years to complete the culture change, but efforts must occur each month with new resident orientation and with each session of New Employee Orientation (NEO). We have begun this journey. There has been an increased awareness that verbal orders are not the desired way to do business and efforts to train staff. We identified that numerous staff in the Emergency Department (ED) believed that they were entering policy orders with protocols, but were not clicking on the button by “policy.” Hence, they were all going in as verbal. Retraining has occurred with that staff and two champions have been identified to continue the efforts. Intensive Care Unit (ICU) staff has identified that many of their verbal orders were “clean-up” and can be better entered as “signature on chart” or “completed”. In addition, nurses are being taught how to flag orders that are obsolete or that need to be renewed.
- **Change the wording on ventilator order sets that would allow obsolete orders to be discontinued upon extubation.** Orders for chlorhexidine mouth care and ALOH/MGOH/SIMTH XS SUSP are no longer needed after extubation and the order to discontinue can be

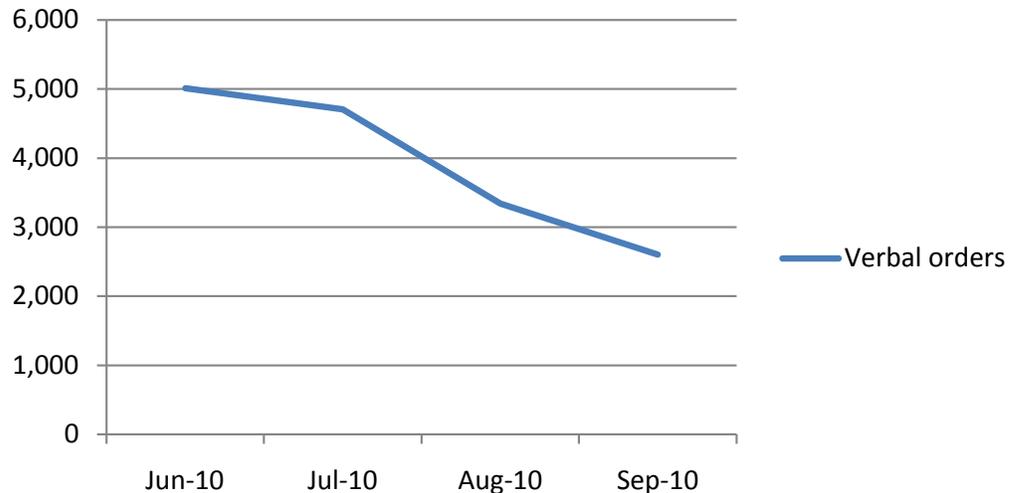
included with the initial order.

- **Include PRN orders for sleep, pain and constipation medications with admission orders whenever appropriate.** This would promote the patient getting what he needs in a timelier and more convenient way. Committee members continue to discuss with providers the best way to capture these orders without ordering unnecessary medications.
- **Establish a write-down, read-back form to be used when verbal orders are taken.** Forms have been printed to make it easier for the nurse to capture all the variables required in a verbal order. These have been distributed to the nurse managers who agreed to start monitoring the process as of August 16, 2010. 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 form allows us to document that all of the required elements of a verbal order are being captured. Also, it quantifies to the unit the extent of verbal orders being used, from where they are coming and who is taking them.

**Outcomes:**

Verbal orders have shown a steady decrease since June 2010. They will continue to be monitored on a monthly basis and reported to the Nursing PI Committee and to the Clinical Bar Code Multidisciplinary Committee.

**Verbal orders**



# HBPC Fall Prevention Program

## Team:



Back: W. Palmer, Psychologist; D. Park, NP; L. Wiebert, RN; T. Martin, RN; J. Westhues, RN;  
Front: P. Williams, Nurse Manager, HBPC; M. Bernard, NP; S. Vasileff, RN; C. Myers, RN; Not  
Pictured: M. Cadwell, Occupational Therapist, J. Morrow, RN.

## Objective:

- Reduce the incidence of falls among Home Based Primary Care (HBPC) patients.

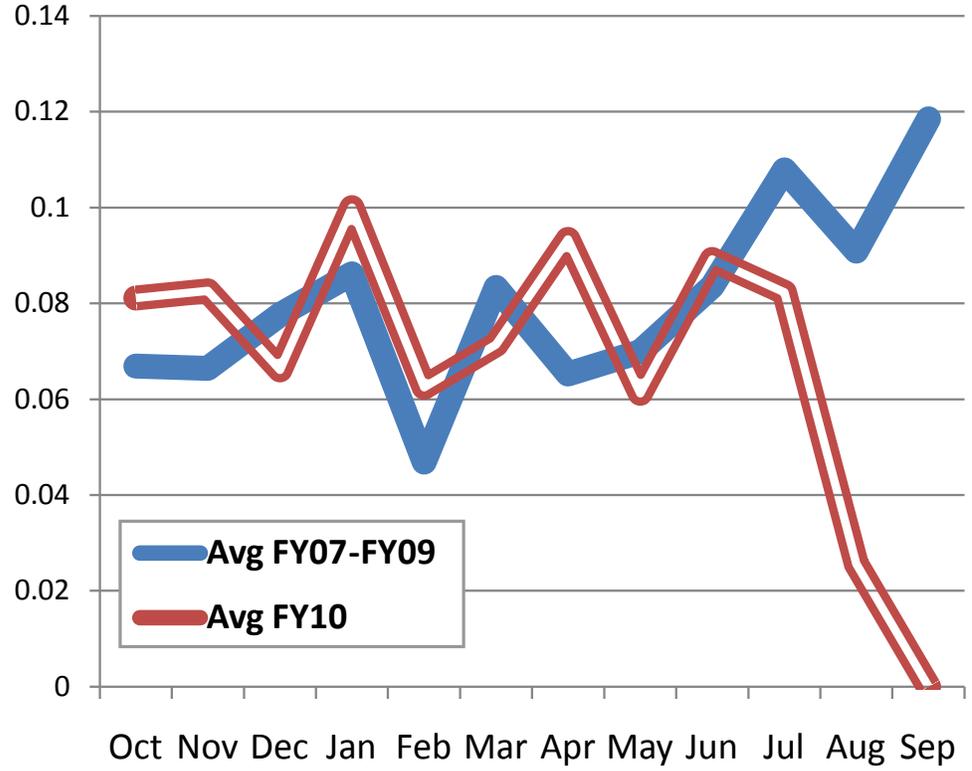
## Methodology:

- An annual report identified increased incidence of falls in 2007, 2008 and 2009 during the months of August, September and October.
- Computerized patient incident reports were monitored by the Patient Safety Manager. Incident reports were forwarded to HBPC Program Manager and Occupational Therapist.
- HBPC Occupational Therapist made follow-up visits related to reported falls and evaluated the need for additional services or equipment.
- The HBPC Occupational Therapist completed a fall report monthly and reported to the team – with recommendations for improvement.
- HBPC Registered Nurse (RN) Case Managers provided additional fall prevention education/instructions and reinforced education during all visits (phone visit or home visit) made in July, August and September.
- Veteran was reminded to get plenty of rest-even when having a lot of company.
- Veteran was reminded to use assistive devices when outside of the home, even when accompanied by family
- Veteran was reminded to use assistive devices when doing yard work.
- Occupational Therapist reviewed fall prevention

**Outcomes:**

- The number of falls experienced among the Columbia HBPC patient population was significantly reduced in August and September 2010.

### Average Number of Falls Per Patient Per Month



# CWT/TR Program CARF Accredited

## Team:



D. Heet, SW; T. Lee, SW.

## Objective:

The Compensated Work Therapy Transitional Residence (CWT/TR) Program sought to receive an accreditation from the Commission on the Accreditation of Rehabilitation Facilities (CARF).

## Methodology:

A facility wide CARF team was developed and began meeting in August 2009.

The first task of the team was to conduct a self-evaluation of conformance to the standards. Prior to the first meeting, the standards were reviewed by the CWT/TR team and the appropriate department/person was identified.

The facility wide CARF team participated in a conference call with the CARF liaison who outlined the process and answered questions from the team.

An "Intent to Survey" was prepared and submitted in December 2009.

CWT/TR participated in a mock CARF survey in January 2010 to assess readiness for the actual survey.

"For Record" memos were developed outlining specific processes for the daily functioning of the CWT/TR.

An Annual Report, Strategic Plan, Accessibility Plan and budget were shared with CWT/TR stakeholders.

CWT/TR staff participated in a three day accreditation survey during which time the CWT/TR was also surveyed by The Joint Commission.

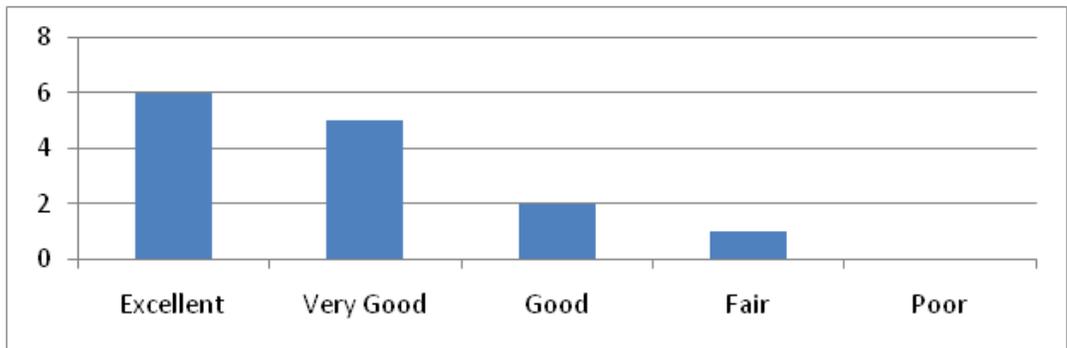
## Outcomes:

The CWT/TR received a three year CARF accreditation, which is the highest accreditation a facility can receive.

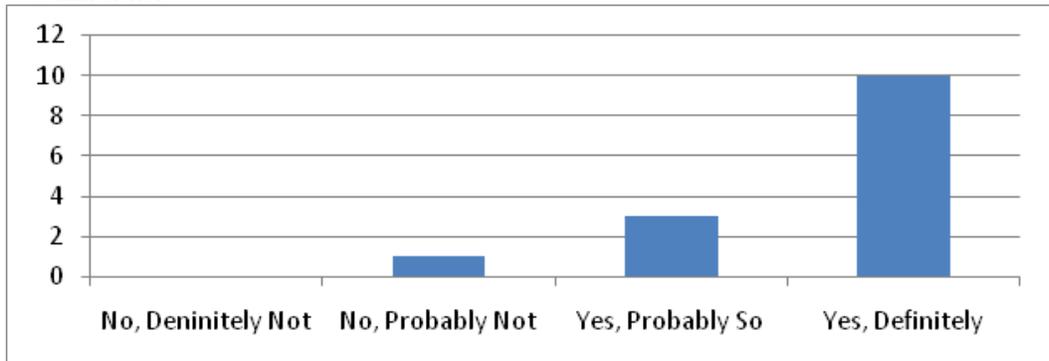
There were only three recommendations noted by the CARF surveyor, all of which have been addressed in an improvement plan.

The outcome of the survey mirrors the feedback provided by the Veterans served in the CWT/TR.

1. How would you rate the quality of the services you have received in the CWT/TR?



2. If another Veteran or a friend were in need of similar help, would you recommend the program to him or her?



# HUD/VASH

## Team:



S. Froese, SW; L. Kurzejeski, SW; B. Witter, SW.

## Objective:

Funding for Housing and Urban Development and Veterans Affairs Supportive Housing (HUD/VASH) comes from collaboration between the U.S. Department of Housing and Urban Development and the Department of Veterans Affairs. Veterans receive intensive case management services designed to resolve current homelessness and prevent future episodes of homelessness. In addition, Veterans receive access to a housing choice voucher, which can subsidize housing rental costs. Eligible Veterans must be homeless and have the ability to live independently.

## Methodology:

The Mission of the HUD/VASH Program at the Truman VA to provide comprehensive case management services that reduce substance abuse, psychiatric relapses, improve the health status and social integration of Veterans and facilitate access to community resources. The improvement of these psychosocial issues, through community based living with case management, increases the Veterans' capacity to function at their highest level.

## Outcomes:

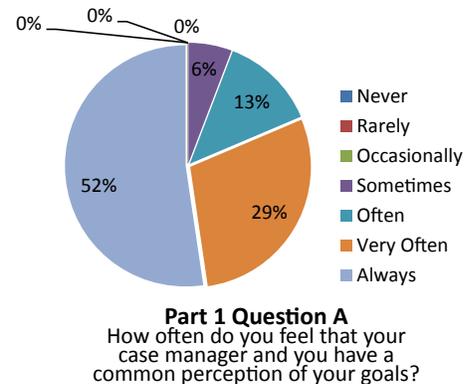
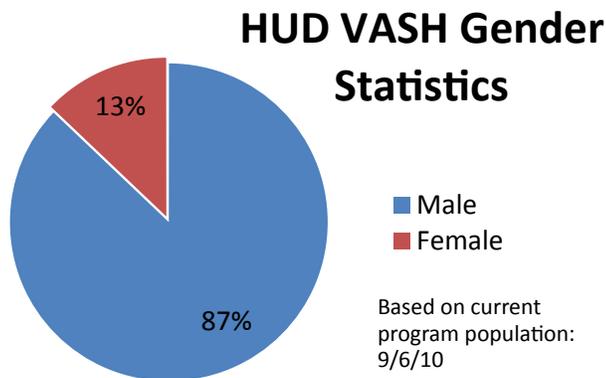
The HUD/VASH program continues to experience success as the program expanded to double its size during the last fiscal year. Of the 70 vouchers, 84 have been awarded to homeless Veterans and 74 of those Veterans have been successfully housed in community based housing. When Veterans graduate from the program, their vouchers are returned and re-used to house other Veterans who are waiting for housing in HUD/VASH. These numbers exemplify the ability to work effectively and efficiently with Veterans and members of the community to link them with permanent housing. Furthermore, the low turnover rate speaks to the ability of the VASH case managers to effectively address the complex problem set associated with

homelessness in order to facilitate a high degree of stability and the ability to maintain housing.

The community has also continued to recognize the need of homeless Veterans moving into permanent housing and numerous community organizations have played an essential role in supporting the VASH program. Two different fund raising drives were held by community partners and the HUD/ VASH program was provided household and hygiene donations that exceeded \$9,000 in value. In response to these donations, the VASH Bonus Bucks incentive program was created where Veterans are credited for adhering to program expectations and can use their Bonus Bucks towards donated items. This program has helped reinforce the skill of financial responsibility and budgeting, and it has improved Veterans communication with their case managers.

**Measure:** Data extracted monthly and reported quarterly using calendar quarters. Scores are the total number of Veterans achieving resident status from the start of performance period to date divided by the total number of awarded vouchers, they are cumulative and include all vouchers and residents date. Expect scores to be low in early months as the denominator will be the combined years vouchers to improve over the course of the year as Veterans achieve resident status.  
**Target/measure of success: 73% by September 30th, 2010 (end of 4th Quarter)** Data entered is through September 30, 2010

VISN	Site Name	Site Code	Number of Awarded Vouchers	4th Quarter		Comments
				Veterans Housed in HUD-VASH	Percent of Vouchers Under Lease (Veterans Housed/Awarded Vouchers)	
<p><b>HOSPITAL SITE</b></p> <p><b>HARRY S. TRUMAN (Columbia, MO)</b></p> <p><b>STATION NUMBER: 589A4</b></p> <p><b>NUMBER OF VOUCHERS: 70</b></p> <p><b>NUMBER OF VETERANS HOUSED: 74</b></p> <p><b>106%</b></p>						



From Satisfaction Survey

# Voucher Based Incentives in the

## Team:



Back: D. Muckerheide, Medical Support Asst.; P. Compney, NP; R. Rogers, Psychologist; Front: P. Quint, RN; D. Heet, SW; L. Brady, Voc Rehab Specialist.

## Objective:

- Although the outcomes of Vocational Rehabilitation (VR) programs such as Compensated Work Therapy (CWT) have improved almost every year since 1993, 43% of participants drop out and 26% are unemployed at discharge (Seibyl, Baldino, Corwl, Medak & Rosenheck, 2002), and as many as 40% of participants drop out within the first 4 weeks of the program (Herbert, Drebing, Mueller, Van Ormer, 2006). These outcomes are similar to those of non-VA VR programs (Noble, Honberg, Hall, Flynn 1997). Two factors that have been associated with these modest outcomes are poor program compliance and substance abuse relapse (Drebing, et al., 2007). Seventy-five percent of Veterans in CWT programs suffer from substance use disorder (Drew, Drebing, Van Ormer, et al. 2001).
- The main objective of the CWT incentive program is to improve CWT outcomes by improving abstinence rates and program compliance.

## Methodology:

- In the first 4 months of the CWT program, workers can earn two incentives each week for biochemical verification of abstinence.
- Every Monday and Thursday, CWT workers report to the 2C nurse and provide a urine sample under observation for biochemical verification of drug abstinence. CWT participants also provide a breath sample for verification of alcohol abstinence.
- An abstinence incentive in the form of a monetary-based voucher can be earned for every drug- and- alcohol negative sample. The Vouchers can be

# CWT Program

traded in for gift cards to the Veterans Canteen Service retail store.

- The first voucher is worth \$2 and increases by \$1 for every consecutive negative sample until the value reaches \$10. After earning three, consecutive \$10 samples, participants also earn one draw from a prize bowl. The prize bowl contains beads of four different colors: white, blue, red and black, representing \$0, \$1, \$20 and \$100 respectively. The amount of the bead that is drawn from the prize bowl is added to the \$10 voucher.
- At week 9, the \$10 vouchers are discontinued, but the prize bowl draws continue. The number of prize bowl draws increases by one draw for each consecutive negative sample until it reaches six draws per sample.
- The abstinence incentive program is 4 months in duration. The reason for choosing a 4 month program is that the team found that of the CWT workers that did not complete the program in the previous 3 years, 75% withdrew within the first 3 months. Thus, this appeared to be an important period and the team wanted to extend the incentives through this period.
- Starting in month seven of the program, CWT workers can earn one incentive each week for evidence of completing a job-search related activity such as completing a resume, filling out job applications or going on job interviews, for example.
- A job search incentive in the form of a monetary-based voucher can be earned for each week that a job search related activity is accomplished. The Vouchers can be traded in for gift cards to the Veterans Canteen Service retail store.
- The first voucher is worth \$5 and increases by \$2 for each consecutive week of completing a job search related activity.

## Outcomes:

- Seventeen Veterans have been enrolled in the CWT incentive program.
- Sixteen Veterans (94.1%) are still in the program. One Veteran left unexpectedly and later reported relapse.
- Thirteen Veterans (76.4%) have achieved 100% abstinence. Of the four Veterans who provided a positive sample, three of them provided only one positive sample.
- Nine Veterans have been in the program for 3 months or longer. Seven Veterans have been in the program for less than 3 months and, as noted above, one Veteran withdrew from the program.
- A total of 377 samples have been collected since the start of the program. 370 of these (98.1%) have been negative for the presence of alcohol or drugs.

# Expanding Efforts for Veteran Ju

## Team:



S. Froese, SW; D. Easter, SW.

## Objective:

The Veteran Justice Outreach (VJO) initiative is part of the VA's system-wide efforts to ensure access to services for the justice-involved Veteran at risk for homelessness, substance abuse, mental illness and physical health problems. Each VA medical facility appointed a VJO Specialist to begin the development of the program, which involved direct outreach to justice-involved Veterans and education/training to law enforcement, court professionals, VA staff and community providers.

## Methodology:

The following processes were created and implemented in order to expand outreach efforts to justice-involved Veterans:

- A mapping assignment was created identifying all of the law enforcement agencies, jails and courts included in Truman VA's 44 county coverage area in Missouri.
- A flyer was developed and distributed to jails in the 44 counties.
- Meetings were conducted with the Chief of Police at the Boone County Jail to discuss implementing monthly informational groups to incarcerated Veterans.
- The team hosted a meeting with professionals from the Office of State Courts, Drug Court Administrators, Judges and Probation Officers involved with specialty courts to educate about the VJO initiative and to provide resources used to identify Veterans in the system.
- The VJO Specialist collaborated with the Homeless Coordinator and OEF/OIF Program Coordinators to develop a pocket size tri-fold outreach tool to be used by law enforcement officers who have contact with justice-involved or homeless Veterans.
- The team conducted law enforcement training to the local Crisis

# Justice Outreach

Intervention Team, which includes University of Missouri Police Officers, City of Columbia Police Officers and officers at the Boone County Sheriff's Department.

- Presentations were provided to University of Missouri Police, VA Police, Drug Court Administrators, Probation and Parole and Public Defenders on the VJO initiative.
- The VJO Specialist was invited to present at the regional VJO conference in Tulsa, Oklahoma. This presentation focused on the process of developing a VJO program in rural Missouri.
- The VJO Specialist was invited to present at the National Coalition for Homeless Veterans conference in Washington, DC. The presentation provided information about local efforts to expand and develop unique partnerships within the community that are specific to justice-involved Veterans.

## Outcomes:

- Due to networking and education, agencies such as the Missouri State Public Defender System, Drug Courts and Probation & Parole now identify Veterans and refer them to the VJO program upon screening.
- Through jail outreach, Veterans from Boone County have been referred and accepted into the Alternative Sentencing Courts and the VJO Specialist participates in weekly staffing with the mental health and drug court team.
- Due to education and training, local law enforcement officers have knowledge of resources available to Veterans.
- More than 70 Veterans have been referred to the VJO program since June 2009 when the VJO Specialist was appointed.
- 96% of these 70 Veterans were assisted with accessing VA services; 3 Veterans were not eligible for VA services.
- Of the Veterans referred that were facing incarceration, 35% were successfully diverted from extended incarceration in jail or prison. 54% are pending outcome of legal proceedings and are engaged in treatment services.
- Recently, Truman VA was approved for a full-time VJO Specialist position.

# Transportation & Lodging for Ca

## Team:



Back: V. Stockglausner, Director HAS; B. Brown, Transportation Asst.; M. Hern, Transportation Asst.; Osgood Fountain, Asst. Director, HAS; Front: C. NeSmith, Travel Clerk; H. Paxton, Supervisor PSA; Not Pictured: W. Campbell, Program Analyst, FIN; W. Park, AA/COS.

## Objective:

Truman VA has been designated as the Cardiothoracic Center for VISN 15. In an effort to reduce the burden on Veterans and their families traveling here for Cardiothoracic (CT) Surgery and to decrease the cost of sending Veterans to non-VA facilities (fee basis appointments), a group was established locally to implement a process for providing transportation and lodging to those patients. Based on a VISN program, Health Administration Service (HAS) would arrange lodging and transportation to this facility from other facilities in this VISN.

## Methodology:

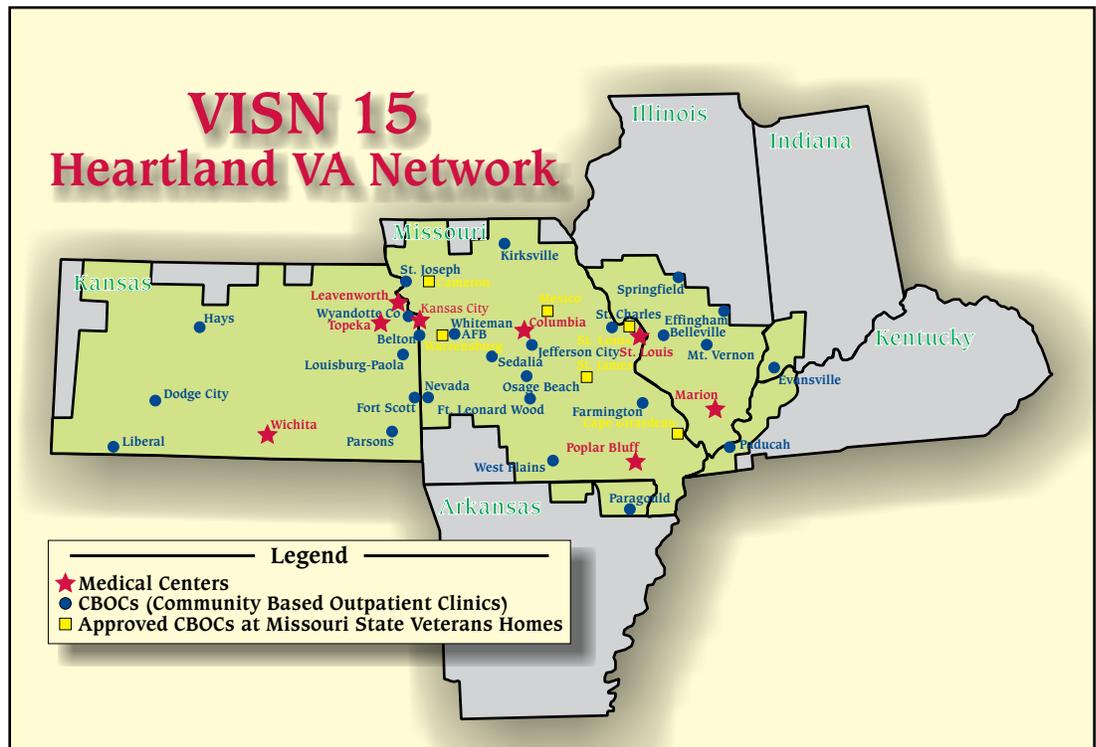
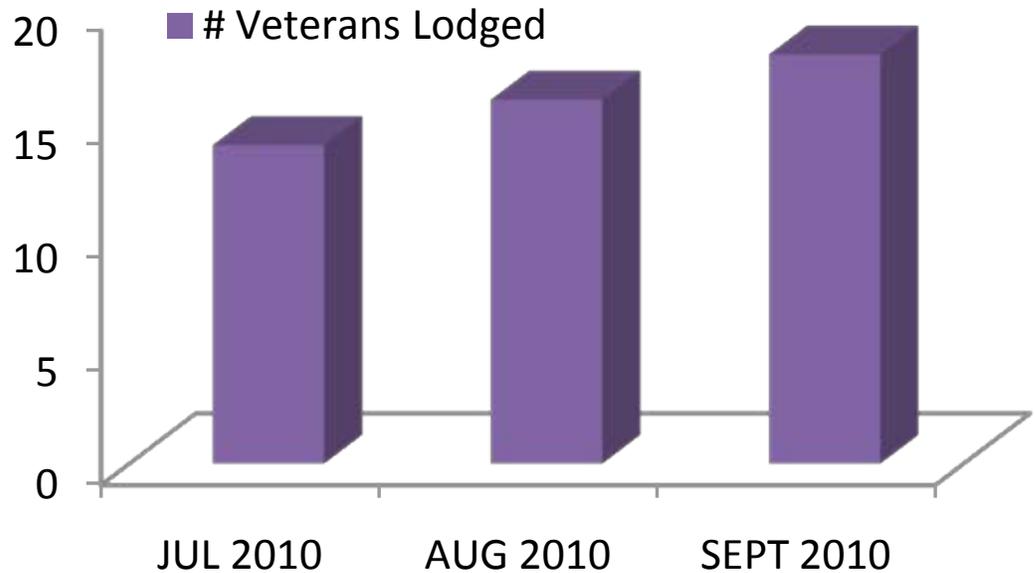
- A Standard Operating Procedure (SOP) was created to document how the process and procedures for lodging and travel would be handled.
- An Access Database was established to document/track payments, dates and names of the Veterans and family members receiving travel and lodging from the Truman VA.
- Social Work and HAS staff members developed procedures to provide notification to those CT referral patients.

## Outcomes:

The CT Referral program for lodging and travel has saved more than one million dollars for the VA. This program has only been in place since July 2010 and has proven to be a sustainable program.

# Radiothoracic Surgery Referrals

Number of Veterans Lodged for CT Surgery Referrals



# Medical Record File Room Closing

## Team:



Back: J. O'Rourke, Med. Rec. Processing Clerk; S. Wallenmeyer, MRT; Front: Teresa Bommel, MRT; Randall Kilgore, HIMS Director; Not Pictured: R. Chirnside, Lead MRT; J. Clasby, Med. Rec. Processing Clerk.

## Objective:

The objective was to close the file room containing all the paper medical records for the facility (approximately 150,000 charts) by the end of the calendar year in order to become "paperless." The records all needed to be placed in boxes, labeled and sent to an offsite storage facility.

## Methodology:

It was determined that the file room needed to be closed in order to transfer our records into electronic records and to free up space. The file room project was to be completed by the end of calendar year 2009.

- Records were pulled from the shelves and certain items were scanned.
- Charts were sorted to determine appropriate storage location and placed in boxes.
- Boxes were labeled using a terminal digit system for future retrieval.
- An Excel inventory list was created to identify which charts were in each box.
- The location of each chart was updated in Vista.
- Boxes were loaded on pallets for shipment to offsite storage.
- Shelving units were disassembled.

## Outcomes:

In December 2009, the file room located in the basement of the facility, which contained all the paper medical records for our patients, was closed. We were able to use our own employees rather than contracting with an outside company, which saved more than \$250,000. The facility has been “paperless” for almost a year and, as a result of the completion of the file room project, we are able to better serve our Veterans, more efficiently handle workload and have saved money and time previously spent searching and copying paper charts.



# Truman Community Living Center

## Team:



Back: V. Ramnarine, Chief Social Work; T. Anderson, Patient Safety Manager; K. Scott, SW;  
Front: V. Robinson-Purdy, NP; L. Johnson, Nurse Manager; M. Fleetwood, Medical Librarian.  
Not Pictured: B. Estes, RN; B. Giles, RN; J. Branch, Occupational Therapist.

## Objective:

This team worked on developing a comprehensive form that would be used to collect current and relevant medical information on all outpatient Veterans who are seeking admission to the Truman Community Living Center (CLC).

## Methodology:

- The team reviewed other skilled nursing facility applications for admission. This effort was to determine pertinent information to be included in the Truman VA application form.
- The team adapted and modified the current form used by the Missouri State Veterans Homes.
- The Medical Librarian on the team recreated the form so that it can be available in a PDF format.
- When a Veteran's name approaches the top of the waiting list, the Application for Admission is sent to either the current nurse or provider for completion. This is to ensure that the most current medical information on the Veteran is received.
- After the Application for Admission has been completed, it is reviewed by the CLC New Patient Referral Team. An acceptance or denial of an admission is determined.

# Application for Admission

## Outcomes:

Since July 1, 2010 to present, a completed Application for Admission was obtained on 100% of the residents who were outpatient prior to their admission to the CLC. This Application for Admission form used by the CLC New Patient Referral Team has been effective in reviewing appropriate admissions to the Truman Community Living Center.

Truman Community Living Center Application for Admission		This Application for Admission to the Truman Community Living Center needs to be completed in its entirety and faxed (573.814.6247) or mailed (3 East Attention: CLC Admission Team, 800 Hospital Drive Columbia, MO 65202) in order for veteran to be considered for admission to the Community Living Center. For questions please call (573.814.6380)	
REFERRED FROM: <input type="checkbox"/> 4MED <input type="checkbox"/> 4STEP <input type="checkbox"/> 6 MED/SURG <input type="checkbox"/> ICU/SICU <input type="checkbox"/> 2B/2C <input type="checkbox"/> ER <input type="checkbox"/> OUTPATIENT CLINIC <input type="checkbox"/> HOME WITHOUT SERVICES <input type="checkbox"/> OUTSIDE HOSPITAL <input type="checkbox"/> COMMUNITY NH <input type="checkbox"/> VET HOME <input type="checkbox"/> HOME WITH SERVICES <input type="checkbox"/> OTHER			
GENERAL INFORMATION			
PATIENT'S NAME		BIRTH DATE	
PLACE OF RESIDENCE AT TIME OF APPLICATION		SOCIAL SECURITY NUMBER	
CITY	STATE	ZIP CODE	TELEPHONE NUMBER
FINANCIAL			
<input type="checkbox"/> SERVICE CONNECTED <input type="checkbox"/> NON-SERVICE CONNECTED <input type="checkbox"/> NOT SC THEN 10-10 EC <input type="checkbox"/> COMPLETED <input type="checkbox"/> PENDING <input type="checkbox"/> EXEMPT		SURROGATE DECISION MAKER: <input type="checkbox"/> N/A <input type="checkbox"/> DPOA <input type="checkbox"/> LEGAL GUARDIAN	
ISOLATION		CODE STATUS	
<input type="checkbox"/> NO <input type="checkbox"/> YES		<input type="checkbox"/> DNR <input type="checkbox"/> FULL CODE	
HISTORY / PHYSICAL INFORMATION			
HEIGHT	WEIGHT	REASON FOR ADMISSION TO CLC AND DURATION OF NEED	
DATE OF LAST TETANUS	DATE OF LAST PNEUMOVAX	HISTORY OF DRUG/ALCOHOL ABUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IMMUNIZATIONS	SPECIFY ALLERGIES	HISTORY OF MENTAL ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>IF APPLICANT HAS A PSYCHIATRIC DX PLEASE ATTACH A COPY OF MOST RECENT PSYCH EVALUATION</small>	
ILLNESSES, SURGICAL PROCEDURES, HOSPITALIZATIONS			
EXPLAIN CONDITION AS COMPARED TO BASELINE HEALTH STATE			
DIAGNOSIS(ES)			
MEDICATION			
LIST ALL MEDICATIONS, DOSAGE, FREQUENCY AND ROUTE OF ADMINISTRATION OR ATTACH A COPY OF THE CURRENT PHYSICIAN ORDERS			

# Truman Community Living Center

## Team:



Back: K. Scott, SW; E. Carr, Recreation Therapist; N. Witt, Chief, Voluntary Svc; S. Gaither, Public Affairs Officer; N. Stevens, Recreation Therapist; Front: V. Ramnarine, Chief, Social Work Svc; R. Winters, NP; V. Robinson-Purdy, NP; L. Johnson, Nurse Manager, ER; Not Pictured: A. Wiggins, Communications Specialist; A. Case-Halferty, Student Intern.

## Objective:

The team worked on developing a Truman Community Living Center (CLC) Welcome Book. The intent was to provide to incoming residents, their families and friends an overview of the CLC mission, care goals, and amenities available on the CLC as well as throughout Truman VA.

## Methodology:

- The team edited the previous CLC book by soliciting information
- to be included in the book from the various disciplines represented on the CLC.
- The Communication Specialist with a Public Affairs Intern recreated the book with the newly acquired information. Photo sessions were arranged for the CLC residents and CLC team members.
- The updated book was reviewed by the Public Affairs Officer. The new CLC packet was sent to Medical Media for layout purposes prior to its reproduction.

## Outcomes:

Since August 1, 2010 to date, 100% of the resident/family who has arrived on the Truman Community Living Center has received a “*Welcome to the Community Living Center*” book. Both residents and families have appreciated that many answers to their frequently asked questions can be found in the Welcome Book.

# Welcome Book

*Welcome to the*  
**Truman  
Community Living Center**



*part of the*  
**Harry S. Truman  
Memorial Veterans' Hospital**  
Columbia, Missouri  
(573) 814-6380

***Our Mission:***

*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 healthcare delivery system.*

# Zeroing In On Missed Medications

## Team:



Back: S. Burpo, Medical Technologist; M. Anderson, Nurse Manager 6 Surg; M. Kruse, IT Specialist; E. Henderson, IT Specialist; T. Williams, RN; L. Harris, RN; Front: V. Rivera, RN; B. Hatfield, Nurse Educator; M. Gross, RN; K. Strom, Informatics Nurse; Jeff Brooks, RRT Not Pictured: B. Albert, RRT; N. Bates, RN; D. Grant, LPN; M. Ibitoye, RN; C. Lawrence, LPN; V. Stone, RN; A. Sydnor, LPN.

## Objective:

The objective of this project was to decrease missed medications to zero and to sustain that rate.

## Methodology:

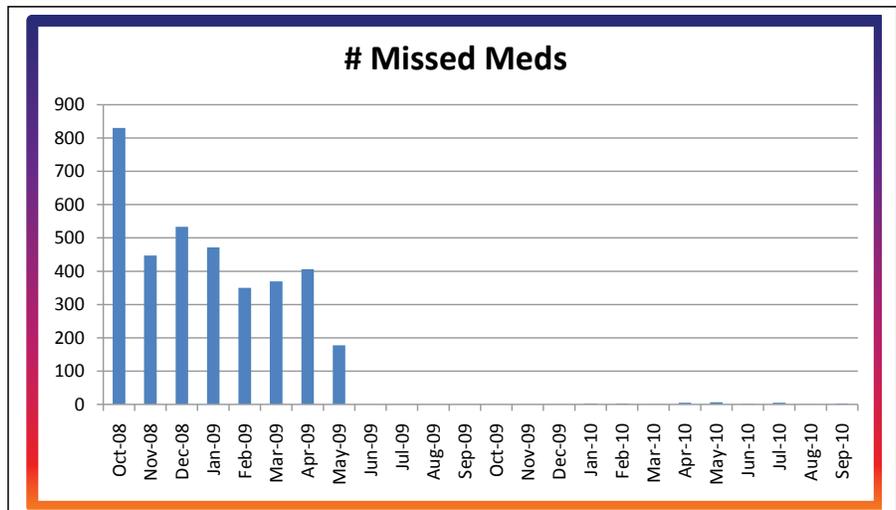
The quest began as the result of an aggregate Root Cause Analysis (RCA) of medication errors in May 2008. The RCA team reviewed 203 events by type and area and chose to focus on missed medications because at least one event was related to a missed anticoagulant. A report that identified medication administrations where the “ordered” amount was different from the “given” amount quantified the magnitude of the problem. This report was developed locally by the Office of Information and Technology (OI&T). In May 2008, missed medications were 390 of 59,633 medications ordered. By August 2008, the count of missed medications had risen to 862 of 58,155 meds ordered. This raised the following question: **Can the number of missed medications be lowered by using Bar Code Medication Administration (BCMA) reports to target interventions?**

The RCA Team recommended that a Missed Medication Report be run after every medication pass by all nurses and respiratory therapists (RT) administering medications through BCMA. This report was to be analyzed by the nurse and discrepancies corrected. At the end of the shift, a Missed Medication Report was to be printed by the nurse, identified by name of the nurse, used in report to the new shift and then submitted to the nurse manager. Any discrepancies reflected on the report were to be reconciled by the nurse prior to handoff to the next shift. Missed Medication Reports were also queued

to print automatically in each nurse manager’s office at 0001 for the previous 24 hours. This provided daily verification of the missed medication status for the previous 24 hours on that unit.

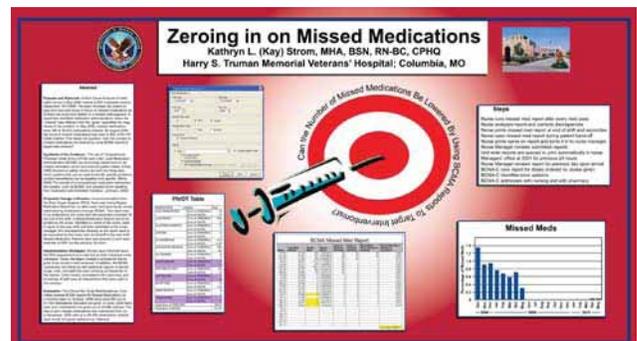
Nurses were informed about the RCA requirement by email and by their individual nurse managers. Nurse managers created a process for the reports to be turned in and reviewed. In addition, the BCMA Coordinator did follow-up with additional reports to identify drugs, units and staff that were showing up frequently on the reports. Pivot tables were used in the analysis. The med log in Computerized Patient Record System (CPRS) was reviewed to determine if there were comments that justified the dosage discrepancy or if there was an issue with how the order was finished by pharmacy. Albuterol was determined to be a huge issue with hundreds of doses showing “not given.” This medication was being finished by pharmacy to give RT two options on the concentration; therefore, one always showed up “not given.” Consultation with pharmacy, re-training of staff and daily rounds by the BCMA Coordinator were interventions used to improve this process. The support from the nurse managers and the Patient Safety Manager were essential. The Clinical Bar Code Multidisciplinary Committee actively reviews BCMA reports on a monthly basis.

In October 2008 there were 830 out of 61,795 medications that were not given. In June 2009, there were zero medications not given out of 55,894 ordered. The rate of zero missed medications was maintained from July through December 2009 with up to 65,408 medications per month that were ordered and given safely to our Veterans. From January 2010 through September 2010, the number of missed meds stayed in single digits.



Across the facility, staff at Truman VA is quite proud of its accomplishment. They reached zero in their quest to decrease missed medications and held that zero for seven months! They continue to hold in single digits since that time.

This project was submitted as an abstract to VeHU and was selected as Best in Category for Patient Safety. It was presented as a Lunch and Learn to a standing room only audience. It was then featured on the cover of the “Messenger,” the monthly national publication of the Bar Code Resource Office.



# Proactive Immunization Protection

## Team:



Back: P Quint, RN; C. Kelly, ADIR/PS; D. Morrow, RN; W. Reed, RN; J. Westhues, RN; T. Shroul, RN; Front: M. Ibitoye, RN; D. Nelson, RN; B. Rahmoeller, Nurse Manager Team Care; K. Strom, Informatics Nurse; Not Pictured: S. Miller, Infection Control Practitioner; M. Anderson, Nurse Manager 6 Surg; S. Biere, RN; K. Clevenger, RN; P. Egesdal, RN; J. Evertsen, Rn; M. Gross, RN; S. Hall, RN; D. Kottman, RN; V. Petersen, RN; J. Thompson, RN; A. Velasco-Detar, RN; J. Warren, RN; D. Watson, RN

## Objective:

Improving influenza immunization rates for patients and staff was a challenge accepted by the Nursing Performance Improvement (PI) Committee.

## Methodology:

Representing many different inpatient and outpatient clinical areas, the members of the Nursing PI Committee used the Improvement Model with multiple Plan-Do-Study-Act (PDSA) cycles to improve the immunization rates of inpatients, outpatients and employees in this integrated medical system during the 2008-2009 influenza season. This collaborative effort throughout the system was supported by all levels, from the staff nurse through the Director.

Staff nurses took ownership and brainstormed to identify creative ways to get patients and staff immunized. The project covered a six month time period from October 1, 2008, through March 31, 2009. Electronic medical records facilitated consistent order entry and provided a system where focused monitoring could identify opportunities for immunizations before they were missed. Influenza immunization was added to all inpatient order sets except for the Intensive Care Unit (ICU). The Bar Code Medication Administration System (BCMA) provided the structure for inpatients to routinely receive their immunization and have it correctly documented. Outpatients were asked about receiving the immunization as they registered and again as the nurse prepared them for their physician encounter. Staff was encouraged in multiple ways to receive the immunization, including messages from the Director, the Infection Control Nurse and their peers.

A key motivator for staff was to focus on the premise to do no harm – it was their responsibility to protect the patient. Signs and posters were liberally displayed and the immunizations were available in the cafeteria, at the Halloween party and by roll-a-round clinics in each department and unit. Prefilled syringes improved the workflow. The Committee focused on making it easy to do it correctly.

Improving immunization rates among patients decreased the patients' risk of getting the flu and having complications. Improving staff immunization rates decreased their risk of getting sick and increased the likelihood that nurse staffing was adequate.

## Outcomes:

- The employee immunization rate, as of January 1, 2009, was 63% and the total number of doses of vaccine given as of January 26, 2009, was 13% higher than at the end of the 2007-2008 season.
- The External Peer Review Process (EPRP) rate for inpatient flu vaccine for FY08 was 63%. The EPRP review for the first quarter of FY09 was 100%.
- The employee immunization rate for FY2010 was 76% for influenza and 42% for H1N1.

