Graduate Healthcare Administration Training Program

vaww.va.gov/vasthcs/ghatp/

PURPOSE

On January 30, 1946, the VA Department of Medicine and Surgery's "Policy Memorandum No. 2 Establishing Teaching Affiliations" established a program of affiliation between the VA and the nation's Medical schools. The intent was to bring the country's medical schools and residency programs into VA hospitals to guarantee quality health care for the veteran while providing an answer to the physician-staffing dilemma faced by VA hospitals. This document signaled the beginning of a federal partnership with educational institutions, which benefits partners, veterans, and the community at large.

Education is just one of the four primary missions of the Veterans Health Administration (VHA). Toward this commitment, the Graduate Healthcare Administration Training Program (GHATP) Board was created in 1992 by the Deputy Under Secretary for Health for Administration and Operations, to replace the Hospital Administration Residency Program (HARP). The GHATP Board oversees the Administrative Resident/Fellow Program, the Health System Management Trainee Program, the U. S. Army-Baylor Program, and the Executive Off-Campus Program. At all times, the Board ensures the quality of the trainees' experiences is second-to-none.

ADMINISTRATIVE RESIDENT/FELLOW PROGRAM

VHA provides in-hospital experiences for students receiving, or having received their master's degree in health services administration (MHA). Generally, the Administrative Resident/Fellow Program is used as a means to recruit, train, and retain highly qualified individuals to become future leaders in VHA.

The program is designed to supplement the didactic component of CAHME or CEPH accredited health service administration graduate programs by providing students the opportunity to apply their knowledge and skills within and outside VHA. The training is completed under the supervision of a GHATP Board approved preceptor during a 12-month period.

The Board trains approximately 45 administrative residents/fellows annually. All preceptors must be approved by the Board through an annual competitive process to receive approval for funding and FTE. The Board provides resident/fellows with training material, evaluation forms, access to a resident/fellow MS-Exchange mail group and the opportunity to attend the ACHE's Annual Congress on Healthcare Management. Although education is the main intent of the program, the Board does monitor retention levels for statistical purposes.

HEALTHCARE SYSTEM MANAGEMENT (HSM) TRAINEE PROGRAM

HSM trainees primarily support health care management officials by analyzing, coordinating, evaluating and managing health care delivery operations, processes and systems. While specific qualification requirements may vary, all positions in the series require certain abilities, knowledge and skills. Hence, every HSM trainee should process a high degree of analytical ability, interpersonal skills and a specialized knowledge of the fundamental practices, principles, and programs of VA's health care delivery system.

The Board trains approximately 15 trainees annually. All mentors must be approved by the Board through an annual competitive process to receive approval for funding and FTE. The Board provides trainees with training material, evaluation forms, access to a MS-Exchange e-mail group, the opportunity to attend the ACHE's Annual Congress on Healthcare Management, and three structured training sessions.

Administrative Resident/Fellow Projects

NAME	FACILITY	TITLE
Chris Annis Administrative Resident	North Texas Veterans HCS	Advanced Clinic Access Implementation: The Change Process at VA North Texas Health Care System
Maria Avdonina Administrative Resident	Atlanta, GA	Managing Demand in the OR - Operating Room Scheduling Project
Seth Barlage Administrative Resident	Louisville, KY	The Genesis of a Service: Organizing Emergency Medicine
Christina Bondi Administrative Resident	Syracuse, NY	Procedure Accessibility Process Action Team (PAT) for Imaging
Atourina Bouza Administrative Resident	GLA-HCS	Gain some, Lose Some: A Gains & Losses On-line Training
Allyson Brandt Administrative Resident	Central Texas Veterans HCS	Tracking Anesthesiology Providers Proficiency and Output: A Basis for Performance-Based Salary Increases
Maria Briggs Administrative Fellow	Miami, FL	Colonoscopy Preparation Education and Outreach
Sherrie Bryant Administrative Fellow	Minneapolis, MN	Improving Tray Assembly & Delivery Procedures Using Advanced Clinical Access (ACA) Principles in Nutrition & Food Service
Li Cai Administrative Fellow	VISN 8	A Plan for Pre-registration
J. Scott Campbell Administrative Fellow	Buffalo, NY	Creating Value Through the Internalization of Stable Patient Transport via Ambulance
Julianne Carpenter Administrative Fellow	St. Louis, MO	Use of Care Coordination Home Telehealth (CCHT) to Improve Clinical Outcomes and Resource Utilization
Jyoti Chadha Administrative Resident	South Texas Veterans HCS	Enhanced Health Care Resources Sharing-Use of VA Space to Create Assisted Living Unit in Kerrville
Steve Chiu Administrative Fellow	GLA-HCS	Fully Equipped: Improving the Equipment Purchase Process at the VA Greater Los Angeles Healthcare System
W. Matthew Cox Administrative Fellow	Jackson, MS	Analysis of the Advanced Clinic Access Program at the G.V. (Sonny) Montgomery VA Medical Center
Charlene Daniel Administrative Fellow	NF/SG - VHCS	Orthopedic Surgery Operating Room Utilization Efficiency
Tracye Davis Administrative Fellow	Pittsburgh, PA	Transforming Dementia Specialty Care with the Eden Alternative
K. Todd Donehoo Administrative Resident	New Orleans, LA	Improving Patient Satisfaction: Provider Wait Time Tracking & Reporting

Administrative Resident/Fellow Projects

NAME	FACILITY	TITLE
Jon Duckert Administrative Resident	North Texas Veterans HCS	Performance Improvement Model: Improving Colorectal Cancer Screening Measures
George Duthie Administrative Resident	Miami, FL	Home Based Primary Care Program Process Reengineering
Mitra Eramian Administrative Fellow	NF/SG - VHCS	Medical Administration Service Process Review Team
Kristin Fortner Administrative Resident	VISN 10	Practical Medical Care: Planning for and Implementing Shared Medical Appointments (SMA) in the VA
Joseph Giries Administrative Resident	North Texas Veterans HCS	Improving the Congestive Heart Failure Discharge Performace Initiatives
Neetu Godhwani Administrative Fellow	Hudson Valley HCS	VA Hudson Valley Extended Care Quality of Life Initiative
Julie Gorham Administrative Fellow	New Orleans, LA	Customer Service Report Cards
Crystal D. Green Administrative Fellow	New York Harbor HCS	Use of the Copy/Paste Function in CPRS- A Survey
Aaron Gross Administrative Resident	U. S. Coast Guard (South Texas Veterans HCS)	Radiology Performance Measure: A Strategic Plan for South Texas Veterans Health Care System (STVHCS)
Erin Guillickson Administrative Fellow	VISN 17	Business Office Consolidation and Correlations with Finanacial Indicators
Lesley Hall Administrative Fellow	VISN 5	The McDermott House Partnership: A Model for Interagency and Community Collaboration
Carianne Johnson Administrative Fellow	Chicago, IL	Establishment of a Transitional Care Unit (TCU)
Meredith Katz Administrative Resident	New York Harbor HCS	Improving Productivity by Reducing Clinic No-Show Rates
Ted Korupp Administrative Fellow	Illiana HCS	Mobile MRI Services for Secondary Care Facilities
Aaron Love Administrative Fellow	Augusta, GA	A New Era for Patient Scheduling: The Implementation of the VistA Patient Recall System v 1.3 at the Augusta VAMC
Alicia Miller Administrative Fellow	Oklahoma City, OK	Satellite Clinics: A Proactive Approach to Growth
Kimberly Moore Administrative Resident	VISN 22	Community Based Outpatient Clinic Study
Binta Odior Administrative Fellow	Atlanta, GA	Electronic Wait List: Establishing and Managing Compliance

Administrative Resident/Fellow Projects

NAME	FACILITY	TITLE
Ghazal Osman Administrative Resident	Houston, TX	Valet Parking: Transporting Our Patient Satisfaction to a Higher Level
Christine Palaschenko Administrative Resident	Cleveland, OH	Lorain CBOC Expansion and Redevelopment
Jo Anne Parker Administrative Resident	VACO - OSP	Getting VATA Broadcast on National TV
Katheryn Powers Administrative Resident	Hines, IL	Implementation of the Green Environmental Management System
Mia Powers Administrative Fellow	Boston HCS	Healthcare Failure Mode Effects Analysis on Healthcare Management in Boston HCS for Returning Service Persons from OEF/OIF
Hayley Raymer Administrative Resident	Houston, TX	Scripting for Improved Customer Service
Eric Rhodes Administrative Resident	Cleveland, OH	Consolidation of Two Division Medical Center
Charles Ritter Administrative Fellow	Portland, OR	Advancing Benchmark Effectiveness and Validity thought the Analysis of Diangostic Related Groups
Melanie Sabik Administrative Fellow	Asheville, NC	Committee Restructuring: An Opportunity for Improving Effectiveness
Joseph Schoeck Administrative Fellow	Madison, WI	VISN 12 Telecommunications Consolidation: Did it Work???
Sangita Shah Administrative Fellow	West Palm Beach, FL	Hurricane Season 2004: How Proper Planning Mitigates the Impact of a Natural Disaster
Desiree Snyder Administrative Fellow	Hudson Valley HCS	Implementation of Facility-Based Telemental Health Programs for VISN 3
Katherine Steinberg Administrative Fellow	GLA - HCS	Optimizing Joint Emergency Department and UCC: An Examination of the Process for Providing Medical Care to Veterans without an Appointment
David VanMeter Administrative Resident	Louisville, KY	Implementing Shared Medical Appointments: Increasing Efficiency and Patient Satisfaction
K. Wade Vlosich Administrative Fellow	VISN 17	Best Practices for Revenue Improvement in the Areas of Patient Intake, Medical Documentation, Coding, and Accounts Receivable
Teresa Whitley Administrative Resident	South Texas Veterans HCS	Patient Safety: Using Information to Affect Change

Health System Management Trainee Projects

NAME	FACILITY	TITLE
Deepa Agusala HSM Trainee	Hines, IL	Faith-Based Initiative - Catholic Charities and Edward Hines Jr. VA Hospital
Randa Attum HSM Trainee	Louisville, KY	Computerized Patient Record System (CPRS) Training for Residents
Amjed Baghdadi HSM Trainee	South Texas Veterans HCS	Wayfinding: Increasing Customer Service Through Navigation
Matthew Funke HSM Trainee	Lebanon, PA	A Comparative Analysis of the VA Stars & Stripes Healthcare Network's Homeless Program Scope to Standards Developed Nationally
Jennifer Griffin HSM Trainee	Central Texas Veteran HCS	Group Clinic Visits: Can Group Clinics Change the Way Health Care is Provided?
David Harden HSM Trainee	Illiana HCS	Managing Fee Basis
Shelley Haynes HSM Trainee	Oklahoma City, OK	The Power of Group Purchasing
Gregory Ingram HSM Trainee	Central Alabama Veterans HCS	Identifying Readiness for the Advanced Clinic Access (ACA) Initiative by Medical Service Assistants in One Veterans Health Care System
Ruth Kirkland HSM Trainee	North Texas Veterans HCS	Reducing Outpatient Phlebotomy Wait Times
Ericka Mattis HSM Trainee	Cleveland, OH	VERA 10: A Beneficial Management Tool
Nickema Moulton HSM Trainee	VISN 5	VA Revenue: A Look into Increasing Funding
Sherrie Williams HSM Trainee	Augusta, GA	Resident Assessment Instrument/Minimum Data Set: Process for Improvement
Laurin Word HSM Trainee	Atlanta, GA	Compensation & Pension Program-Department of Defense Separation Physical-"ONE EXAM"

Administrative Resident/Fellow Projects

Christopher G. Annis

1600 Saddle Creek Circle # 522
Arlington, Texas 76015
817-557-4919
christopherannis@gmail.com

EDUCATION:

Trinity University, San Antonio, Texas
M.S., Health Care Administration
December 2005

Texas A&M University, College Station, Texas
B.S., Health – Community Health Option
August 2003

EXPERIENCE:

1/05-Present

Administrative Resident, Department of Veterans Affairs
North Texas Health Care System – Dallas, Texas

7/04-12/04

PRIME Administrative Resident, Department of Veterans Affairs
Audie L. Murphy Division – San Antonio, Texas

- Managed multiple projects for the Primary Care/Managed Care Product Line
- Assisted Primary Care in communicating with physicians/staff on projects

7/99-8/04

Senior Tire Tech, Discount Tire Co. – San Antonio, Texas

- Supervised efficient operation of service bays
- Worked with team to provide customer service
- Supervised team of service bay employees

5/03-8/03

Administrative Intern, Department of Veterans Affairs Medical Center - Houston, Texas

- Worked with team to conduct financial, demographic, access and quality management projects
- Performed environmental inspections of hospital
- Prepared administrative reports and presentations using Microsoft Excel, Power Point, and Access
- Developed proposal to replace outpatient clinic using CARES initiative

ACTIVITIES:

Volunteer Activities

- Texas Children's Hospital, 6/95 to 8/99
  - Worked with physicians
  - Camp counselor for wellness center
- Ben Taub Hospital, 6/99-8/99
  - Assisted in emergency room

Extracurricular Activities

- Student Associate – American College of Healthcare Executives
- Texas A&M Pre-Health Care Administration Society, 3/01-8/03
  Offices Held: President, 12/01-1/03
- Texas A&M University Association of Former Students, 8/03-Present
- Texas A&M University 12th Man Foundation, 8/03-Present
- Texas A&M University Pre-Medical Society, 9/98-5/01
- Texas A&M Biomedical Science Association, 9/98-5/01

HONORS:

- Texas A&M University, Dean's List, 8/03
- Texas A&M University, Distinguished Student, 12/02

Facility

VA North Texas Health Care System – Dallas, TX
4500 S. Lancaster
Dallas, TX 75216

Contact

Christopher G. Annis, Administrative Resident
(Training Start Date: January 9, 2005)
Contact: (214) 857-1148
Email: Christopher.Annis4@med.va.gov

Project Title

Advanced Clinic Access Implementation: The Change Process at VA North Texas Health Care System

Project Description

Background:
Historically health care organizations have viewed the demand for care as insatiable. Therefore, the typical approach to access was predicated on the false assumption that barriers needed to be constructed in order not to be overwhelmed with patient demand. Improving access to patients meant having complex scheduling systems and different types of appointments. Advanced Clinic Access hopes to not control the daily patient demand for care but rather predict it and respond accordingly. Based on a basic supply and demand study and the importance of improving our patients' access to care, VA North Texas Health Care System (VANTHCS) began implementing Advanced Clinic Access (ACA) in July 2004. Long waiting times, delays in care, and access to primary care are the main drivers to implementing ACA. The goal of using ACA is to reduce these problems that presented themselves in the past and result in a more patient-driven model of providing consistent care at all times.

Objective: To improve the access to primary care through the use of the Advanced Clinic Access model.

Development:
After an evaluation and reorganization of resources based on the ACA model of care, implementation began at the Sam Rayburn Memorial Veterans Center in Bonham, Texas which serves approximately 15,000 uniques. In August 2004, implementation was done at the Fort Worth Outpatient Clinic, which serves approximately 18,000 uniques. After the successful implementation at these two sites, Dallas was to follow. At the Dallas facility, approximately 40,000 uniques are served. ACA was implemented in Dallas October 2004. The following ten key changes we made to realize the gains of ACA.

1. Work Down the backlog
2. Reduce Demand
3. Understanding Supply and Demand
4. Reducing Appointment Types
5. Plan for Contingencies

6. Manage the Constraint
7. Optimize the Care Team
8. Synchronize Patient, Provider, and Information
9. Predict and Anticipate Patient Needs
10. Optimize Rooms and Equipment

Required Resources

- Eliminating the Walk in Clinic
- Four additional providers to handle number of uniques seen and to meet the national panel size performance measure

Benefits Seen

The benefits seen of ACA are:

- Increased access to primary care providers
- Overall patient waiting times decreased
- Patients see familiar provider
- Continuum of care
- Reduced no shows
- Standardization of panel sizes
- Standardized protocols on teams
- Contingency planning
- Standardized supplies in provider's rooms

Outcomes

Comparing data accumulated before and after the implementation of ACA, the aim of reducing clinic waits below 30 days has increased and the amount of no shows has decreased. Thus, patient access to their primary care provider has improved since the implementation of the ACA model.

Station Name	Established Patients	% Under 31 days - FY 2004 (July)	% Under 31 days - FY 2005 (Dec.)
Dallas	Primary Care	87.4%	97.7%
Bonham	Primary Care	92.5%	98.0%
Fort Worth	Primary Care	91.1%	97.1%

Application Potential At Other Facilities

ACA implementation at other facilities is occurring and has occurred at many others across the VA system. Data indicates that access to the clinic sites has improved when ACA was implemented. Generally, positive results are shown after approximately six months once the individual facilities work out their local problems with implementation. More importantly, improving access to primary care providers help improve the quality of care given to our nations veterans.

Maria S. Avdonina

1429 Holly Lane | Atlanta, GA 30329 | (404) 405-8057
mavdonina@yahoo.com

EDUCATION

August 2003 - present	**MHA,** Dept. of Health Policy & Management Graduate School of Public Health, University of Pittsburgh
December 2002	**Master of Science** Neuroscience Graduate Program, University of Iowa, Iowa City, IA, 52246
August 2000	**Bachelor of Science** in Neuroscience University of Pittsburgh, Pittsburgh, PA, 15260
1997-1998	Study Abroad Fellowship at St. Petersburg State University, St. Petersburg, Russia

PROFESSIONAL EXPERIENCE

Administrative Resident, GS-7
VA Medical Center, Atlanta, GA, June 2004 - present

- Serve as an Administrative Resident under the guidance /supervision of the Director
- Participate in strategic planning sessions
- Prepare presentations for the Executive Leadership
- Create, develop, and review management reports
- Participate in committees and task groups, fill acting roles and complete projects contributing to this objective
- Participate in local budget development and execution
- Become familiar with federal regulations and standards
- Review VHA administrative policies and requirements, and gain understanding of major accreditation processes
- Study patient accounts, billing processes and accounting procedures

Graduate Research Assistant
University of Iowa, Department of Pharmacology, May 2001 – December 2002

- Demonstrated ability to work under pressure in a fast paced, dynamic environment
- Managed project from conception to completion
- Represented university at various meetings and conferences
- Presented research results
- Taught new employees investigative procedures

University of Pittsburgh, Department of Physics and Astronomy, 1994 – 2000

- Supported department as administrative assistant
- Coordinated communications, scheduling and curricula

COMPUTER and FOREIGN LANGUAGE SKILLS

Proficient in Pascal, Excel, PowerPoint, Word, Access, Minitab (for statistics), Internet
Fluent in Russian and French

AWARDS

Interdisciplinary Biomedical Undergraduate Summer Research Fellowship at the University of Iowa (6/2000 -7/2000)
Fellowship Award at the Center for Neuroscience of the University of Pittsburgh (CNUP) (6/1999 - 8/1999)
Study Abroad Scholarship (1997-1998)
Dean's Honor List (1994 -2000)

Facility: Atlanta VA Medical Center
1670 Clairmont Ave.
Atlanta, GA 30033
Contact: Maria S. Avdonina, MS
Administrative Resident
(404) 321-6111 (x 4823)

Training Start: June, 2004

Title: Managing Demand in the OR - Operating Room Scheduling Project

BACKGROUND AND PURPOSE OF THE PROJECT:

The ultimate goal is to improve our efficiency in handling existing, as well as projected increases in workload. The goal of the Surgical & Perioperative Care Service Line (S & PC) is to efficiently provide veterans with the highest quality surgical care, the best clinical outcomes, and to do so while conserving resources. The number of surgical procedures performed in this hospital continues to grow; our case load has grown from 3,223 in FY98 to 4,791 in FY04 and workload is projected to increase in the upcoming year. Several of our specialties are growing at a faster rate than the overall service specifically, Urology, Orthopedics, and Ophthalmology. Of particular concern are the Spine procedures performed in the Spine Clinic, which sees and schedules 2.5 patients for every surgery that is performed. Obviously, unless this problem is adequately addressed, the delivery of healthcare for these patients can potentially be compromised. Similar concerns exist for our busiest services to include General Surgery, Urology and Vascular Surgery.

Efficiency in the operating rooms and its supporting infrastructure are of paramount importance. Unfortunately, there are a multitude of issues that impede the optimum delivery of care. Presently, we are consistently challenged with problems that involve poor Operating Room (OR) Utilization Coordination. The most significant challenge is our ability to monitor the duration and usage of operating rooms and turnover times so that surgery schedules can be changed appropriately. Start and end times dictate the flow and number of complicated or less complicated procedures that can be scheduled. The goal of the proposed project is to increase operating room utilization by improving scheduling. An improved and more realistic scheduling will result in improved utilization of O.R. space over time.

METHODOLOGY:

- *Start by determining:*
  - Flow of Operating Room Activities

  Determination of Operating Times for a given procedure:
  - Total Surgery Time
  - Total Time In Operating Room
  - Non-Operating O.R. Time

- Select a Study Period: (e.g. FY 05- FY 06)
- Selection Criteria:
  - Top Ten Surgeries based upon CPT code for Principal Procedure
- Complete similar analysis of all surgical specialties
- References:
  - Operative Reports
  - Anesthesia Clinical Record
  - CPT manual.

DATA COLLECTED:

- Time Patient In O.R.
- Operation Began Time
- Operation End Time
- Time Patient Out O.R.

- Data Reviewed by Anesthesia Attending and Surgery Attending

RESULTS/FINDINGS:

- Better estimate of global time for OR procedures
- Significant non-operative time in room should be considered
- Significant room "turn over" times should be considered
- Estimates of case duration are not accurate

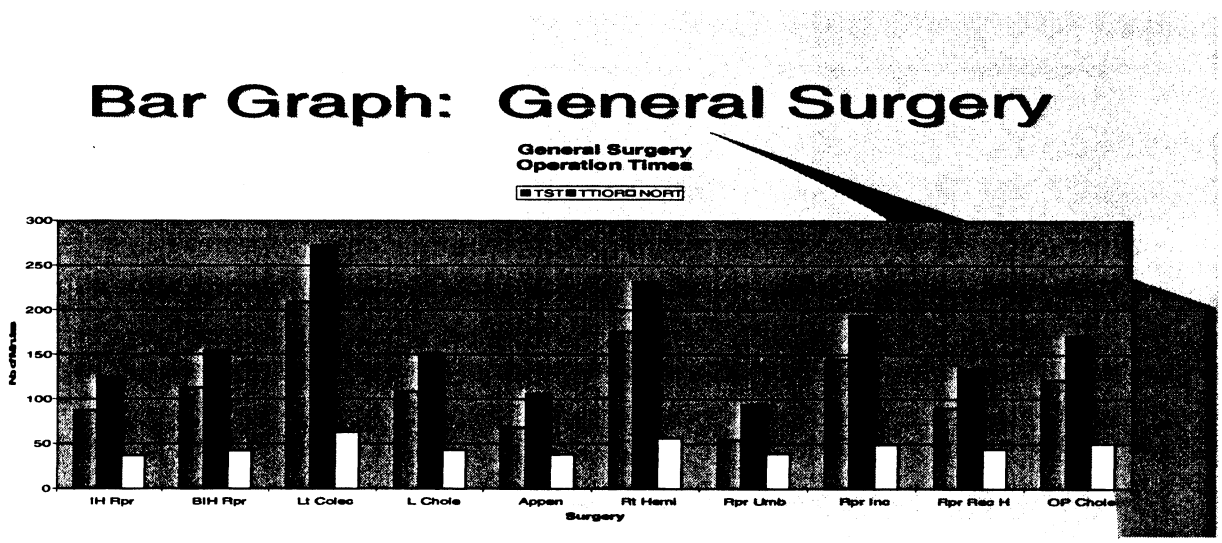
Next Steps

- Share data with operating room team/staff
- Data can be utilized to more realistically schedule cases
- Review data after 6 months to note any changes

Table: General Surgery

Summary General Surgery Operation Times

Procedure	Cases	Average TST	Median TST	Average TTIOR	Median TTIOR	NORT
Ing Hernia Repair	148	87	84	124	120	37
BIH Repair	21	113	108	155	152	42
Colectomy, LT	34	209	204	272	262.5	63
L Cholecystectomy	31	108	103	151	150	43
Appendectomy	26	68	68.5	106	111.5	38
RT Hemicolectomy	39	175	161	231	228	56
Rpr Umb Hernia	22	54	55	94	89.5	39
Rpr Inc. Hernia	15	144	90	193	140	49
Rpr Recurrent HI	24	90	80	134	130.5	44
Op Cholecystectomy	16	121	122.5	171	180	50



ANTICIPATED OUTCOMES and BENEFITS:

Quality: Reduction in surgical backlogs.
Timely Access: Decrease in patient waiting times due to increase in utilization.
Increase in New Customers: Increased efficiency will give us the capacity to handle projected increases in workload in requests for all types of ambulatory surgical procedures.
Increase Access to Existing Customers: We will have the capacity to more efficiently handle existing workload.
Cost Savings: Increase in MCCR revenue from additional procedures, minimize overtime pay expenses for O.R. staff by more accurate scheduling.

Seth William Barlage

1011 Clerkenwell Road, Louisville, KY 40207
(618) 203-2997, seth.barlage@med.va.gov

Health Care Experience

June 2004 – Present **Department of Veterans Affairs, Louisville VA Medical Center**, Louisville, KY

Administrative Officer of Emergency Medicine & Administrative Resident

- Improved the efficiency and effectiveness of Emergency Medicine by providing onsite management to a department that became an individual service line in June 2004.
- Assisted with the direct supervision of 22 Emergency Medicine employees – six physicians and sixteen Registered Nurses.
- Responsible for employee compliance with VA mandatory training.
- Accountable for monitoring twelve departmental performance measures through balance scorecards, which I developed using Excel, and communicating the results to the Chief of Staff and Emergency Medicine employees.
- Developed the Emergency Medicine business plan, which requested CUM FTEE increases, and illustrated overtime and agency savings through cost-benefit analysis. My plan was fully approved.
- Participated in JCAHO preparedness, focusing on the data management, medication management, and infection control system tracers.
- Assisted in the hiring of two Emergency Medicine employees by chairing an interview panel and developing behavior-based questions.
- Responsible for monitoring and driving the effort to vaccinate all applicable Veterans within Emergency Medicine.
- Conducted monthly environment of care inspections, generated work orders, and followed up on inspection issues.

Patient Advocate

- Listened and responded, either orally or in writing, to Emergency Medicine patients' complaints by researching the patient's issue with doctors and nurses involved in the patient's care.

Summer 2003 **Alton Memorial Hospital, a Member of the BJC Health System**, Alton, IL

Administrative Intern

- Accountable for the development and presentation of business plans for an inpatient observation unit and an Alzheimer's special care unit, of which the business plan for the Alzheimer's Special Care Unit became the basis for its development.
- Assisted in the facilitation of quality improvement efforts using Failure Modes, Effects Analysis and Root Cause Analysis.

Nov 2002 – Feb 2003 **Saint Louis University Hospital**, St. Louis, MO

Patient Ambassador

- Provided quality customer service by performing rounds to assess and respond to patients' non-clinical needs.

Summer 2001 **Blue Cross Blue Shield of Illinois**, Champaign, IL

Administrative Intern

- Assisted in the hiring process by participating in panel interviews and conducting skill assessments.
- Generated and analyzed inventory reports and researched claims.

Spring 2001 **Southern Illinois Healthcare**, Managed Care Department, Carbondale, IL

Administrative Intern

- Analyzed proposed contracts from managed care companies.
- Designed and created a brochure titled "Patient Rights and Responsibilities."

Education

May 2004 **Saint Louis University**, St. Louis, MO

- Master of Health Administration

May 2002 **Southern Illinois University**, Carbondale, IL

- Bachelor of Science in Health Care Management
- Magna Cum Laude
- Minor in Marketing

Honors

- Selected as one of the "25 Most Distinguished Seniors at SIUC," April 2001
- Elected to the Honor Society of Phi Kappa Phi, April 2001
- Named to the Dean's List at all college institutions, January 1998 – May 2002
- Received the AmerenCIPS scholarship, Aug. 1998 – May 2001

Professional Affiliations

- *American College of Healthcare Executives (ACHE)*
  - Active member of the national organization, May 2000 – Present
  - Participated as a Program Assistant at the annual ACHE Congress, March 2002
- *Kentucky American College of Healthcare Executives Chapter*
  - Board Member, Chairman of Events Committee, Sept. 2004 – Present
  - Responsible for coordinating special networking and educational sessions as well as community and volunteer activities.
  - Responsible for developing sponsor relationships for chapter events

Facility: Louisville VA Medical Center

Contact: Seth W. Barlage, MHA, Administrative Resident
800 Zorn Avenue
Louisville, KY 40206
(502) 287-5091

Start Date: June 6, 2004

Project Title: **The Genesis of a Service: Organizing Emergency Medicine**

Background / Description of Program:
The Emergency Department at the Louisville VA Medical Center has traditionally been a matrix configuration between Ambulatory Care, Nursing Service, and the Business Office. Operating under the umbrella of three different services created a structure that lacked clear management accountability, as well as promoted confusion, inconsistency, and turnover. The lack of a consistent management structure, combined with several untoward events, led to a full evaluation into the functioning, structure, and operation of the Emergency Department.

The evaluation of the Emergency Department led to many surprising findings that ignited discussion about the feasibility of organizing the Emergency Department and making it a separate service line. The findings of the evaluation included: excessive use of overtime and agency, fragmented communication with Emergency Department personnel, lack of consistent practice patterns, improper utilization of a triage system, inability to fill vacancies with dedicated and loyal staff, inadequate access to necessary resources, and low staff morale.

The decision was made to move forward with the organization of Emergency Medicine Service. The Director selected a Nurse Practitioner as the Chief of Emergency Medicine, and an Administrative Resident to serve as the Administrative Officer. Based on recommendations from the appointed committee, the Chief and Administrative Officer's responsibilities would be to achieve the objectives laid out below. The service was aligned under the Chief of Staff to afford Emergency Medicine the same status as all other clinical services, as well as create a direct authority line for physicians to the Chief of Staff.

Objectives:
The purpose of developing and organizing an Emergency Medicine service line is to bring all Emergency Medicine personnel under one, onsite management team in order to: 1) Monitor and ensure required staffing levels to promote quality and patient safety, 2) Promote accountability by tracking and monitoring performance measures, 3) Decrease cost by reducing unnecessary overtime and agency use, 4) Increase clear and effective communication along with consistent management practices to Emergency Medicine staff, 5) Increase availability and access to necessary resources, 6) Fill vacancies with dedicated and loyal staff, and 7) Standardize practice patterns and implement an effective triage system.

Planning and Development:
Initially, FTEE from the previous matrix configuration were transferred to Emergency Medicine Service. Minimal staffing levels were established using workload and minimum requirements for safe nursing care in order to rationally apply the dearth of medical center resources. This data helped us to create minimum, nurse-staffing levels that varied based upon the time of day and day of the week. The minimum, nurse-staffing levels created a foundation for scheduling that would assist in improving patient safety and reducing unnecessary overtime and agency use. Additionally, three historically, clerical positions were converted to a multi-skilled Health Technician position to better support Emergency Medicine personnel both clerically and clinically. Physician schedules were also reviewed and changed to provide greater, more equitable coverage during peek hours – better matching supply and demand. FTEE vacancies that were available, but never filled, were another critical step in maintaining a properly functioning department. By filling RN vacancies and requesting and receiving the authority to hire Health Technicians, productivity and employee morale increased noticeably.

To aid in the daily operational support of the nursing staff and to maintain the integrity of minimum, nurse staffing levels, a charge nurse was appointed as part of the administrative team. Responsibilities included nurse scheduling, facilitation of patient flow through the Emergency Department, dissemination of information, and role modeling of clinical and non-clinical initiatives in the unit.

Due to the service line formation, communication to the Emergency Medicine staff improved as a result of having one management voice. Onsite management presence, monthly staff meetings, and the production of an Emergency Medicine specific newsletter, contributed to the proper functioning of the Emergency Department by enhancing effective

communication and coordination of quality care in the Emergency Medicine Service. Also, Emergency Medicine personnel as a team developed the service specific mission statement, giving them a sense of purpose.

To track and monitor organizational and departmental performance measures, a departmental balanced scorecard was created, which included clinical, fiscal, and operational measures. The balanced scorecard results are communicated monthly to Emergency Medicine employees through the newly developed ER Newsletter and the monthly staff meetings – keeping them abreast of how their work contributes to the overall success of the medical center.

In order to provide access to adequate and necessary resources, Emergency Medicine personnel were assigned to various boards and committees. By having a presence and staying actively involved, Emergency Medicine Service will remain knowledgeable, be able to provide necessary resources, and be prepared for applicable changes that results from decisions generated from the boards and committees.

In order to standardize practice patterns and implement an effective triage system, Emergency Medicine Service instituted the "Emergency Severity Index (ESI)" as the triage tool. The ESI five-level triage system is a research-based, widely accepted, effective triage algorithm that yields rapid, reproducible, and clinically relevant stratification of patients into five groups – from level 1 (most urgent) to level 5 (least urgent). The ESI provides a method for categorizing Emergency Department patients by both acuity and resource needs. Emergency Medicine is also adopting the VA/DOD Clinical Practice Guidelines to assist in standardizing care for Veterans in the Emergency Medicine Service. To date, the ischemic heart disease guidelines have been adopted and fully implemented in Emergency Medicine, and implementation of the other modules are being rolled out to provide a system-wide approach to the care of the ischemic heart disease patient.

Resources Required for Implementation:

Organizing Emergency Medicine into its own service line may require all or parts of the following list depending upon the availability of resources and expertise at each medical center.

- Dedicated management staff
- Workload information and staffing methodology
- Correct organizational alignment to provide best cultural fit for staff
- Presence on applicable boards and committees
- Departmental balance scorecard measures
- Service line budget and FTEE

Outcomes:

- Established minimum, nurse staffing levels using a staffing methodology.
- Decreased total overtime and agency cost from an average of $12,115 to $7,393 per pay period.
- Increased clinical FTEE from 17.35 to 19.12 (Through PP05-01).
- Appointed a charge nurse to monitor the nurses' schedule, facilitate patient flow through the Emergency Department, and disseminate important clinical information to staff.
- Increased communication as a result of having onsite management presence, monthly staff meetings, and the Emergency Medicine newsletter.
- Created a departmental balanced scorecard to hold Emergency Medicine accountable, which included clinical, fiscal, and operational measures.
- Assigned Emergency Medicine personnel to various boards and committees in order to provide access to adequate and necessary resources.
- Standardized practice patterns by implementing the "Emergency Severity Index" as the triage tool and adopting VA/DOD Clinical Practice Guidelines to assist in standardizing care for Veterans.
- Implemented the ESI five-level triage system and VA/DOD Clinical Practice Guidelines to assist in standardizing care for Veterans.

Application Potential in Other Facilities:

Emergency Medicine as a distinct clinical service line only exists in relatively few VA medical centers across this country. For many Veterans, Emergency Medicine Service is their point-of-entry into the VA healthcare system. Therefore, it is critical that the quality of emergent medical care exceeds or at least meets the standard of care in the community. Although it has not been formally recognized, emergency care does exist in the Veterans Health Administration (VHA). Central Office is currently addressing the development of Emergency Medicine throughout VHA to address this critical entry-point for Veterans into the VA healthcare system. There is now a Field Advisory Committee for Emergency Medicine, which will work through the initial restructuring issues including key needs and core operating principles. In February, the committee will continue its discussion and also begin addressing major service issues such as IT needs, staffing, space, overcrowding, and protocols. As for now, the outcomes resulting from the formation of Emergency Medicine Service at the Louisville VA Medical Center, illustrates the potential tangible and intangible benefits that other facilities may receive if they so choose to implement this cost-saving, beneficial service line formation.

Maria Cristina Briggs

Miami VA Medical Center
1201 NW 16th Street
Miami, FL 33125
Tel. 305.575.7000 ext. 6732
Maria.Briggs@med.va.gov

EDUCATION

Master of Health Administration May 2004
University of Florida Gainesville, FL
Recipient, Malcolm Randall Fellowship

Master of Education August 2001
Emphasis: Social Studies
University of Florida Gainesville, FL

Bachelor of Arts with Honors May 2000
Major: History Minor: Secondary Education
University of Florida Gainesville, FL

PROFESSIONAL EXPERIENCE

Administrative Fellow
Miami VA Hospital and Clinics, Miami FL May 2004 - present

• Wrote a VA Best Practice on the seamless transition team outreach to returning Operation Iraqi Freedom/Operation Enduring Freedom Combat Veterans that is available on the VA Virtual Learning Center, member of Miami VAMC and Network 8 Seamless Transition Committees, participated in outreach OIF/OEF Veterans.
• Created a Colonoscopy patient education page on the Miami VA Internet website and established a process for disseminating information to patients.
• Member, ex-officio, of SOARS Education and Development Subcommittee, worked with a team to create a JCAHO/OIG/SOARS crosswalk and assembled a power point presentation for the Miami VAMC Director to present at a VA SOARS conference.
• Member, staff, Network 8 High Tech/High Cost Workgroup.
• Participated in the competency folder audit for the Nursing and Director Services in preparation for a JCAHO survey and an OIG inspection.
• Assisted in formulation of content and materials for annual Strategic Planning Summit. Presented Baldrige Award information to Summit participants.

Administrative Resident
University of Louisville Hospital, Louisville KY May 2003 - August 2003

• Participated in the planning and implementation of a mock JCAHO survey.
• Assisted in the creation of a quiz on appropriate restraint usage for nurses and constructed a display about restraints for the hospital Safety Fair.
• Participated in and analyzed the results of physician interviews conducted by Vice Presidents. Summarized and organized results as components within the Cancer Center expansion team report and presentation.
• Worked with team that created a simple nursing chart review tool to assist in concurrent chart review. Created a template for the nursing directors to aggregate their results and graded and tabulated the results for the first month of reviews.

PROFESSIONAL ACTIVITIES

American College of Healthcare Executives
South Florida Healthcare Executive Forum

Maria Cristina Briggs
Administrative Fellow (May 2004)
Miami VA Hospital and Clinics
1201 N.W. 16th Street
Miami, Florida 33125
Tel. 305.575.7000 ext. 6732

Colonoscopy Preparation Education and Outreach

APPROACH

ISSUE

The no-show rates and cancellations for colonoscopies, along with poor patient understanding of the procedures and inadequate preparation were significant issues for the Miami VA Hospitals and Clinics, leading to:

- Patients not receiving needed medical care
- Significant Morbidity / Mortality rates for colorectal cancer
- Financial concern with idled staff and resources (63% non-attendance of those scheduled when project began in October, costing $360 apiece)

GOALS

The colonoscopy project was undertaken with the focus of patients becoming partners in the provision of their health care.

- Patient understanding and knowledge about the procedure
- Involve patients in their own medical care
- Provide patients with accessible, appropriate educational resource
- Improve the quality of Bowel Preparation to lessen repeat procedures
- Decrease the numbers of patients canceling their colonoscopies due to insufficient information and preparation

PLANNING

The colonoscopy project was conducted in several stages. This ensured that all persons involved were consulted and contributed, resulting in:

- Outline of actions required to complete project within Baldrige framework
- Flowchart illustrating sequence of actions in order to complete page and outreach to Veterans in a timely manner
- Meetings with Leadership, Medicine, Nursing, Information Resource Management, Patient Education and Medical Administration Services to introduce project and solicit suggestions

DEPLOYMENT

IMPLEMENTATION

The Administrative Fellow executed the following plan:

- A colonoscopy web page that was linked to Hospital web site, featuring procedure and preparation information (in English and Spanish), as well as links to approved federal patient sites, modules and an interactive quiz
- Colonoscopy web page may be accessed online at: http://www1.va.gov/visn8/miami/education/colonprep.cfm
- Educating and motivating staff members on goals and potential benefits of project for patients
- A randomized survey conducted in GI Clinic to assess patient access to Internet

- Improving patient education in GI Clinic through appointment reminder calls and educational materials
- Follow-up sessions with involved staff to ensure continued focus
- A randomized survey conducted at GI Station on procedure days to determine if patients accessed the web page

RESOURCES

Cost effective projects are particularly important to VA Medical Centers in difficult budget years. This project was low cost in terms of time and manpower required for the creation of the web page, maintenance of the site, outreach to and surveying of patients.

- Time of Administrative Fellow, Assistant Director, Chief and Assistant Chief of IRMS, Hospital and Network Webmasters, MAS Clerks and Patient Education Coordinator
- Space allotted for the page on the server
- Paper and pencils used for copies and completion of surveys

RESULTS

FINDINGS

The colonoscopy project has yielded many positive results, finding that patients want to become more involved and responsible for the success of their health care.

- GI Clinic survey (n=60) found 63% of patients have access to Internet
- 13% of the participants were female; the ages ranged from 23 to 86
- GI Station survey (n=114) found that 65% of patients who received colonoscopy web site address accessed it for education information
- A review of physician colonoscopy procedure notes found all of the patients who accessed the colonoscopy page had successful procedures
- The January colonoscopy no-show and cancellation rates are approximately 60%, a decrease of 3%, or about 20 patients

APPLICATION

Colonoscopy procedures are a concern of all VA Medical Centers. We are mandated to offer them to all patients over age 50 and at regular intervals thereafter. This project is a cost effective addition to other facilities patient education programs as:

- Patient education information is largely universal
- Preparation information may be modified to reflect facility instructions
- Spanish preparation instructions, sample menus and contact information
- Colonoscopy web page meets VHA Internet patient information guidelines
- Virtual project allows for the web page to be easily transmitted throughout VHA

CONCLUSION

The colonoscopy project has been successful in reaching a significant portion of the targeted patient population by improving the efficiency and effectiveness of colonoscopy procedures. The colonoscopy is an important preventative tool to diagnose and treat colon cancer. Implementation of this project has improved the care and increased the participation of Veterans.

RECOMMENDATIONS

There are several potential expansions of the colonoscopy page and outreach efforts to patients:

- Spanish version of the entire colonoscopy page
- Work station with computer terminal in GI Station for patients to view web page will allow those without Internet access to utilize the resource

CHRISTINA Y. BONDI

Syracuse VA Medical Center (00)
800 Irving Avenue • Syracuse, NY 13210
Office: (315) 425-4600 • Mobile: (315) 440-8745
Christina.Bondi@med.va.gov

EDUCATION

University of Houston – Clear Lake (UH-CL) Houston, Texas
Master's of Healthcare Administration/Business Administration
Expected Graduation Date (upon completion of the residency requirement) – May 2005

Texas A&M University College Station, Texas
Bachelor of Arts, Biology, 2001

PROFESSIONAL EXPERIENCE

Syracuse VA Medical Center Syracuse, New York
Administrative Resident: 40 hours/week June 2004-Present

- Mentored by the Medical Center Director through the Graduate Healthcare Administration Training Program (GHATP). Includes rotations through the various areas of the facility and attending managerial meetings and training
- Serving as the point of contact in the facility's Wellness Committee to encourage healthy lifestyles and wellness among our employees through exercise activities and "Lunch and Learn" sessions (March 2005) on nutrition and stress management that occur daily
- Serving on the Imaging Procedural Accessibility Process Action Team (PAT), working to improve processes to reduce the backlog on unread films by 90% and the wait time to schedule an appointment down to 15 days
- Served as co-chair and tracked the Medical Center's collections for the Combined Federal Campaign raising approximately $90,000 within six weeks, an increase of 6.5% over the previous year's contributions, earning the 2004 United Way's Spirit of Caring Award for Leadership Development
- Developed and implemented a formal application process for the Syracuse VA Medical Center GHATP Residency position to include an informational brochure about the program specific to the Medical Center resulting in increased interest in this program with over twice as many applicants as last year

Foley's (May Department Stores Company) Houston, Texas
Sales Associate: 25 hours/week September 2003-May 2004

- Provided total customer service to hundreds of customers daily while completing the didactic portion of a graduate program
- Recognized for the most enthusiastic sales program
- Continuously worked and interfaced with numerous department managers and sale personnel daily

Darnall Army Community Hospital Fort Hood, Texas
American Red Cross Volunteer: 40 hours/week September 2001-December 2001

- Volunteered Daily at the Largest Community Hospital in the Army Medical Department at the Largest Military Installation in the Department of Defense with Over 140,000 Health Care Beneficiaries
- Participated in a Full-Time Preceptorship in Clinical Operations Supporting 13 Clinical Departments and Multiple Specialty Services
- Contributed to the Hospital's Management of a Centralized Patient Appointment Service and Patient Representative Office
- Participated and Contributed in a Hospital "No-Show" Appointment Data Analysis
- Produced Hospital Databases and Spreadsheets for the Family Practice Clinic
- Created an Administrative Database to Track and Improve Appointment Utilization

Texas A&M University Biology Undergraduate Programs Office College Station, Texas
Student Worker: 20 hours/week September 1998-May 2001

- Created and Managed the Biology Student Database to Maintain Enrollment Trends
- Assisted Students with Class Schedules and Degree Options
- Scheduled Meetings with Students and Faculty

PROFESSIONAL AFFILIATIONS

Student Member of the American College of Healthcare Executives July 2004-Present

Syracuse VA Medical Center
800 Irving Ave
Syracuse, NY 13210
(315) 425-4600

Christina Bondi, Administrative Resident
(Start date: 27 June 2004)

Procedure Accessibility Process Action Team (PAT) for Imaging

Background

Imaging has been an area of focus for improvement for some time; providers have identified Imaging as the #1 problem department in the facility. Due to the lack of Radiologists, Computed Tomography (CT) images were not being read within a reasonable period of time. Additionally, the facility was not meeting the 96-hour verification time, which has been decreased to 48 hours for fiscal year (FY) 2005, and a large backlog in CT scans and plain films developed as a result. Furthermore, the next appointment for a CT was not available for at least 70 days (as of 08/2004).

Objective

To improve the process of accessibility to our imaging department as well as reduce the time of verification of films.

Planning

For this project we utilized the Plan, Do, Study, Act improvement methodology:

- Plan: create a Process Action Team, focus on major issues, request mobile CT & digital equipment, identify barriers;
- Do: create contract, send films to other VA, negotiate mobile CT arrangement, build new digital rooms, change policies;
- Study: in progress;
- Act: refine all processes.

Development and Implementation

The Procedure Accessibility PAT was formed and included the Diagnostics and Therapeutics Careline (D&T) Manager and Administrative Officer, the Radiologist supervisor, a technologist, a Program Support Assistant (PSA), and myself, the Administrative Resident. The PAT came together and developed 8 major items that were in need of attention in order to achieve the process improvement goal. The eight subjects created include: Policies, Consult/Ordering Screens, CT Backlog, Physician Taskforce, Teleradiology Infrastructure, Waits/Delays, Timeliness of Verification, and Scheduling.

There were two major policies that were focused on for this project: a contrast policy, which enables limited contrast injections given only when a Radiologist is present, and a pre-operation policy, which required routine chest X-rays to be ordered before all operations. The contrast policy was approved on 22 September 2004 to enable contrast injections without a Radiologist and was implemented, and the pre-operation policy was modified to limit the need of chest X-rays to specific types of surgery.

In regards to consult/ordering screens, the improper ordering of tests for certain diagnoses was also causing an overutilization of imaging. Additionally, physicians were not identifying the reason for a procedure, and thus a complete study was performed on vascular surgery and Orthopedics requests. There were also problems with cancelled and held requests which gave no explanation/reason or further processing. The results of these issues were modifications and additions to the appropriate screens to improve and assist in the ordering and scheduling process.

The CT backlog and wait times were the main focus of this PAT. CT's were being scheduled at our facility for patients whose original point of service was at another facility in the Veteran Integrated Service Network (VISN), where the CT service was available; these were successfully diverted back to those facilities by communicating this issue with the facilities as well as the providers. Other components in this section of the improvement process involved working with a Radiologist in another VISN, negotiating a contract with a nearby private facility to help read images, and obtaining approval to hire

another Radiologist, all of which were successful/approved. Lastly, we will be bringing in a mobile CT in April 2005 to assist with the scheduling delay and eventually building an additional CT unit.

A physician taskforce for ordering imaging exams was revitalized. Radiology was asked to develop informational booklets to give to providers discussing appropriate procedures to order. A designated radiologist was made available during a set period of time providing additional assistance. Standardized protocols could not be developed since each procedure possibly required different techniques even for simple/basic procedures. The taskforce was also to review templates of ordering tests, criteria for CT's, and better use between tests, i.e., Ultrasound (US), CT, Barium Enema (BE). Ideas from providers to streamline testing are also being sought.

Teleradiology is one of the most advanced ways for improving our imaging process. Through teleradiology we are sending electronic images from one of our Community Based Outpatient Clinics for reading as well as to one of our Radiologist's at home. All providers as also being encouraged on the education, which is being offered, of the Veterans Health Information Systems and Technology Architecture (VISTA) imaging program for reading digital images.

Another subject matter in this improvement process concerns waits/delays. There are staffing problems on the floors and no one is available to bring patients down to imaging, thus further delaying the schedule. Imaging specific escorts from Voluntary Services was requested and the use of VIP volunteers in Imaging for transport was investigated. The use of more volunteers to ensure on-time arrival of patients to Imaging is being implemented.

Timeliness of Verification is another main focus of the PAT. All Radiologists were requested to verify their films everyday, first thing in the morning and again before they go off-duty; this is currently in process. The Radiologist Supervisor will monitor delinquency reports weekly. Incomplete films will be tracked on an imaging grid. The program support assistant will report on Radiologist productivity monthly. We are still waiting on a response from the Picture Archiving and Communication Systems (PACS) team for improvement of dictation system. CT's are being read digitally (as of 12/13/04), when we will also be going filmless.

Scheduling problems also contributed to the CT wait times. One factor involved patients who travel with the Disabled American Veterans (DAV) van; there was no master list of those patients and thus arrival times varied and delayed all other scheduled CT's. This was corrected by recruiting a part-time employee to call patients and verify travel arrangements.

Resources Required

The resources required for this project include the following: buy-in from clinical staff including Radiologists, time to implement the appropriate software changes and training for the modifications, support from management as well as support from other VISNs and other community hospitals, a suitable company to contract with for the mobile CT unit to include training, and additional staffing for the new MRI unit as well.

Overall Outcomes

As a result of the Procedural Accessibility PAT, our CT wait time is down to 45 (11/30/2004) from 70 days for a scheduled exam. The target is to decrease to 15 days by 30 March 2005. We will continuously monitor progress through daily unverified film reports and performance measures. Currently (02/2005), on meeting the target of 90% of imaging reports verified within 48 hours, Syracuse is at 30% and our Rome CBOC is at 5%. Monitors will routinely be reviewed to demonstrate improvement, refining/correcting any setbacks. Additionally, we will request provider feedback and take action to correct deficiencies. Once targets are met, they will be changed to exceed expectations.

Application Potential in Other Facilities

The processes implemented are very applicable to other VA Medical Centers. The changes in software, such as the ordering screens, can be made through their ADPAC or Information Systems personnel. Working with other VISNs to help with unread films can be done across the system by sending electronic images. Training on ordering procedures, i.e. ordering appropriate tests, and reading digital images can be done throughout the system as well.

ATOURINA BOUZA

♦ 11301 Wilshire Blvd. (691/00) ♦ Los Angeles, CA 90073 ♦
310.478.3711 ext. 48559 ♦ Atourina.Bouza@med.va.gov

EDUCATION

University of Southern California — Master of Health Administration
Los Angeles, CA — Expected May 2005

University of California, Irvine — B. S. in Applied Ecology
Irvine, CA — June 2002

EXPERIENCE

VA GREATER LOS ANGELES HEALTHCARE SYSTEM — Los Angeles, CA
Administrative Resident — *July 2004-present*

- Organizing a series of lectures to improve Administrative Officers' competency in areas such as HR
- Establishing a brochure, and working on a recruit plan, to bring in volunteers to assist nurses
- Developing an internal customer service program for nursing employees to improve morale
- Composing and developing "Gain Some, Lose Some: Gains and Losses On-Line Training Course"
- Provided administrative support for the Dermatology Chief Search Committee

VA GREATER LOS ANGELES HEALTHCARE SYSTEM — Los Angeles, CA
Special Assistant, Research and Development — *June 2003-July 2004*

- Composed and submitted a supplemental NIH grant application to fund a VA Clinical Research Center (CRC)
- Completed a federally funded grant application for a Clinical Research Center of Excellence
- Developed an online investigator manual for new investigators
- Improved, updated and remodeled Research and Development's website

FLYING SAMARITANS AT UC, IRVINE — Irvine, CA
Volunteer — *September 1998-Present*

- Organize fund raising events and social activities
- Set up donation drives and collected clothes, shoes, and toys for clinic patients
- Operate a free health care clinic with other volunteers, doctors, dentists and nurses in Mexico
- Train volunteers and students to triage clinic patients
- Translate physicians' orders to patients
- Dispense medication and educate patients about prescribed drugs

SANTA ANA POLICE DEPARTMENT–JAIL DIVISION — Santa Ana, CA
Account Clerk — *June 2002-June 2003*

- Reviewed details of and processed medical claims for inmates
- Analyzed details of and processed bails and bonds
- Delivered bails and bonds to Santa Ana Court House
- Counted and delivered commissary monies to Santa Ana City Hall
- Data entry

SKILLS

Computers

- MS Excel, Word and Powerpoint

Language

- Able to converse in Spanish

ORGANIZATIONS AND AWARDS

- Member, American College of Healthcare Executives (ACHE)
- Member, UC, Irvine Flying Samaritans
- Co-President, USC Student Health Council (2003-2004)
- Ambassador to the President of the University of Southern California
- Trojan Recognition Award for excellence in scholarship, leadership and service to the life of the University of Southern California (2004)

Facility:	Greater Los Angeles Healthcare System
Contact:	Atourina Bouza, MHA *Administrative Resident* 11301 Wilshire Boulevard Los Angeles, CA 90073 310.478.3711 ext. 48559
Start Date:	July 26, 2005
Project Title:	**Gain Some, Lose Some: A Gains & Losses On-line Training Course**

Project Description

All large medical facilities must track patient movement amongst its wards to determine vacant beds, operating beds, occupancy rate, length of stay, and to provide quality care for the patient. In the VHA, the Gains and Losses (G&L) Sheet contains information regarding patient movements for the preceding 24 hours. Ward clerks and occasionally nurses track gains (admissions and transfers) and losses (discharges, transfer outs and deaths) by inputting the changes into DHCP.

At GLA, ward clerks have a high error rate in entering gains and losses information into DHCP. If these errors are not detected and corrected in a timely manner, severe consequences may result. First, the patient's safety is put at risk because corrections to the patient's record cannot be made until the patient is discharged. The physician's orders and the patient's medications might be deleted if any corrections are made while the patient is still receiving care. Second, these can mistakes lead to inaccurate billing, which can cause the medical center to lose funding, if they are not corrected within a certain time frame. Next, each error on the G&L sheet will require a medical records clerk to spend an hour of his/her time researching the error, communicating with the physician(s) and reviewing documentation to verify the movement. On average, a medical records clerk will spend 3-4 hours a day cleaning up G&L mistakes, leaving the only half of the day to be spent on his/her actual duties. In addition to the listed consequences, inaccuracies in the G&L affect the number of available beds and the length of stay, amongst other statistics, which may end up shaping the medical center's performance scores.

Objectives

The main objective for this project was to analyze the patient movement process and determine when, where and why the inaccuracies were arising on the G&L sheet. A secondary objective was to develop and implement an intervention that would address the source of the inaccuracies.

Planning

Interviews and meetings with individuals who play a major role in maintaining the G&L sheet revealed that GLA ward clerks do not receive any training or information about tracking patient movement on the G&L sheet. Usually, they learn from other ward clerks or nurses who learned from another ward clerk or nurse. This type of training has become problematic because current ward clerks are teaching a new ward clerks the wrong method of inputting the information into

DHCP. In order to minimize the amount of errors that occur, improve patient safety, and reduce the amount of staff time wasted on researching and correcting each error, employees need to be properly trained on entering the information into the G&L sheet.

Development

Ward clerks spend a considerable amount of time entering patient movement into the computer; therefore, designing an interactive online training course on G&L would provide the best training for several reasons, including:

- Incorporation of DHCP screens and commands into the training to familiarize clerks with the computer system
- Clerks will practice entering data into DHCP by being presented with various scenarios and asked to log the admission, discharge or transfer
- Course would be available on the Intranet, allowing clerk to take it at his/her convenience

This online interactive training course will begin with an introduction to Gains and Losses and explain its significance to patients' safety, which should take about 10 minutes to review. It will then define a gain, a loss, and the different types of transfers and will ask the clerk to spend approximately another 10 minutes identifying the definitions. The scenarios section will follow and will resemble real encounters; therefore clerks will be prepared when they experience the situation in the ward. This section will be the most interactive because there will be different parts to each scenario, so it will require about 25 minutes complete. The training course will end with a quiz that will summarize all the G&L material that has been presented, which should take about 15 minutes to accomplish. In addition, links to obtain more information about G&L will be provided, along with important phone numbers and contact persons.

Resources Required for Implementation

The resources required to implement the "Gain Some, Lose some: A Gains and Losses Online Training Course" are minimal. An online course is inexpensive to set up and requires little time to update and maintain. The largest resource will be the time invested in designing the course, making sure it contains the appropriate content and it is user friendly, etc., and placing it on the Intranet. After the course is finalized, employees will be able to access it easily on the Intranet.

The training will be required of all current and new employees who are involved with tracking patient movements. The training should not take any longer than 60 minutes, and should be completed on an annual basis.

Application Potential in Other Facilities

The G&L sheet is utilized daily at medical centers throughout the VHA to track patient workload statistics. Most facilities give employees a handbook, which lists instructions and gives a description on how to input patient movement into the computer, but it does not provide them with the hands on training. Other facilities rely on current employees to teach new employees, which may complicate the process even more because of the incorrect information that is passed on. The "Gain Some, Lose Some: A Gains and Losses Online Training Course" should minimize the amount of errors that occur because it familiarizes the clerks with DHCP, allows them to practice entering information into DHCP, and provides them with contact information if they have any questions or concerns.

ALLYSON M. BRANDT

707E 7th Street
Georgetown, TX 78626

Cell: (512) 864-4311
Email: allysonbrandt@yahoo.com

EDUCATION

Georgia State University, Atlanta, Georgia, Master of Health Administration, Expected graduation May 2005
Georgia State University, Atlanta, Georgia, Master of Business Administration, August 2004
Emory University, Atlanta, Georgia, Bachelors of Art in Sociology, May 1999

PROFESSIONAL EXPERIENCE

CENTRAL TEXAS VETERANS HEALTH CARE SYSTEM, Temple, TX — August 2005 - Present
Provides the highest quality of care to Central Texas veterans.
Health Administration Resident

- Rotate through services within health care network
- Participate in preparation for JCAHO and IG visits
- Complete various projects and assignments, as assigned by Director

PER-SE TECHNOLOGIES, Atlanta, Georgia — October 2003 – March 2004
Provides business solutions for healthcare providers.
Account Analyst
Provide client management support to Anesthesiology Practice Account Managers.

- Analyzed monthly reports for trends in charge volume, collection volumes and ratios, accounts receivable statistics and payer mixes.
- Managed healthcare provider credentialing and enrollment in government-sponsored and private health insurance plans.
- Performed Cash Forecast for clients.

AMERICAN CANCER SOCIETY, Atlanta, Georgia — **October 2000 – December 2002**
Nonprofit, community-based volunteer health organization.
Project Coordinator (January – December 2002)
Coordinate cancer control training sessions to meet staff and volunteer needs; serve as key contact to staff and volunteers nationwide.

- Developed systematic approach that streamlined the planning and billing processes for quarterly nationwide meetings.
- Assembled and collaborated with subject matter experts to create training meetings in response to staff and volunteer needs.
- Created and launched Toolbook Click2Learn on-line training course for staff and volunteers in effort to diversify effective training modules.
- Conducted five monthly "Cancer Control Basic Training" sessions for new National Cancer Information Center Specialists via video-teleconferencing.

Staff Assistant (October 2000 – December 2001)
Provide administrative support to Director and Knowledge Manager, Development and Training, Cancer Control.

- Created and managed database of more than 1000 training participants that facilitated attendance record-keeping and follow-up evaluation process.
- Coordinated department meetings and monitored expenses consistently under budget.

FACILITY

Central Texas Veterans Health Care System
1901 Veterans Memorial Dr.
Temple, TX 76504

CONTACT

Allyson Brandt, Administrative Resident
(254) 743-0830
Allyson.Brandt@med.va.gov
Start Date: August 23, 2004

PROJECT TITLE

Tracking Anesthesiology Providers Proficiency and Output: A Basis for Performance-Based Salary Increases

PROJECT DESCRIPTION

Background:
On December 3, 2004, President George Bush signed into law the VA Health Care Personnel Enhancement Act of 2004 (S.2484). The law was enacted to assist the VA in physician recruitment by redesigning the physician pay structure to include not only locality-based pay, but also performance-based pay. Across the VHA nationwide, tools to track physician productivity and performance are being implemented to provide justification for future proposals for pay increases.

Anesthesiologists' work output is comprised of two components 1) complexity of the case and resources used during the case (measured by American Society of Anesthesiologists base units), and 2) amount of time required to perform the case from the preoperative to postoperative stage. This two-part output measure is distinctive to anesthesiology, and therefore demands a unique tool to capture the appropriate data.

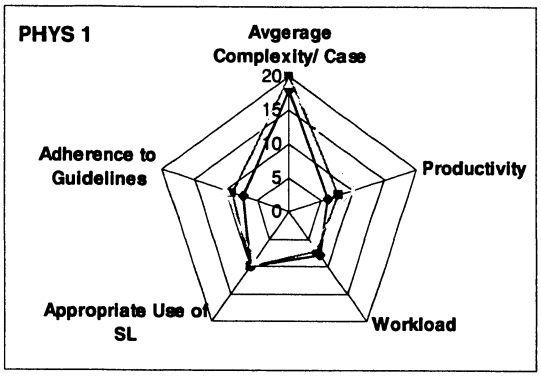
Objectives:
1) Create a user-friendly and accurate tool to track anesthesiologists' proficiency and output data.
2) Convert the data into useful information and make available to the Anesthesiology Section and Surgery Service Chiefs for annual reviews and ad hoc reviews when necessary.

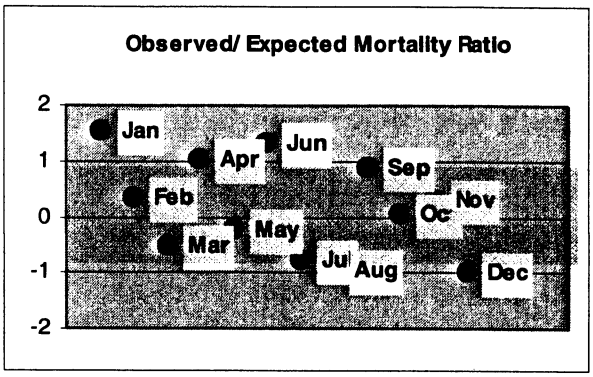
Planning and Development:
An initial meeting with Administrative Resident, Surgery Service Chief and Anesthesiology Section Chief was held to communicate needs and outline goals of the project. Considerable literature review was performed to research existing models that track provider productivity. Also, extensive review was completed regarding the anesthesiology services billing process. The literature review and follow up interviews with anesthesiology providers yielded a picture of the desired tool and its utility.

The tool contained proficiency and output measures that were captured on a monthly basis. Proficiency was defined as, "performing professional duties in a competent manner resulting in expected outcomes", while output was described through workload data and total time of care.

Data Collection:
Surgical CPT codes were converted into ASA codes using the 2005 ASA Crosswalk. ASA codes correspond with relative anesthesia base units. Each provider's base unit and time unit totals were used in productivity, workload and average complexity per case calculations. Adherence to guidelines and appropriate use of sick leave measures were collected by the supervisor, based on observations. Providers began the month with 10 points in each category. Noted abuses of each measure resulted in point deductions.

Average complexity per case, productivity, workload, appropriate use of sick leave and adherence to anesthesia guidelines were plotted monthly on each provider's spider diagram chart. Progressive months were plotted on the diagram yielding a visual representation of longitudinal improvements or declines in each of the measures. The figure below is a sample spider diagram.

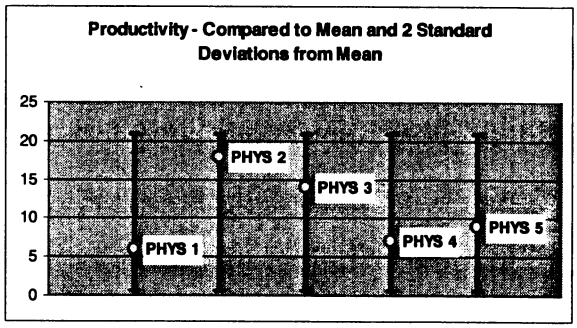




Observed mortality rates given preoperative ASA classification (I, II, III, IV or V) were collected following surgical procedures. These rates were divided by the expected mortality rates, yielding an observed to expected mortality ratio. Each month's ratio of observed to expected mortality rates was plotted on a line graph. The desired ratio range (+1 to -1) was highlighted. The figure above is a sample graph.

Provider data was shared with each provider at reviews and as necessary, and rolled up into department measures. All data was maintained within an Excel workbook – each physician's data was housed on separate worksheets, with links to monthly worksheets that generated the department tallies.

Discussion:
On a monthly basis, each physician's measures across the categories were used to determine a department mean and standard deviation. The figure below is a sample grid used to plot each physician (labeled nondescriptly to preserve anonymity) and 2 standard deviations from the mean. The data allows supervisors and administration to make comparisons among physicians and note measures that are considerably far from the department mean.



The information not only provided ongoing useful feedback, but also a basis for recommendations for physician salary increases at year end. According to the VA Health Care Personnel Enhancement Act of 2004 (S.2484) beginning on January 8, 2006, VA physicians' pay will include a performance-based element. The monitor developed to track anesthesia providers' proficiency and output was adopted by the hospital and the information was used to propose salary increases for providers where appropriate.

Benefits and Applications:
Because no such model previously existed, the unique tool developed and the information yielded from its application provided great benefit to the supervisors in Surgery Service. The tool can be broadly applied to any setting, within or outside the VHA, which provides anesthesia services. Resources required are minimal: data entry and MS Excel knowledge.

Sherrie L. Bryant

1772 Oakdale Ave. #211, West St. Paul, MN 55118 Phone: (859)312-9919 Email: slb7806@yahoo.com

Education:

Martin School of Public Policy and Administration: **Masters in Health Administration**
University of Kentucky, Lexington, Kentucky (August 2004)
Overall GPA: 3.4 on a 4.0 scale

Gatton College of Business and Economics: **B.A. in Business Management**
University of Kentucky, Lexington, Kentucky (May 2001)
Overall GPA 3.0 on a 4.0 scale

Academic/Professional Employment and Development

Minneapolis Veterans Medical Center, Minneapolis Minnesota **9/2004-Present**

Administrative Fellow

- Served as community liaison for the 2004 Combined Federal Campaign (CFC); Collected $73, 603.22 from the medical center
- Participant of the Advanced Clinical Access (ACA) Collaborative for the Food & Nutrition Department; Looking at ways to provide same day appointments and improving the process of tray delivery.
- Implemented a clinicians' lounge for the medical center
- Participant of the radiology taskforce that is looking at improving the services and turnaround times for the radiology department.
- Conducted local management audit for Fiscal by reviewing reports, performance development plans (PDP), and internal audits

Norton Southwest Hospital, Louisville, Kentucky **03/2004-08/2004**

Administrative Intern

- Conducted a study at looking at ways to improve the through-put and financial performance of observation patients at the hospital by looking at the volume, diagnosis, reimbursement rates, average length of stay (ALOS), denials and clinical policies of these patients.
- Attended senior leadership meetings to understand the operations and structure of the Norton Healthcare System.

Orthopaedic and Sports Medicine Clinic, Lexington, Kentucky **02/2003-02/2004**

Patient Relations Assistant

- Registered patients by collecting information on their demographics, employment and health insurance
- Obtained referrals from outside primary care physicians and health insurance companies
- Scheduled patient's appointments and updated the daily appointment schedule as changes occurred.
- Entered ICD-9 codes and co-payments into the charge entry system for physicians

Job Related Skills:

- Create spreadsheets, tables, and charts in Microsoft Excel; Proficient in PowerPoint and Microsoft Word

Awards and Affiliations

Recipient of Commonwealth Incentive Award, 2002-2004
Special Contribution Award, December 2004
American College of Healthcare Executives, 2004-2005

Training

Controlled Substance/Drug Diversion Inspection Certification, January 2005
Advance Clinic Access Collaborative Learning Sessions 1 & 2, October and December 2004
Applied Data Management I Training, December 2004

Facility: Minneapolis VA Medical Center (MVAMC)

Contact: Sherrie Bryant, Administrative Fellow (00)
One Veteran Drive
Minneapolis, MN 55417
(612)467-3515

Training: September 2004

Title: Improving Tray Assembly & Delivery Procedures Using Advanced Clinical Access (ACA) Principles in Nutrition & Food Service

Introduction

In 1999, The Veterans Health Administration (VHA) collaborated with the Institute for Healthcare Improvement (IHI) to learn strategies for reducing delays and waiting times in traditional clinical settings. There were initially 134 VA teams across the United States that learned how patients can be seen on the same day they contacted the clinic. This principle is known as advanced clinical access (ACA). By April 2001, VHA had expanded the principles of ACA throughout the entire system. Their ultimate goal was to create a system that allowed patients to see their providers when they choose. ACA is continuously being implemented throughout the VHA system with results showing that waiting times are being decreased and same day appointments are being offered.

Description of Project

In October 2004, Minneapolis VA Medical Center participated in the ACA Collaborative (Wave 2) for VISN 23. Administrative and ancillary departments as well as clinical areas were encouraged to attend. The Nutrition and Food Service (NFS) was one out of three of the non-traditional clinical settings that participated. The NFS divided into two teams. One team was called Nutrition on Time (NOTs) and the other team was called Trays on Time (TOTs). The NOTs focused on the outpatient clinical side of nutrition and the TOTS focused on the process of tray assembly and delivery for inpatients. I will focus on the TOTs application of ACA.

Objective

TOTs goal is to give every patient 45 minutes to eat before tray pick-up by March 31, 2005. Their office efficiency goal is to decrease the number of tray line errors by March, 31, 2005

Planning and Development

ACA has three core strategies: Shape demand, match supply and demand, and redesign the system to increase the supply.

- Shaping demand is the ability to predict and absorb demand. The main goal is to reduce demand. The TOTs first goal is to give every patient 45 minutes to eat before tray pick-up. This would help reduce the number of trays food service workers would have to pick-up due to giving more time to eat. The second goal of

reducing tray line errors would help decrease the number of times the tray assembly line has to stop or slow down to correct tray errors.

- The second strategy is matching your supply with demand. In ACA you want the supply and demand to be equal. TOTs wanted to know whether they had too many food service workers delivering and picking up trays. This may have been the reason why trays were being picked up early. In the tray line process, the TOTs wanted to know if one tray line position had too many items to put on a tray which may be a cause of the increase in errors.
- The third strategy is redesigning the system to increase your supply. The NOTS will create a flow diagram for tray delivery as well as the tray assembly line. The flow diagram will help you identify constraints, process variations, and unnecessary steps.

Data Collection

TOTs collected data on the time a patient was given to eat for the three different serving times. The July data was when they had three food service workers from the tray delivery line and the September data was after they decreased staffing by one. A flow diagram for the tray delivery process was created to identify constraints. There was also a data collection of the number of times a tray passer delivered a tray to a patient and the number of times nursing staff had to deliver it. For the second goal of decreasing the number of errors on the tray line, TOTs collected data on the number of errors by tray line position and they created a flow diagram for the tray line process of preparing a tray.

Outcomes

In July 2004 the average time to eat was 42 minutes with three tray passers and in September it increased to 45 minutes with only two. In the tray delivery flow diagram there were some operational constraints that were identified. One constraint was that the cart may have not made it to the floor due to a programming malfunction. Another constraint was that patients eating in the dining rooms were not there sometimes and the tray passer had to deliver it to the ward or leave it for nursing. The second constraint was that table numbers were sometimes not on the trays. Tray passers use table numbers to help identify where a patient is sitting. In the tray assembly process, the cold food position had the most errors and Thursdays had the highest number of errors. The only constraint was when the tray was not correct and the tray checker had to ask for the needed items or take off unneeded items.

Future Actions

The TOTs are currently working on standard operating procedures (SOPs) for tray delivery. After observing and collecting data on tray delivery, we concluded that everyone was not delivering trays the same way. They have also alphabetized trays in the extended care dining room to make it easier for tray passers to locate patients' trays. They will continue to monitor the time given to eat as well as the patient satisfaction scores. They are continuing to analyze areas of improvement in the tray assembly line process to reduce errors. Monthly trainings and unit meetings can help address some of the needed areas of improvement. Contingency plans are also a factor in ACA. TOTs are in the process of creating these plans for the department.

Li Cai, M.H.A.

5000 Culbreath Key Way, # 8-314, Tampa, FL 33611
CELL PHONE: (813) 389-0266 **WORK PHONE:** (727) 319-1265
E-MAIL: licai47@hotmail.com

EXPERIENCE

Administrative Fellow **07/25/2004 – Current**
VISN 8: VA Sunshine Healthcare Network, Bay Pines, FL
Job Responsibilities: Complete rotations through areas of operation at network and medical center levels, attend management meetings, analyze data and management functions, and participate in special projects.
Job Accomplishments: Participated in JCAHO survey at Bay Pines VAMC, took part in hurricane disaster preparedness/relief efforts, attended VHA Senior Management Conference, coordinated the network strategic planning retreat, member of the interview panel for Network CIO position, certified Administrative Board Investigator, gathered and analyzed data for compliance audits, Advanced Clinic Access, the CFO reorganization process, and numerous operational measures, member of the Network Balanced Scorecard Workgroup, refined Network Performance Measures Report Card, developed a plan for Pre-registration at the James A. Haley VAMC, and currently in the process of implementing the plan.

Administrative Intern **05/11/2003 – 08/15/2003**
VISN 8: VA Sunshine Healthcare Network, Bay Pines, FL
Job Responsibilities: Attend management meetings, complete rotations through departments, and participate in special projects.
Job Accomplishments: Completed network market analysis for VHA's CARES initiative, took part in IT management review; and participated in a special project to increase revenues in the telemedicine program.

Consultant **09/1999 – 12/31/2002**
University of Florida – Department of Computer and Information Science and Engineering, Gainesville, FL
Job Responsibilities: Assist students with assignments and class materials through office hours, phone, and e-mail; proctored, wrote, and graded exams and quizzes.
Job Accomplishments: Managed the administrative functions and educational materials for a university course with 1400+ students. As head consultant, I managed a staff of ten consultants.

LIST OF PREVIOUS POSITIONS

Research Assistant **09/2003 – 05/2004**
University of Florida – Department of Health Services Research, Management and Policy, Gainesville, FL
Senior Clerk **11/2001-08/2002**
University of Florida – Registrar's Office, Gainesville, FL

EDUCATION

Master of Health Administration **May 2004**
University of Florida Gainesville, FL

Bachelor of Science in Business Administration **May 2001**
University of Florida Gainesville, FL
Major: Finance
Minor: Economics

PROFESSIONAL & CIVIC AFFILIATIONS

American College of Healthcare Executives (Member 2002 – Current)
North Central Florida Health Care Executives (Board Member 2002 – 2004)
University of Florida Health Administration Student Association (Vice President 2002 – 2004)

AWARDS AND ACCOMPLISHMENTS

U.S. Public Health Service Traineeship Award
Shands Auxiliary Hospital Scholarship
Dean's List – Warrington College of Business (University of Florida)
Miami-Dade County Miami Herald/Knight Ridder Silver Knight Winner in Mathematics

VISN 8: VA Sunshine Healthcare Network
Li Cai, Administrative Fellow
Start Date: July 25, 2004
10000 Bay Pines Blvd, Bldg 24
Bay Pines, FL 33744
(727) 319-1125
Project Title: *A Plan for Pre-registration*

OBJECTIVE

The objective of the project was to implement an effective pre-registration process at the James A. Haley VA Hospital. The purpose of pre-registration is to remind patients of upcoming appointments and update patient demographic and insurance data. The goal is to reduce the number of no shows and returned mail due to bad addresses, and update patient insurance information.

PLANNING

During my Business Office rotation at the James A. Haley VAH, I was asked to examine the pre-registration/intake part of the Revenue cycle at the medical center. To get an overview of the Revenue cycle I rotated through the different sections in the Business Office and learned about their functions and how they affect the Revenue cycle. My main area of focus was with the Health Administration Section (HAS), which is the area responsible for the pre-registration/intake activities. The areas that were closely observed in the HAS were the Enrollment Center, Admissions, and its nine clinics. Time was spent with the staff to inquire about the pre-registration process, how it affects them, and how it can be improved.

A task force was created in 2003 to tackle the issue of pre-registration at the medical center. The task force recommended implementing centralized intake. Their recommendation was not approved due to lack of space for a centralized intake area. The advantage of this pre-registration project is that it will not need any new space as it will utilize current space during its off tour hours (the VAH's Enrollment Center). The HAS clerks were surveyed for volunteers to put in extra work for the call center. Ten individuals volunteered, 5 Eligibility and 5 from the clinics. The clerks were very excited about the opportunity for overtime work. The VAH's union Master Agreement was reviewed to identify any union issues that might affect the employees. Advice was sought from section chiefs on how to put together the plan for the call center and the orientation for the employees. A "Pre-registration Desktop Guide and Manager's Guide" has already been published by the VHA Chief Business Office and will be used as the training manual for clerks. Measurements such as percentage of no shows and associated costs, number of returned mail due to bad addresses, and number of unverified insurance are to be monitored.

DEVELOPMENT

The Pre-registration Call Center will take place at the James A. Haley VAH's Enrollment Center between the hours of 8am – 2:30pm on Saturday. Ten clerks and 1 supervisor will be working overtime to cover this shift. According to union mandates, a half-hour lunch and one 15-minute break will be given to the staff. The HAS Chief will be responsible for making sure clerks are trained on how to conduct the pre-registration calls. Clerks will be calling patients who have appointments coming up within the next two weeks. During the call, patients will be asked to update demographic and insurance data as according to the five pre-registration screens. If needed a means test or co pay test will be mailed out to the patient for completion and return at time of appointment. If calls are not answered an appointment reminder will be mailed out to the patient. Attached with this reminder will be a 10-10EZ form where the patient can make changes to address or insurance and bring back during time of appointment.

RESOURCES REQUIRED

- Location: Enrollment Center (Saturday, 8am – 2pm)
- Materials: Long distance access for clerical staff and training manual
- Staff:
  - 5 Clerks from clinics (GS-5, $27,569 annually) – Overtime cost = $19.81/hr
  - 5 Clerks from Eligibility (GS-6, $30,731 annually) – Overtime cost = $22.09/hr
  - 1 Supervisor (GS-7, $34,149 annually) – Overtime cost = $24.54/hr
- Total weekly staffing costs = (5 x $19.81 + 5 x $22.09 + $24.54) x 6 = $1,404.33
- Staffing costs for a one-month period will be equivalent to four weeks for a total of $5,617.32.

BENEFITS

An effective pre-registration process allows the organization to maintain the accuracy and confidentiality of patient information, improve customer satisfaction by keeping patients informed about their healthcare, and improve the flow of the Revenue cycle. Updating patient information on a regular basis can ensure that patient mailing addresses are current, annual means test and co pay tests are completed in a timely manner, decrease the number of appointment no shows, decrease the time patients spend registering for care at the medical center, and allow for better communication between provider and patient.

COST SAVINGS

From November 2003 to October 2004, a total of 5,827 bill statements to first party payers were returned due to bad addresses. The dollar values associated with these bills totaled $1,154,807. In an effort to correct erroneous addresses, MCCF's Patient Financial Services section launched an aggressive calling campaign in FY 04 to fix bad addresses. 1,953 addresses, with associated bill values of $436,815, were corrected. A balance of $717,992 was not collected due to bad addresses. The other area that is greatly affected is third party collections. In September of FY04, there were 49,373 patients treated with 2,703 of them having unknown insurance. Insurance that has not been verified in over a year was 13.5 percent.

The HAS handles the pre-registration of patients. However, due to the workload that is present in the HAS, a proper pre-registration process is difficult to implement without additional staff or space. The effects of pre-registration on the HAS is not revenue but costs. In October 2004, there were a total of 1,016 no shows in the HAS clinics. Costs of no shows in FY04 totaled $1,363,935.52. By reducing the number of no shows, the medical center can reduce costs and the wait list by scheduling patients in vacated appointment slots.

With a proper pre-registration process, the medical center can proactively take measures to reduce this number of unknowns and verify that the medical center has the correct insurance information for the patient. Pre-registration has the potential of increasing medical center revenues by millions of dollars through cost savings in the reduction of no shows and increase collections through the reduction of bad addresses and incorrect insurance information.

APPLICATION POTENTIAL IN OTHER FACILITIES

Pre-registration is a mandate of the Veterans Health Administration. However, by November of FY05, four out of the six medical centers in VISN 8 reflected the need to improve their pre-registration process. Historical data shows that this is an issue that the VISN needs to focus on. One thing to keep in mind is that there are nine clinics under the HAS in Tampa. This is a small portion of the total number of clinics at the medical center. There are a total of 50 performance clinics. Application potential can be extended to these clinics, the medical centers in VISN 8 and VHA. This project has low implementation costs and a potential for high returns. By overcoming the space issue that is affecting many medical centers across VISN 8, this project has the potential of assisting medical centers in implementing a proper pre-registration process in-house without the use of contractors.

OUTCOMES

The Business Office Chief at the James A. Haley VAH approved the plan for the Pre-registration Call Center. Due to budget constraints and mandatory ceilings on overtime placed in an effort to manage resources, the project is currently waiting for approval by the Associate Director at the medical center. The next step in this project is to compare the cost of outsourcing pre-registration to a contract service versus conducting it in-house. A survey was taken throughout VISN 8 and four of the six medical centers have contracted out their pre-registration activities to two companies (RMA Healthcare Services and Receivery Services). The two medical centers that have contracted out pre-registration for the past year have the highest number of patients pre-registered the VISN. The other two medical centers recently awarded contracts after the need for a better pre-registration process was realized. With a workload of 507,183 outpatient visits in the month of January 2005, Tampa is concerned about the feasibility of conducting pre-registration in-house for all of its clinics. Tampa has a great interest in using a contracted service, however, there were mixed reviews on the satisfaction of the services by the medical centers we surveyed. The next step is to contact these two companies and get cost estimates. These costs will then be compared to the costs of implementing pre-registration throughout all of the clinics at the James A. Haley VAH without the use of overtime. A list of pros and cons will be developed for the two options and a recommendation will be made to the Business Office Chief for approval.

(James) Scott Campbell

Jamesscott.Campbell@med.va.gov
(716)688-6058 home
(716)560-4715 cell
63 Wood Acres Drive
East Amherst, New York 14051

Current Position:

Administrative Fellow
VA Western New York Healthcare System
Buffalo, NY 14215

Education:

Cornell University, College of Human Ecology, Sloan Program in Health Administration
Ithaca, NY
Master of Health Administration, May 2004, GPA 3.97

State University of New York University at Buffalo School of Dental Medicine
Buffalo, NY
Matriculated Fall 1999, Leave of Absence Granted Spring 2001

State University of New York College at Geneseo
Geneseo, NY
Bachelor of Science, Biology, May 1999, GPA 3.69

Honors and Awards:

Rising Star Award, 2004
Sloan Alumni Scholarship, 2003
Tucker Scholarship 1999, 2000
Barrett Academic Scholarship 2000, 2001
Deans List 1996-1999
Presidents List 1996-1997

Work Experience:

July 2004 - Present

Administrative Fellow, VA Western New York Healthcare System, Buffalo, NY

- Successfully completed Six Sigma training and a project with anticipated one year post implementation value in excess of $100,000 and net present value of nearly $500,000.
- Developed customized Executive Performance Plans for greater than twenty-five of the top administrators, ensuring correlation to organizational strategic objectives
- Designed Nursing Home Care Unit staffing ratios based upon Resource Utilization Group Score (RUGS) relative value system to increase staffing efficiency and ability to better accommodate daily variations in resident census
- Collaborated with other senior administrators in the development of the Local Leadership Council Center Memorandum, the senior executive oversight committee within the VA Western New York Healthcare System
- Participated in the transition to JCAHO constant state of readiness through completion of JCAHO Hospital Accreditation Leadership Chapter
- Completed Baldrige site visit preparatory documents for all supervisors and managers at the VA WNYHS in anticipation of the first ever Baldrige site visit to a federal institution.

May 2003 - Aug 2003

Administrative Intern, SUNY UMU University Hospital, Syracuse, NY

- Worked as a member of a cross functional administrative team in the development and submission of a CON to the NYSDOH to expand the inpatient bed count from 366 to 398
- Performed a Physical Space Inventory for the Pediatric service line, and used this PSI to program the first children's hospital in Syracuse; Central New York Children's Hospital
- Worked collaboratively with architectural, mechanical, and structural consultants, hospital administration, various service line representatives including clinical chiefs, and ancillary service personnel to strategically plan a $100 million dollar physical plant expansion
- Developed a University Hospital Administrative Policy for regulating compliance of Medical Service Groups to ensure higher state and federal reimbursement rates

Community Activities:

Dec 1999-Dec 2000

American Student Dental Association Representative

- Acted as student liaison to academic administration, providing leadership to student body in conjunction with other student officers

May 2000-September 2000

University at Buffalo School of Dental Medicine Orientation Program Coordinator

- Designed and implemented a new orientation program for entering first year dental students

Additional Skills/Interests:

- Experience working with Microsoft Word, Excel, PowerPoint and Outlook
- Historical home restoration, sailing, skiing

References:

Available upon request

(James) Scott Campbell
Administrative Fellow (completion date 07/12/2005)
VA Western New York Healthcare System
Jamesscott.Campbell@med.va.gov or (716) 862-8576

Creating Value Through The Internalization of Stable Patient Transport via Ambulance

Background

The VA Western New York Healthcare System (WNYHS) operates as a two-campus system, often relying upon contracted ambulance services for the movement of medically necessary transportation eligible patients. This mode of transportation occurs in one of two ways, either as an emergent trip (911 call and patient is taken to the closest Emergency Department), or more frequently as a non-emergent trip. Non-emergent trips involve transportation of relatively stable patients to or from area hospitals, medical centers within the Veterans Integrated Service Network (VISN), skilled nursing facilities, other healthcare providers and occasionally private residences. Non-emergent ambulance services are typically used for such things as hospital admission, discharge, ancillary testing, appointments, etc.

Project Description

The VA WNYHS had operated its own ambulance for sometime, but the ambulance was located at the smaller of the two facilities and predominantly serves as a Nursing Home Care Unit (NHCU). Without a resource commitment to dedicated ambulance operators, the ambulance was typically operated only for transport of NHCU patients, and even then it was often underutilized. For instance, approximately 240 non-emergent runs were required in the 3rd quarter of FY2004, and at the time of project selection it was estimated that the VA operated ambulance was used for less than 6% of these. The use of contracted ambulance services is not only expensive as the average price is well over $300 per trip, but to a large extent avoidable since much of the non-emergent transportation demand is known in advance. Internalization of currently outsourced stable patient transportation services was therefore believed to be capable of providing significant organizational savings. A cost-benefit analysis needed to be performed to make the business case for internally providing a greater number of ambulance transports, but before the analysis could be completed it would first be necessary to gain a better understanding of the demand for non-emergent ambulance transportation. After achieving this understanding, the labor supply could then be optimally configured to attain the Six Sigma training project goal of saving at least $25,000 within one calendar year of implementation.

Data Analysis

Data collection and analysis was much more labor intensive than anticipated as electronically stored information did not meet the project requirements. Instead data had to be gathered from original community ambulance service provider invoices, and for this reason only 3rd quarter FY 2004 data was used in the analysis. A spreadsheet was developed with each trip acting as a record and containing fields such as patient name, SSN, ambulance carrier, type of ambulance required (ALS or BLS), time and date of call, weekday, mileage for which the VA was billed, one-way mileage according to Mapquest, time required for trip according to Mapquest, total charges, etc. The cost-benefit analysis would be based upon the VA WNYHS operating only the existing ambulance, thereby requiring the exclusion of overlapping trips from the data set to ensure that the model did not overestimate the financial implications of internalizing transport. For example, if a trip began at noon and would not be completed until three hours later, then any trips that began between 12 pm and 3 pm would be excluded. Data was then analyzed using Minitab statistical software and the optimal 40-hour staffing workweek was determined.

Anticipated Results

Approximately 90% of VA WNYHS stable patient transportation via ambulance was provided by Rural Metro Medical Services. During development of the cost-benefit analysis it became

apparent that according to Rural Metro contracted rates, we had been overcharged and consequently overpaid for many of the services provided. Clauses within the contract since 11/01/2001 state that the first 15 miles of each trip will not be charged as they are already included in the fixed portion of the cost structure. Each mile beyond 15 is charged at a variable rate of over $4/mile. Bills generated by Rural Metro Medical Services did not always reflect these "free" miles, and we were frequently charged for them. Extrapolating the errors that occurred in the 3rd quarter of FY 2004 to the time period over which the Rural Metro contract was in place led to the conclusion that recoverable damages were likely in excess of $60,000 (or $20,000 per year).

Even after deducting these overpayments from the financial model, and overestimating many of the anticipated internalization expenses on which the model was built, net cash savings of over $13,000 per year should be achieved. Admittedly this does not seem like much money, but overall organizational value is expected to be much higher. According to the model developed, Emergency Medical Technicians (EMTs) would be involved in the transport of patients via ambulance on average 13.5 hours per workweek, and even after administrative duties, over 20 hours can be dedicated to working within the Emergency Department. At the discretion of the Emergency Department nurse manager EMTs will be expected to perform such functions as provision of patient care, intra-facility transport of patients, transport of lab specimens, etc. When the project is fully valued at one-year post implementation, it should be worth approximately $130,000, and the net present value of savings is estimated at closer to $500,000!

Next Steps

The project inadvertently and unintentionally discovered the need to perform greater due diligence on billing invoices received from Rural Metro Medical Services. The first thing that was developed was a simple chart containing the most frequent trips and associated costs according to Mapquest and current contract prices. The chart will be used by travel clerks and fund control point managers to quickly and easily determine the accuracy of bills received. An internal audit of Rural Metro invoices will also be performed to determine if in fact we have been consistently overcharged by Rural Metro Medical Services for the time period in question. Pending audit results, a letter has been drafted to let Rural Metro Medical Services know of our intention to recover damages, and also to provide them with the aforementioned billing charge chart so that they can internally monitor bills prior to mailing them. In this way we can reduce re-work that might otherwise occur within both organizations as a result of denied payments.

The Finance and Resources Committee approved the hire of two full time employees to operate the ambulance and the Emergency Department nurse manager developed a Position Description for the newly created jobs and has submitted them to Human Resources with the anticipated classification as Health Technician GS-06. A database is in the process of being developed that will better capture all of the necessary information for ambulance trips to enable us to monitor the program once it is implemented and to change the capital or labor resources as necessary. Finally, if the piloted program works well there is the potential to expand the scope within our facility to additional hours, and the ability to expand the program to other Medical Centers within the VISN.

Conclusions

In addition to providing a valuable Six Sigma learning experience this project was of significant strategic relevance to the organization as implementation of the recommendations will increase the number of employees at the VA WNYHS, will increase the accountability of ambulance services to VA patients thereby increasing customer satisfaction and because it will produce a quantifiable savings that can be reallocated toward the completion of other organizationally important objectives.

JULIE CARPENTER

915 North Grand, 118/JC
St. Louis, Missouri 63106

Work (314) 652-4100, X 5308
Julie.Carpenter3@med.va.gov

EDUCATION

2004 MHA-Health Administration, Washington University School of Medicine, St. Louis, Missouri
2000 BSN-School of Nursing, Southern Illinois University at Edwardsville, Edwardsville, Illinois

EXPERIENCE

6/04 to Present **VA MEDICAL CENTER – ST. LOUIS,** St. Louis, Missouri

Health Systems Specialist

Reponsibilities:

- Participate in the steering committee for the Care Coordination/Home Telehealth program start-up
- Involved in the creation of the Clinical Nurse Leader role
- Participate in various committees and work groups as assigned
- Analyze/Manage nursing overtime budget

6/00 to Present **HAWTHORN CHILDREN'S PSYCHIATRIC HOSPITAL**, St. Louis, Missouri

PRN Nurse/Relief Evening Supervisor (8/02-Present)

Responsibilities:

- Offer medication teaching and health education to patients and families
- Supervise psychiatric aids and provide feedback to staff and supervisors when necessary

Charge Nurse/Relief Evening Supervisor (6/00-8/02)

Responsibilities:

- Managed twelve bed acute psychiatric unit

5/03 to 6/03 **JOHNS HOPKINS BAYVIEW MEDICAL CENTER,** Baltimore, Maryland

Administrative Intern

Responsibilities:

- Shadowed the Department of Surgery Administrator
- Performed a physician billing code analysis
- Analyzed and presented results from an operating room scheduling pilot study
- Determined nursing efficiency in the Wound Center

AFFILIATIONS

- Washington University School of Medicine, Brown Bag Lecture Series Representative, Health Administration Class of 2004, 2002-2004
- American College of Health Care Executives, Student Associate, 2002-2004
- American College of Health Care Executives, Member, 2004-Present
- National Association for Healthcare Quality, Member, 2004-Present

FACILITY

St. Louis VA Medical Center (STLVAMC)

CONTACT

Julie Carpenter, RN, MHA
Administrative Fellow
(314) 652-4100, x5308
Start Date: June 28, 2004

Executive Office/00JC
915 North Grand
St. Louis, MO 63106

PROJECT TITLE

Use of Care Coordination Home Telehealth (CCHT) to Improve Clinical Outcomes and Resource Utilization

PROJECT DESCRIPTION

Introduction

Chronic diseases complicate the lives of over 90 million Americans and are responsible for approximately 70 percent of all deaths in the United States. With these alarming outcomes, healthcare had to develop a plan to manage these diseases in a more effective and efficient manner, hence, the creation of disease management programs. Disease management programs are aimed at actively managing diseases so there are fewer exacerbations.

Objective

The objective of the CCHT program is to improve the outcomes for enrolled veterans in the following areas:

- Prompt intervention
- Decrease in overall healthcare costs
- Improve continuity of care
- Improve management of disease states
- Prevention of early institutionalization
- Improve compliance with plan of care
- Appropriate utilization of resources
- Improve level of independence
- Informed decision making
- Improve quality of life
- Improve patient and family satisfaction
- Improve provider satisfaction

Planning

A local CCHT committee was formed to guide the implementation of this program. Care Coordinators were identified based on the diagnoses included in the program. In order to ensure STLVAMC would be able to fulfill the enrollment requirement set forth by the Veterans Integrated Service Network (VISN), a patient review was completed by each Care Coordinator. STLVAMC worked closely with the VISN CCHT Steering Committee to secure funding and equipment.

Development

Before the CCHT program could be implemented, the CCHT committee had to produce a policy, create a consult, write a consent form, and design an informational brochure. In addition, all of the Care Coordinators and managers involved in the program had to complete training modules on care coordination and attend training sessions for the telehealth equipment from Health Hero. This training ensured and documented staff competency in the use of the equipment. Once all requirements were fulfilled, the Care Coordinators were able to enroll patients in the program.

RESOURCES REQUIRED FOR IMPLEMENTATION

VISN 15 was given the funds to begin the CCHT program by the Veterans Health Administration (VHA). VHA signed a national contract with Health Hero for the home telehealth equipment. Health Hero provided the medical center with Health Buddies, which are text-messaging devices and peripherals, such as weight scales and blood pressure cuffs, which interface with the Health Buddy.

Existing disease-specific care coordinators assumed telehealth coordination as a collateral responsibility.

ANTICIPATED OUTCOMES AND BENEFITS

Once the CCHT program is fully implemented, it will facilitate on-going communication and early intervention. It is expected the enrollees will experience fewer exacerbation of symptoms, which will lead to higher quality of life for the patient, fewer hospitalizations, and fewer unscheduled clinic visits, which all lead to improved customer satisfaction and cost savings for the medical center.

APPLICATION POTENTIAL AT OTHER FACILITIES

VISN 15 and other VISNs in the telehealth pilot are taking the lead from VISN 8, who experienced great success in its Care Coordination Program. Since chronic diseases affect so many of our veterans everywhere, Care Coordination Programs are one way to greatly improve patient outcomes and decrease medical center costs at any facility.

JYOTI CHADHA

E-MAIL: JYOTI.CHADHA@MED.VA.GOV
3631, HANSFORD PL, PEARLAND, TEXAS-77584 • PHONE (281) 997-0912.

EDUCATION

Master in Health Administration, University of Houston Clear-Lake 2003-finish May 2005.
Masters in Business Administration, University of Houston, Clear-Lake 1997-2000.
Post Graduate Diploma in Rehabilitation, All India Institute of Physical Medicine and Rehab, Bombay 1988-1989
Diploma in Occupational Therapy, All India Institute For Physically Handicapped, School of Occupational and Physiotherapy, New Delhi, 1984-1987. Licensed Therapist in Texas.

ACCOMPLISHMENTS

- Acting Administrative Officer for a large Geriatric unit and an entire hospital division.
- Did cost analysis of Rehabilitation Service as cost cutting exercise ($358,000).
- Led a team of OT, PT and ST as Director of Rehabilitation for regional Nursing Homes.
- Developed a Web site for more effective marketing strategy with use of available resources to cut cost and increase revenues

EXPERIENCE

2004-Present South Texas Veterans Health Care Systems, San Antonio, TX

Administrative Resident in the Director's Office. Presently involved in Telephone steering committee to centralize the telephones, Assisted living project in Kerrville and DSS project involving labor mapping for Nursing.

2003-2004 Summer internship with Baylor college of Medicine, Houston, TX.

Assisted in formulation of business plan for holistic approach in field of geriatric medicine to identify need for rehabilitation services.

2002- 2003 Memorial Hermann, Houston, TX.

Acted as education and performance co-coordinator to improve on employees performance and productivity with improving the over all process. Assisted in developing the specialized program for visually impaired with projected revenue of 500,000 dollars. Developed Web site for Home health for more effective marketing strategy with use of available resources to cut cost and increase revenues

1994–2004, Licensed Occupational therapist in state of TX

Held variety of positions, working in different settings ranging from outpatient clinics and hospitals to nursing homes, covering population from neonates to geriatrics. Assigned to different institutions to provide therapy management and consulting services. Key positions held at Richards Healthcare were: Senior Occupational Therapist, Director of Rehabilitation

1994-1994, Fawcett Memorial Hospital, Port Charlotte, Florida

Senior Therapist

1992-1994, Charing Cross Hospital, Fulham Palace Road, Hammersmith, London, UK - Occupational Therapist in Neurology

COMMUNITY SERVICE

1991-1992, Prayas Foundation for Integrated Learning, New Delhi, India

Co-Founder and Vice President of "Prayas", an experimental volunteer based integrated school for handicapped children. Responsible for administering care services, fund raising, resources through local hospitals and providing services for underprivileged children in slums.

Project Title-Enhanced Health Care Resources Sharing-Use of VA space To Create Assisted Living Unit In Kerrville

Jyoti Chadha, OTR/MBA Administrative Resident, South Texas Veterans Health Care System, San Antonio

Description & Background

The Kerrville Division (KD) of the South Texas Veterans Health Care System (STVHCS), located 65 miles Northwest of San Antonio, where it currently provides acute medical, intermediate medical, primary and long term care services for approximately 16,000 veterans residing in the Texas Hill Country. The KD has 20 authorized medical beds; a 5 bed PCU and 154 long terms care beds. Kerrville enjoys successful affiliations with local institutions such as the Schreiner, Howard Colleges and with the University of Texas Health Science Center at San Antonio. The KD has developed and extensive primary care delivery system and was the recipient of the 1994 VA Deputy Secretary's Scissors Award for their accomplishments. The KD is a major provider of health care for South Texas. The facility stands on 70 acres including a 1.7-acre inactive national cemetery.
The KD has elevated itself as center of excellence for geriatric services. It has many components for providing state of the art care for its veterans. Current services include Primary Care Teams, Specialty Clinics, Ancillary Diagnostic Services, Palliative Care, Respite Care, Long-term Dementia Care, Geriatric Primary Care, Home-Based Primary Care, Community Nursing home, and Long Term Care Rehabilitation Services. One gap in the care available to veterans with lower income is assisted living. VHA has no statutory authority to provide the room and board costs of assisted living, but can offset veterans' costs by supporting personal care through the Homemaker/Home Health Aide Program. The STVHCS sought to develop a contractor-operated assisted living program in unused space at the Kerrville facility.

Project Objective

The objective was to make assisted living services available to veterans who could not afford care in a private facility so that nursing home placement and its attendant loss of freedom and costs can be deferred or avoided. Long-term care planning data models indicate that STVHCS will experience a tripling of demand for home and community based services and nursing home care in the next ten years. Some veterans who require long-term care are eligible to receive this care at VA expense. The average per-diem for nursing home care is approximately $105, with per annum costs of $38,000/resident. For some veterans eligible for long-term care at VA expense, we believe assisted living can provide a less restrictive alternative to nursing home care. VHA will avoid the costs of nursing home care for that period of time when assisted living is able to meet the needs of the veteran. Assisted living costs top $30,000 a year according to a 2004 MetLife Study. STVHCS however, is looking for option far below that amount as most of veterans get compensation of only $875 to $1,300 a month. This new program will serve as a regional resource for frail, elderly veterans and their spouses, providing a level of care not currently available to those with income limitations.

Project Solution

Kerrville has 18,000 square foot clinical space available and has been looking for services that can benefit their veterans and the ALU appears to be a positive option. The challenge was to find regulatory support for this concept of a private ALU with in a VA facility within Statutory Title 38 governance. The Veterans Health Care Eligibility Reform Act Of 1996 expands on the "Enhanced Health Care Resources Sharing-Use of VA space" an authorization under Title 38 U.S.C. Section 8153, where sharing partners may use their own resources to make capital improvement to VA premises; however VA must approve proposed improvement in advance. The Assisted Living Information letter issued on October 7, 2003 by Secretary Principi, Department Of Veterans Affairs Central Office gave authority to VA facilities to use this authority to establish shared resource programs. All the proceeds from the sharing agreement will be credited into medical care appropriations.

The available space can be divided and used to accommodate more than 40 individuals, with provision for cafeteria-style commercial kitchen, eating and recreational areas, as well as separate entrance, exits and asphalt surface parking adjacent to the building. Dining would be communal in a large dining room area that would double as an activity room. Personal size refrigerators and microwave ovens would be permitted wherever appropriate. An appraisal company was asked to analyze fair market rent that would include maintenance, utilities (excluding telephone, computer lines, TV cable), pest control, police surveillance and

trash disposal. The suggested rental rates for Kerrville area were found to range from $11.00 to $14.52 per square foot per year.

The unit would be licensed by the State of Texas as Type B facility[1] and would be subject to all Texas statutes and regulations governing assisted living. The contract will be signed between Veterans and the vendors and will be treated as any other private facility. The STVHCS is sensitive to its role and association in such an arrangement. A program of accountability is being crafted to protect the interests of veterans in vendor provided services e.g. vendor must report the following events to VA within 24-hours of becoming aware of the event; reportable events as applicable by State requirements; incidents of mental, physical, sexual, and verbal abuse or neglect, exploitation, corporal punishment, and involuntary seclusion; sentinel events; serious injuries specifically include loss of limbs or functions; reportable or communicable diseases, for both staff and residents; change in charges to residents' or changes in the methodology used to determine charges. A Root Cause Analysis will be conducted for all incidents of abuse, neglect (as stated above) and sentinel events. For all other types of occurrences, the analysis and reporting methodology, including timeframe may be determined by VA and would follow State requirements.

The contract will be awarded for five years and in addition to clauses protecting the interests of veterans mentioned above, it includes sections protecting the interests of VA and the vendor, particularly around the capital investments made by the vendor. The objective for STVHCS is to fill a gap in the continuum of care for older, disabled, and/or chronically ill veterans by providing veterans and their spouse's access to affordable assisted living at below market cost. In addition, VA seeks to avoid costs of nursing home care for veterans who can be cared for in an assisted living facility and at the same time generate revenue from currently unused space at the Kerrville facility. There are also cost avoidance opportunities through enrollment of ALU veterans in the VA's Home-Based Primary Care Program.

Project Benefits

There are direct cost benefits to STVHCS and veterans as most the patients who are qualified to go to assisted living nursing units are kept in nursing homes which can be as much as three times more expensive than the ALU. VA is able to fill a gap in the continuum of care for older, disabled, and/or chronically ill veterans by providing veterans and their spouse's access to affordable assisted living at below market cost. In addition, VA generates revenue from currently unused space at the Kerrville facility. There are also cost avoidance opportunities through enrollment of ALU veterans in the VA's Home-Based Primary Care Program.

	Private Services	VA arranged Services
Nursing Home (semi private room)	$ 60,000/Year	$38,000/Year
Assisted Living	$ 30,000/year	$12,000/Year (Kerrville ALU)

There are intangible benefits of improved quality of life for both veterans and their spouses by keeping them in community setting. Primary care will be able to monitor more efficiently as they would have more family involvement and longevity will be improved. Patients would have the independence of living in community setting and retain access to all the amenities of the hospital. The relatively cool climate of the Texas Hill Country, picturesque campus-like grounds of the Kerrville VA, and ability to accommodate spouses will make this program very attractive to veterans throughout the large catchments area of the STVHCS. Patient satisfaction will increase and thus it will reflect on our performance measure. KD will be one stop-shopping model for Excellence in Geriatric continuum of care.

Application Potential for other facilities

This effort can serve as a model for all VA facilities interested in sharing their facility space, Staff and Services. VHA will defer the cost of nursing home care for The period of time when assisted living is able to meet the needs of the veteran. Veterans and their spouse's gain access to affordable assisted living at below market cost. Because of use of local contractors competing for this space, the VA/STVHCS will be supporting, not competing with the local business community.

1. In a Type B facility a resident may: require staff assistance to evacuate; be incapable of following directions under emergency conditions; require attendance during nighttime sleeping hours; or not be permanently bedfast, but may require assistance in transferring to and from a wheelchair

STEVE CHANG-LUNG CHIU

steve.chiu@med.va.gov • 310.478.3711 x49828

VA Greater Los Angeles Healthcare System • 11301 Wilshire Blvd. (691/00) • Los Angeles, CA 90073

WORK EXPERIENCE

VA Greater Los Angeles Healthcare System June – Oct 03, July 04 – present
Administrative Fellow, Administrative Intern (2003)

- Redesigned the Physical Medicine and & Rehabilitation resident curriculum to better meet patient needs and to comply with new ACGME standards
- Developed a CPRS-based method for identifying patients with complex conditions for more appropriate care and VERA reimbursement
- Restructured equipment purchase process to include clinical participation, an objective equipment prioritization metric, and collaboration with the Strategic Planning Committee
- Organized the effort to convert acute care nursing wards to a completely paperless system

Health Services Department, UCLA School of Public Health Sept - Dec 03 & Apr - June 04
Teaching Assistant, Health Services Organization and Finance

- Led discussions concerning a wide range of aspects of the U.S. healthcare system to teach public health students of all emphases the importance of healthcare finance and organization in their respective fields of study
- Wrote examinations on the course's core concepts, which were well received by both professor and students

AIDS / HIV Caregiving Study, UCLA School of Public Health Dec 02 - June 03
Staff Research Associate

- Conducted reviews and critiques of the surveys on which this study of HIV caregiving stress was centered
- Inspected computer-based questionnaires for glitches

ACTIVITIES

Public Health Students Association, Community Outreach Chair, UCLA. 2003 - 2004

- Constructed network of UCLA schools and organizations to start an ongoing campus-wide food and clothing drive for local homeless programs
- Utilized network in developing a business plan and designing a health education fair for the homeless and mentally ill women of the Ocean Park Community Center's Daybreak Shelter

American College of Healthcare Executives, Fundraising Co-Chair, UCLA. 2002 - 2003

- Organized various fundraisers including TV tapings, raffles, and social events to help raise over $2500 for ACHE and $350 for the cause of healthcare for the homeless
- Promoted and participated in the programs of other ACHE committees including child ID fingerprinting and Medi-Cal / Healthy Families Program information fairs

HONORS / AWARDS

STEPHEN W. GAMBLE AWARD FOR HEALTH CARE LEADERSHIP 2004
JOHNS HOPKINS STUDENT EXCELLENCE AWARD FOR LEADERSHIP AND SERVICE 2002
JOHNS HOPKINS UNIVERSITY OUTSTANDING LEADERSHIP AWARD 2001 - 2002

EDUCATION

Master of Public Health, University of California - Los Angeles June 2004
School of Public Health, Health Services Department, Health Policy Track

Bachelor of Arts, Johns Hopkins University May 2002
Biology with a minor in Psychology, Dean's List 2001-2002

SKILLS

Writing, editing, research, & presentation skills, experience with Word, PowerPoint, Excel, CPRS, VistA, & QDS

Facility: VA Greater Los Angeles Healthcare System
Start Date: 26 July 2004

Contact: Steve C. Chiu, MPH
Administrative Fellow
11301 Wilshire Blvd.
Los Angeles, CA 90073
(310) 478-3711 extension 49828

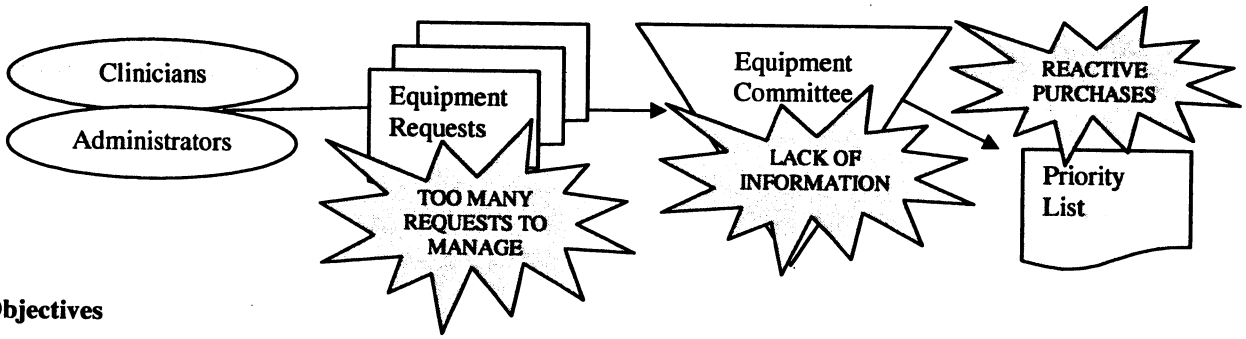
FULLY EQUIPPED:

Improving the Equipment Purchase Process at the VA Greater Los Angeles Healthcare System

Background

The process for purchasing equipment at the VA Greater Los Angeles Healthcare System (VAGLAHS) is tedious, subjective, and reactive. The Equipment Committee receives hundreds of clinical and administrative equipment requests per year, is forced to make impossible decisions between priorities that do not compare well (i.e., promoting patient safety v. implementing JCAHO recommendations), and is regularly faced with unanticipated emergency equipment needs. The committee is also often made to choose between funding two different pieces of clinical equipment based on highly technical medical justifications that few or none of its members understand.

Current Equipment Request Process



Objectives

The objectives of this project are to a.) investigate the problems with the current equipment purchase process, b.) recommend solutions, c.) refine recommendations and gain buy-in from stakeholders, and d.) implement recommendations.

Planning

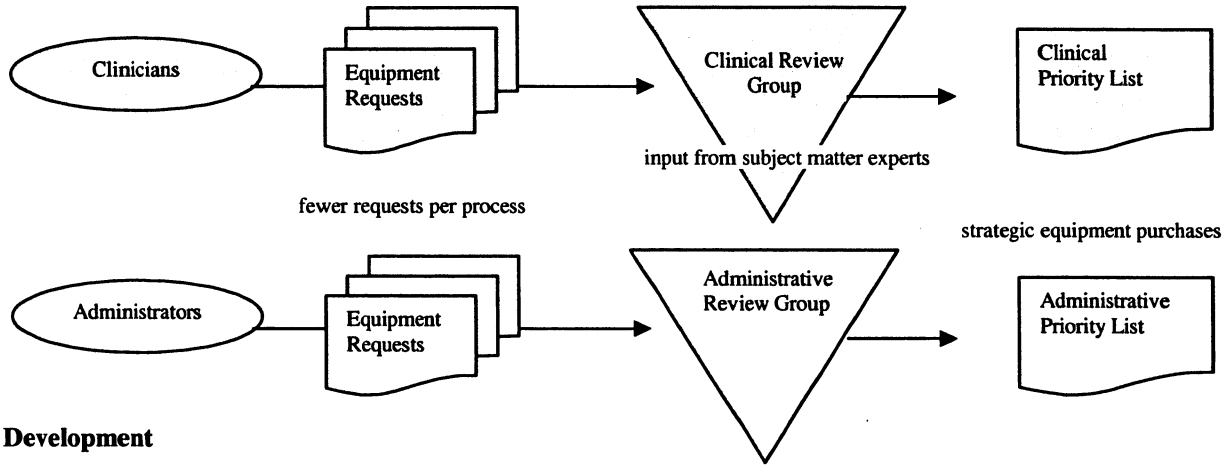
To investigate the problems with the current equipment purchase process, an immersion learning technique was employed. This technique involved learning to enter a VistA equipment request, interviewing various staff involved in the current process, and attending meetings of the Equipment Committee. This investigation revealed four major problems with the current equipment purchase process:

1. Arbitrary Equipment Prioritization Methodology
2. Vague Protocols
3. Lack of a Strategic Plan for Purchasing
4. Lack of Involvement by Subject Matter Experts

In response to the problems above, the following recommendations were made:

1. Develop a metric for judging the value of a piece of requested equipment.
2. Write a formal Standard Operating Procedure (SOP) to delineate the finer details of the process.
3. Collaborate with the VAGLAHS' new Strategic Planning Committee.
4. Divide the equipment purchase process into two parallel processes. In these parallel processes, review groups staffed by clinicians and administrators will replace the existing Equipment Committee.

Proposed Equipment Request Process



Development

To refine the recommendations and to gain buy-in from stakeholders, the recommendations were presented to different groups, including the Equipment Committee and the Hospital Services Operations Council. Smaller focus groups within the Equipment Committee were also held. Attempts were made to address each concern that arose during the presentations.

In regards to implementation, the equipment value metric has been finalized, will be used by the review groups in making objective decisions, and will be shared with equipment requesters. An SOP is in the process of being written; the equipment value metric will be written into the SOP along with the role of the Strategic Planning Committee. The SOP will steer the implementation of the new equipment purchase process, while the Strategic Planning Committee will guide the future decisions of the review groups.

Anticipated Costs and Benefits

Costs: The core of this process improvement project requires no technological or material solutions. As such, the cost of this project will not extend beyond the staff hours that were and will be expended in implementing the above recommendations.

Benefit 1 – *Time Saved*: Separation of the current equipment purchase process into two parallel processes will save staff time (though it is acknowledged that some of the clinical staff hours required by the new process may be more expensive than the hours put in by administrators in the current process). Further measures to eliminate the filing of unnecessary forms (as outlined in the SOP) will save even more staff time.

Benefit 2 – *Money Saved*: The addition of subject matter experts into the equipment purchase process and the future partnership with the Strategic Planning Committee will allow GLA to make more informed purchases, to identify opportunities for sharing equipment, to recognize and prevent potential equipment emergencies, to reduce duplicative purchases, to reduce clinical and administrative errors by standardizing the equipment fleet, and to spend less and receive more overall.

Application Potential in Other Facilities

In this time of growing workload for staff, drastically diminished budgets, and increasing technological needs, every facility must learn to save time and money while coordinating expenditures to get the greatest benefit for the lowest cost. The principles behind the proposed process for purchasing equipment at the VAGLAHS can accomplish those objectives for any VA facility, large or small. Every VA facility may use the metric that was developed for GLA (1), should have a similar SOP (2), and should tie their equipment purchases to the recommendations of a strategic planning committee (3). As for the parallel clinical and administrative processes (4); they are most suitable for larger VA facilities and may even find beneficial applications in entire healthcare systems or Veterans Integrated Service Networks.

William Matthew (Matt) Cox

500 Avalon Way #1317, Brandon, MS 39047
Phone: (601) 368-3887 Mobile: (901) 493-7846 E-Mail: wmattcox@yahoo.com

Objective: To develop medical center operational knowledge and technical skills so as to assume a position of greater responsibility in healthcare administration.

Education:

University of Memphis — Memphis, TN
Master of Health Administration
Graduated: May 2004

University of Mississippi — Oxford, MS
Bachelor of Business Administration
Graduated: May 2000

Work Experience:

6/04-Present — G.V. (Sonny) Montgomery VA Medical Center — Jackson, MS
Administrative Fellow

- Completed service level rotations
- Participated in and developed minutes for executive level meetings
- Developed and implemented departmental improvement projects (e.g. Advanced Clinic Access, PM&RS Staffing Evaluation, Developed Training Plan for AOs, etc.)
- Coordinated facility wide Combined Federal Campaign (CFC)

1/04-4/04 — Regional Medical Center at Memphis — Memphis, TN
Administrative Intern

- Participated in departmental rotations
- Created business plan for geriatrics unit
- Observed senior level management process
- Assisted in contract negotiations

8/03-5/04 — University of Memphis — Memphis, TN
Child Health Data Consortium
Graduate Assistant

- Processed and compiled child health data
- Utilized geographic imaging software (Arc GIS)
- Gained research experience

Professional Activities:

University of Memphis Student Chapter of the American College of Healthcare Executives- 2002-Present

- Vice President

American College of Healthcare Executives- 2002-Present

Medical Group Management Association- 2002-Present

American College of Medical Practice Executives- 2002-Present

Healthcare Financial Management Association- 2003-Present

References Available Upon Request

Facility

G.V. (Sonny) Montgomery VA Medical Center
Jackson, Mississippi

Contact

Matt Cox
Administrative Fellow
1500 E. Woodrow Wilson Dr.
Jackson, MS 39216
(601) 368-3887
Training Start Date: June 2004

Project Title

Analysis of the Advanced Clinic Access Program at the G.V. (Sonny) Montgomery VA Medical Center

Project Description

Advanced clinic access was originally implemented at the G.V. (Sonny) Montgomery VA Medical Center in 1999. At that time, a team composed of personnel from various services executed the program. This team began the implementation in primary care and extended it to specialty areas. With VHA's continued focus on advanced access, it became apparent that a different approach was needed. This new approach consisted of the creation of both the Advanced Clinic Access Coordinator position and the Advanced Clinic Access Committee. The Advanced Clinic Access Coordinator reports directly to the Nurse Executive but interacts daily in a staff capacity with the Director, Associate Director, and Chief of Staff. This reporting structure allows the Coordinator the autonomy and authority to implement the principles of advanced access. In addition, this structure allows the executive leadership team to intervene in the event of any noncompliance. The Advanced Clinic Access Coordinator is a full time position solely focused on implementing the advanced clinic access principles throughout the medical center and sustaining the gains made from this implementation. This position can be described as an in house consultant who works with the clinics to successfully implement this program.

During the process of reemphasizing advanced clinic access throughout the medical center, many barriers have become more apparent. These include lack of provider buy-in, limited physical plant capacity, increasing patient demand for services, provider productivity, multiple measures of wait times, limited community resources for contracting, provider recruitment, and lack of resources. To overcome these barriers, the medical center has undertaken many new initiatives. These initiatives include the use of telemedicine and locum tenums, creating the advanced clinic access coordinator position, chartering an advanced clinic access committee, implementing group appointments, and expanding primary care teams.

During November of FY 2005, advanced clinic access was reemphasized in Neurology Service. The following is a detailed list of the steps completed or ongoing concerning this reemphasis.

1. BACKLOG
    a. Baseline data on waiting times, number of no shows, and number of inappropriate consults was collected.
    b. Analyzed baseline data and oriented clinic staff to advanced access principles.
    c. Neurology operations were observed to determine if the providers, clerks, or nurses contributed to the backlog.
    d. Plan developed to implement all of the ten key changes.
2. REDUCE DEMAND
    a. Neurology consults were reviewed for appropriateness.
    b. Service agreements between Primary Care and Neurology were restructured to reduce inappropriate consults.
    c. Return intervals were scrutinized to determine patients that were stable.
    d. Patients with abnormal return intervals and determined to be stable were recommended for discharge from Neurology. At this time, a total of fifty patients of the 300 identified as stable have been discharged. This is an ongoing process.

The next steps in Neurology Service's plan are as follows:

3. UNDERSTAND SUPPLY AND DEMAND
4. REDUCE APPOINTMENT TYPES
5. PLAN FOR CONTINGENCIES
6. MANAGE THE CONSTRAINT
7. OPTIMIZE THE CARE TEAM
8. SYNCHRONIZE PATIENT, PROVIDER, AND DATA
9. PREDICT AND ANTICIPATE PATIENT NEEDS
10. OPTIMIZE ROOMS AND EQUIPMENT

When all ten key changes have been implemented, the expected results include a significant reduction in waiting times, reduction of no shows, and a reduction of inappropriate consults/referrals. It is further expected that these changes will bring about an increase in patient/provider satisfaction, improved continuity of care, and a reduction in costs associated with all of the improvements.

Application Potential in Other Facilities

The principles of advanced clinic access are applicable to all VA medical centers as well as all other public healthcare institutions. The application of the advanced clinic access principles is governed only by the willingness of the leadership team to employ the change. Clinical and non-clinical support is also critical for the successful implementation of this program.

Resources Required for Implementation

Staff- An individual should be identified to manage this program. This individual should have a clinical background, the capacity for data analysis, and the people skills necessary to keep staff motivated to achieve the appropriate results. This individual will need to report directly to top leadership.
Committee Structure- An Advanced Clinic Access Committee will need to be added to help manage the implementation of the advanced access principles. This committee's responsibilities should include clinic wait times (waiting for appointments), next available appointments, service availability, outpatient customer satisfaction, wait time performance measures, consult tracking and completion, and clinic cancellation rates. This will also include the review of no-show and walk-in rates and trends for all clinics.

Outcomes, Benefits, and Cost Savings

Advanced clinic access has reduced the medical center's wait times, no shows, and inappropriate consults. The following chart illustrates some of the improvements made in the performance measure clinics by implementing the principles of advanced clinic access.

Clinic	Percent of Next Available Appointments Seen in 30 Days		Next Available Wait Time	
	June 2001	June 2004	June 2001	June 2004
Audiology	71.70%	98.20%	18.3	11
Cardiology	44.20%	100.00%	37.4	16.5
Combined GI	44.00%	80.00%	55.7	8
Combined Mental Health	62.90%	81.00%	29	18.4
Combined Primary Care	57.90%	95.50%	56.2	10.6
Eye Care	84.60%	98.00%	24	16.3
Podiatry	0.00%	66.70%	120.9	44.8
Urology	76.90%	100.00%	20.3	23.9

These improvements have lead to enhanced patient/provider satisfaction and improved continuity of care. In addition, the costs associated with no shows and inappropriate consults have been reduced.

Since the implementation of advanced access requires many months, these results have not been realized in Neurology Service at the present time. Some preliminary calculations do indicate that the measures (wait times and no shows) are showing positive trends.

Future Direction

The G.V. (Sonny) Montgomery VA Medical Center is committed to fully implementing the principles of advanced clinic access. The process of fully implementing advanced access consists of disseminating the principles throughout the medical center and sustaining the gains already made from previous implementations. Although the process will be challenging, the end product will be a more efficient and cost effective healthcare delivery system.

Charlene D. Daniel

75 SW 75h St., F28
Gainesville, FL 32607

(352) 219-3445
cdee817@hotmail.com

EDUCATION

Master of Health Administration
2002-2004
University of Florida, Gainesville, Florida

Bachelor of Health Science in Rehabilitative Services
Minor: Business Administration
1997-2001
University of Florida, Gainesville, Florida

EXPERIENCE

North Florida/South Georgia Veterans Health System

Administrative Fellow (June 2004 - present)

- Performed an unannounced Audit of the Agent Cashier for compliance with applicable laws, policies, procedures, and quality assurance.
- Conducted a General Audit of the Business Office for Fiscal Quality Assurance for FY 2004.
- Performed study of orthopedic surgery operating room utilization efficiency for performance improvement.
- Responsible for preparing Management Briefings for Nursing, Prosthetics, and Human Resources Services.
- Created Access database to provide centralized system for tracking contracted providers, department vacancies, and justification of contact renewals.
- Responsible for preparing final reports to the Associate Chief of Staff for Outpatient Clinics as a member of outpatient clinic process review team.
- Assisted with completion of business plans for proposed VA Community Based Outpatient Clinic in Jackson, Putnam, and South Marion County, Florida.
- Responsible for creating on-line Baldrige National Quality survey and guiding three Services with self-assessment and action planning based on survey results.

Shands Hospital at the University of Florida

Administrative Intern (May 2003- August 2003)

- Developed business/marketing plan for Department of Radiation Oncology, which examined the profitability of maintaining two Cancer Centers.
- Prepared storyboards for Joint Commission on Accreditation of Healthcare Organizations survey.
- Analyzed and reported results of pilot employee fitness program which recommended fee structure for hospital-wide program.

Administrative Intern (August 2001- December 2001)

- Prepared analysis of top 40 high frequency and top 40 high dollar procedures based on department and CPT codes from 1996-1999 for Managed Care Contracting & Financial Analysis Department.
- Analyzed May 2000 fee schedules based on CPT code to National 50th, 75th, and 90th percentile rates.

Administrative Intern (May 2000- August 2000)

- Audited cost of patients receiving benefits after contract termination for Managed Care Department.
- Assisted with Managed Care orientation that explained the importance of managed care, aspects of insurance, patient advocacy, and quality care.

Component Specialist (October 2002 – May 2004)

- Responsible for pooling blood and blood products for transfusion, performing routine laboratory clerical procedures, collecting and distributing patient specimens, and the preparation of specimens for analysis.

PROFESSIONAL MEMBERSHIPS

American College of Healthcare Executives (ACHE) National Association of Health Services Executives (NAHSE)

Charlene D. Daniel
Administrative Fellow
North Florida/South Georgia Veterans Health System
1601 S.W. Archer Road
Gainesville, FL 32608
(352) 376-1611 ext 5614
Training Start Date: June 7, 2004

Orthopedic Surgery Operating Room Utilization Efficiency

BACKGROUND

The number of surgical procedures performed at North Florida/South Georgia Veterans Health System rose 2.5% from FY 2003 to FY 2004. In the first quarter of FY 2005, surgeries increased 6.4% compared to the first quarter of FY 2004. Continuous quality improvement efforts have enhanced operating room (OR) efficiency, creating opportunities for performing additional cases. In an attempt to meet the demands of growing caseloads, orthopedic surgery has requested the permanent use of a second operating room, which would increase weekly OR time from 46 to 64 hours.

The OR Committee evaluated the feasibility of this request and discovered data that suggested current orthopedic OR time is underutilized. Delays in surgery start times and turnover times were documented for 118 out of 141 cases in the first quarter of FY 2005, and 45 out 48 cases in January 2005. Delays in surgery start times and turnover times compromise the efficient utilization of OR time, and have serious implications in patient wait times, throughput, and continuity of care. Although, there are inherent delays to surgery start and turnover times due to the interdependences of numerous services, identifying reasons for the delays will be beneficial to OR efficiency and performance improvement in orthopedic surgery.

OBJECTIVE

To enhance Orthopedic Surgery operating room efficiency by:

- Identifying delays influencing operating room start times and turnover times.
- Proposing and implementing improvements to reduce process delays.
- Decreasing delays in start times and turnover times to eliminate underutilization of OR time.

PLANNING AND DEVELOPMENT

To accomplish the stated objectives, orthopedic surgeries will be observed during February 2005. The patient will be followed from the pre-op holding room to the operating room and start and turnover times will be recorded along with reasons for delays. Next, a flow chart of the process will be created to identify delays in patient flow and gaps in the system. Then a cause-effect analysis will be conducted to set priorities and goals for improvement. Through the observational data collected delay causes will be identified and recommendations proposed. Lastly, an action plan will be developed, implemented, and monitored for successful reduction in start and turnover time delays.

APPLICATION POTENTIAL IN OTHER FACILITIES

Continuous performance improvement is a universal concept throughout VHA. Managing OR efficiency by reducing delays in start and turnover times is applicable to other facilities and a priority of all surgical services. Other facilities can adapt the understand, analyze, and improve model of performance improvement to recognize areas of operating room work flow and process delays to best achieve their organizational goals.

BENEFITS, COST-SAVINGS

Gains in performance improvement will greatly impact inefficient use of operating room times, patient wait times, and enhance the effectiveness of current allocated operating room times. Decreasing delays in start and turnover times will improve quality of care by reducing patient wait times and eliminating unnecessary anxiety to both the patient and their families caused by delays. In addition, process improvement diminishes the intrinsic cost of re-work, and waste associated with inefficient systems. Since most OR nurses are full-time hourly or salaried employees, the cost of providing nursing care during scheduled hours is a sunk cost, however the underutilization of operating room times reduce productivity. Opportunity costs are associated with the inability of surgical sections with comparable growth in caseload to orthopedic surgery to increase their operating room time.

RESOURCES REQUIRED FOR IMPLEMENTATION

Resources required for implementation include support and buy-in from the chief of surgery service, the associate chief of nursing for OR, attending surgeons and anesthesiologists, resident surgeons and anesthesiologists, the charge nurse, operating room nurses, pre-op holding nurses, supply processing and distribution section, environmental services, and other stakeholders in OR management. Additional resources will be established during data collection, and observations of the patient flow in orthopedic surgery operating room.

OUTCOMES

The target outcome of this process is to reduce start and turnover time delays in orthopedic surgeries, identify and eliminate gaps in operating room work flow process, and implement changes to provide efficiency in utilization of operating room time beneficial to all areas of surgical service.

TRACYE B. DAVIS

635 E Waterfront Dr., Apt. #5307
Homestead, PA 15120

Phone: (314) 368-9817
email: davis_tracye@yahoo.com

OBJECTIVE

I am an energetic, results-oriented professional with proven leadership, analytical, and critical thinking skills seeking an administrative position in which to advance my career within the VA healthcare system.

EDUCATION

Washington University School of Medicine, St. Louis, MO — 2004
Masters of Health Administration

Trinity University, San Antonio, TX — 2002
Bachelor of Science, Biology

PROFESSIONAL EXPERIENCE

VA Pittsburgh Healthcare System, Pittsburgh, PA — 6/2004-Present

Administrative Fellow

- Compiled and analyzed data from the annual employee satisfaction survey. Led work groups to review results and develop action plans. Monitored the progress of action plan implementation.
- Worked with dementia care unit staff to incorporate the "Eden Alternate." Resulted in a minimization of medications, decreased assaults, and decreased falls.
- Served as the interim Compliance Officer. Responsibilities included monthly part-time physician time and attendance audits, bi-weekly audits of unsigned notes and orders, and the submission of monthly billing indicator reports and quarterly compliance education reports to the VISN.
- Served as the interim Quality & Patient Safety Specialist. Responsibilities included the preparation of quality assurance reports, participating in root cause analysis teams, the publication of monthly newsletters, conducting mock tracers in preparation for external review, and the coordination of system-wide Quality & Patient Safety events.

Washington University School of Medicine, St. Louis, MO — 10/2002--5/2004

Research Intern

Hand Hygiene Study:

- Observed staff on intensive care units to track the use of anti-microbial soap and hand sanitizer.
- Created and presented educational materials on hand hygiene to medical staff.
- Analyzed data to determine if hand hygiene compliance increased post-education.

Influenza Study:

- Reviewed patient medical charts to identify a pool of at-risk patients to participate in the study.
- Explained the objectives and potential risks of the study to patients to gain consent, and performed nasopharyngeal swabs to collect samples.
- Tracked the occurrence of influenza to determine if and where the virus was being spread.

Boston Medical Center, Boston, MA — 5/2003-8/2003

Health Administration Intern

- Administered surveys on all patient units to assess HIPAA compliance. Reported results to senior management and proposed recommendations for improvement.
- Observed in-patient unit staff on the communication of critical results. Observations revealed that there was no system in place to ensure critical results were given to the responsible provider in a timely manner and the "read-back" system was not being used consistently. Results led to the establishment of a work group to address those issues
- Wrote and edited proposals for nursing research grants.
- Assisted with the development and implementation of a continuing education program to increase awareness of nursing research.

VA Pittsburgh Healthcare System

Contact: Tracye B.Davis, M.H.A
Administrative Fellow
7180 Highland Drive, 003B-H
Pittsburgh, PA 15206
(412) 365-4042

School Affiliation: Washington University (St. Louis, MO)

Start Date: June 28, 2004

Transforming Dementia Specialty Care with the Eden Alternative

Background:

Many people believe that to enter a nursing home is to take an irreversible step down the path toward disability and death. However, Harvard-trained physician William H. Thomas knew that nursing homes could be more than just a place to house the elderly until death. In 1991, Dr. Thomas proposed the Eden Alternative: a vision of something better and a dramatic change in the way nursing homes operate and exist.

The core concept of the Eden Alternative is to eliminate the plagues of loneliness, helplessness, and boredom among elderly patients by putting the "home" in "nursing home." It is a culture change involving the transition from the established medical model to a person-centered, human habitat model by incorporating plants, animals, children, variety, and life. Thus, loneliness is replaced with companionship, helplessness is replaced with hope, and boredom is replaced with spontaneity. Furthermore, patients and staff will feel empowered as a spirit of commitment, community, and growth is created. Once this happens, a nursing home will finally be capable of providing genuine long-term care.

Objective:

The Eden Alternative is currently being implemented on the Dementia Special Care Unit of VA Pittsburgh Healthcare System's Heinz III Progressive Care Center. The goal of this project is to improve the well-being of the dementia residents and those who care for them by transforming the unit into a human habitat where life revolves around relationships that provide a pathway to a life worth living. Such a habitat is based on the psychosocial, residential model of care that includes close and continuing contact with plants, animals, children, and the outdoors.

Planning/Implementation/Development:

Implementation of the Eden Alternative officially began in April of 2004. The following changes have been made since its inception:

- ✓ An activity room has been added that is furnished with a player piano, wall mural, basketball arcade game, pool table, and foosball table.
- ✓ Staff are being trained to lead reminiscing groups to stimulate patients' minds.
- ✓ Patients are responsible for watering, weeding, and caring for plants that have been added throughout the unit and in the outdoor patio/garden area.
- ✓ Music from live bands, the player piano, and the record player is bringing additional life to the unit.
- ✓ Activities, both scheduled and unscheduled, are more available. These activities include off-station field trips, crafts, birthday parties, etc.
- ✓ The former bedtime routine was eliminated allowing the residents to decide when they are ready to sleep.
- ✓ The smoking lounge has been eliminated to provide a healthier environment for the residents.
- ✓ Aromatherapy is used to stimulate residents.
- ✓ Animals are on the unit. A bird sanctuary with two love birds, an aquarium with a variety of fish, and a dog named Scooter are now a part of the Dementia Special Care Unit community.
- ✓ A support group for caregivers has been implemented so that residents' families can offer input and suggestions.
- ✓ Under the direction of the team physician and through a collaborative effort of all staff, patients are weaned off whatever medications possible and are only given the least amount of appropriate medications.
- ✓ The unit accepts more visitors, including schoolchildren, pet therapists, and music therapists.
- ✓ Construction has been done on the entrance and dining room to create more space on the unit.

Some of the future plans for the Dementia Special Care Unit include: (1) the implementation of a dining choice program that would allow the residents to select their own meals from a menu of options, (2) remodeling of the communal bathroom to include a whirlpool tub, shower for ambulatory residents, and separate dressing areas, and (3) the addition of a large "social space" with lounge furniture where residents can gather.

Benefits/Outcomes:

Numerous benefits have occurred since the implementation of the Eden Alternative. First, the Dementia Special Care Unit now has the lowest average number of medications per patient than any other unit in the facility. The fall rate has decreased by 23%, and the assault rate has decreased by 73%. Furthermore, the residents are more engaged, have better attention focus, and exhibit increased leg strength.

K. Todd Donehoo

Home:
3630 Loyola Drive #142
Kenner, LA 70065
(504) 305-4266
tdonehoo@cox.net

Business:
1601 Perdido Street
New Orleans, LA 70112
(504) 568-0811 ext. 2568
todd.donehoo@med.va.gov

EDUCATION:

2002-2005 **University of Alabama at Birmingham, Alabama**
Master of Science in Health Administration
Degree to be awarded May 2005

Master of Science in Health Informatics
Degree awarded August 2004

1988-1990 **Auburn University, Auburn, Alabama**
Bachelor of Science in Business Administration: Finance
Degree awarded August 1990

EXPERIENCE:

2004 - **VA Medical Center** **New Orleans, LA**
Administrative Resident
- Designed and managed project to facilitate tracking/reporting of outpatient provider wait times.
- Project and committee activities to include HPDM, Eye Clinic reorganization, Disaster Preparedness, VAMC space/utilization survey, Combined Fed Campaign and others.
- Rotated through all Service Lines and Corporate Functions, VISN and Central Offices.
- Presented multiple subject matter topics to top management and leadership team.

2000-2001 **E-Loan.com** **Jacksonville, FL**
Sales and Service Manager; Processing Manager
- Operations management activities; direct leadership for five supervisors and their teams performing functionally specific activities in support of the overall business model.
- Customer service and retention; strategic planning and process improvement implementation.
- Team development: hiring, performance feedback, leader selection and mentoring.

1996-2000 **EDS – Electronic Data Systems** **Phoenix, AZ and Montgomery, AL**
Operations Management; Implementation Supervisor
- Actively engaged in three new account implementations and ongoing account operations management: William D. Ford Federal Direct Student Loan Program (loan origination and loan consolidation), Mitsubishi Electronics, Mitsubishi Wireless Communications, GM Roadside.
- Performed various tasks and roles to include applicant screening, interviewing, hiring, training, compensation, corrective action administration, quality assurance, process documentation and congressional correspondence.

1992-1996 **Region's Financial Corporation** **Montgomery, AL and Ft. Walton Beach, FL**
Branch Manager; Loan Officer
- Managed branch staff and day-to-day operational activities.
- Experienced consumer and mortgage lender with some commercial loans in the portfolio.

1991-1992 **Norwest Financial, Incorporated,** **Ft. Walton Beach, FL**
Credit Manager
- High volume consumer lending, collection and marketing activities.

American College of Healthcare Executives, Student Member, 2002 to present.
Healthcare Financial Management Association, Student Member, 2003 to present.

IMPROVING PATIENT SATISFACTION

PROVIDER WAIT TIME TRACKING & REPORTING

Todd Donehoo

Administrative Resident

VA Medical Center, 1601 Perdido Street, New Orleans, Louisiana 70112-1262
Todd.Donehoo@Med.VA.Gov Office: (504)568-0811 x2568 Fax: (504)589-5211

Project Description

The primary driver for this project was the inability to accurately track and quickly report how long patients waited to see their provider. Question #6 in the Survey of Healthcare Experiences of Patients (SHEP) asks, "How long after the time when your appointment was scheduled to begin did you wait to be seen?"

Prior to project implementation, clinic wait time performance was measured by the percentage of outpatients who responded to the SHEP and report waiting for a provider 20 minutes or less. The returned SHEP results are rolled up into quarterly reports with data that is three to six months old and purely subjective based on patient memory or perception.

The Provider Wait Time Tracking and Reporting project was conceived as a vehicle for improving the delivery speed and objectivity of wait time data for the New Orleans VA Medical Center outpatient clinics. The belief is that readily available performance measure information should be available as desired and in a format that empowers leaders to respond to clinic service delivery issues in a timely and focused manner.

Project Objectives

Previous attempts to document patient flow through the clinics and the time waiting to see a provider were conducted manually with a clipboard and stopwatch. Those efforts were labor intensive and required additional person-hours to enter data into a database. This manual tracking process was not cost effective and therefore unsustainable over time.

The Provider Wait Time Tracking and Reporting project objective was to automate the collection of data variables such as the time when the patient checked in, the scheduled appointment time and the time when the provider actually sees the patient. The implemented process incorporates the use of barcode scanners located at each PSA station to scan the Veterans Identification Card (VIC) just prior to entering the exam room with the provider.

Project Planning and Development

The planning and development activities were divided into four general phases:

1) Assessment of current Vista data, clinic processes and available resources.
2) Identification of data, processes and resources to be developed, acquired or purchased.
3) Creation and/or refinement of processes; stakeholder buy-in and consensus building.
4) Installation, testing and reporting results followed by full project implementation.

Of note – the majority of planning and development activities centered on relationship and consensus building with clinic staff and incorporating their ideas and suggestions into the final implementation model.

Potential Project Applications

Project generated data and the subsequent information it provides will help to facilitate administrative decision-making. A few project data application examples are listed below:

- Tracking clinic start times.
- Provider-specific performance.
- Ad-hoc reporting by specialty, etc.
- Allocating appointment time slots.
- Staffing level justifications.
- Identifying intraday problem times.
- Focusing leadership/staff attention.
- Performance trending.

Implementation Resources Required

Internal: Vista query programming, hardware and peripheries installation.

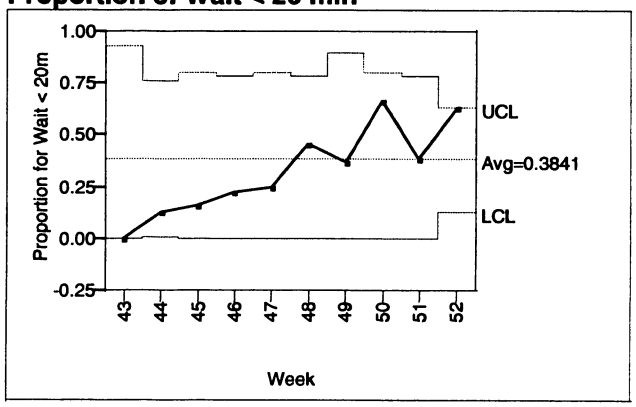
External: Purchase bar code scanners, brackets and cables.

Outcomes/Benefits

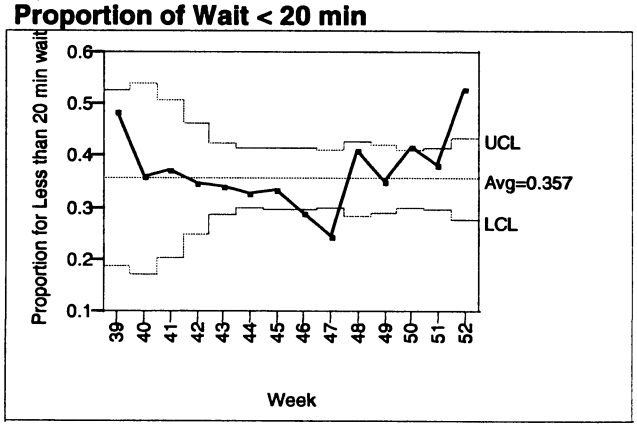
Following project implementation, the objective point of service data became available to Medical Center leaders within 24 hours of its capture. The data, captured electronically by scanning the patient VIC, may be used for a variety of analyses and reporting purposes. At the New Orleans VA Medical Center, this new source of information helps leaders "drill down" and focus on specific portions of individual clinic processes as desired. One significant result is that process improvement time and effort is minimized and operational efficiency is increasing.

In the charts below it is evident that variation in provider wait time performance still exists. What is most important to note is the upward trending performance measures for Primary Care and for all outpatient specialty clinics since full implementation in week 43.

PRIMARY CARE / MEDICINE
Proportion of Wait < 20 min



ALL CLINICS - ALL DATA
Proportion of Wait < 20 min



The full impact and potential of this project implementation has yet to be realized, however, the response from clinical and Medical Center leaders has been positive. The information derived from this project will help to raise the awareness of providers with regard to the timeliness of service delivery and overall performance.

Evidence of project acceptance includes the Associate Chief of Staff for Quality Improvement submitting it to the VISN as a best practice. Another example is the Ambulatory & Primary Care Associate Director for Clinical Operations publishing an article featuring the project's challenges and outcomes to the National Association of VA Ambulatory Care Managers (NAVAAM) Newsletter.

JON DUCKERT

5225 Maple Ave #5310
Dallas, Texas 75235
903-244-6456
Jon.Duckert@med.va.gov

EDUCATION:

Trinity University, San Antonio, TX
M.S., Health Care Administration
December 2005

University of Texas, Austin, TX
B.A., Biology
May 2003

EXPERIENCE:

1/05-Present — **Administrative Resident, VA North Texas Health Care System** – Dallas, TX

6/04-12/04 — **Intern, Aetna** – San Antonio, TX
- Developed provider networks in new geographic markets
- Assisted with the pricing and negotiating of facility contracts
- Participated in network oversight committees and sales meetings

5/02-9/02 — **Research Assistant, University of Texas** – Austin, TX
- Researched lizard brain receptors responsible for mating behavior
- Ensured high quality DNA synthesis, gel electrophoresis, and bacterial cultures
- Maintained detailed notes critical for team's research

5/01-11/01, 3/02-7/02 — **Clinical Assistant, Brackenridge Hospital** – Austin, TX
- Delivered direct patient care and assisted nursing staff
- Participated in a primary care team model to increase nurse retention
- Gained different perspectives of care from doctors, nurses, and patients
- Acquired an understanding of workflow at the clinical level

ACTIVITIES:

Volunteer Activities
- Volunteered at Race for the Cure – 3/04
- Child Life Program volunteer at CHRISTUS Santa Rosa – 2/04
- Ushered Drug Free Awareness Concert – 10/03
- Volunteered at Parmer Woods Nursing Home – 11/02, 3/03
- Participated in City Wide Hold Up benefiting Easter Seals – 10/02
- Hosted Spring Classic Softball Tournament benefiting Children's Medical Center Foundation of Central Texas – 4/02, 4/03
- Participated in Project 2002 benefiting Austin area residents – 2/02
- Hosted Baseball Clinic for underprivileged children – 10/01

Extracurricular Activities
- Service Event Officer –Trinity University's Health Care Student Association
- Student Associate – American College of Healthcare Executives
- Student Member – Medical Group Management Association
- Texas Iron Spikes – 8/99 to 5/03

HONORS:

- Trinity University Graduate Assistantship
- University of Texas Dean's List
- Eagle Scout

CONTACT

Jon Duckert, Administrative Resident (Training Start Date: January 9, 2005)
VA North Texas Health Care System
4500 S. Lancaster
Dallas, TX 75216
Phone: (214) 857-1147
Email: Jon.Duckert@med.va.gov

TITLE

Performance Improvement Model: Improving Colorectal Cancer Screening Measures

PROJECT DESCRIPTION

Background
Colorectal cancer (CRC) is the second leading cause of cancer-related death in the United States. The Center for Disease Control reported that, in 2004, an estimated 57,000 deaths were caused by CRC. In that same year, nearly 147,000 new cases of CRC were diagnosed. Studies have shown mortality rates from CRC are reduced by 15% to 33% when screening for CRC using periodic fecal occult blood testing (FOBT). [1]

In FY 2001, prior to the inception of Ambulatory Care's performance improvement model for CRC screening, the VA Office of Quality and Performance reported VA North Texas Health Care System (VANTHCS) as 43% compliant for this measure.

Objective
Improve the quality of care to veterans through the creation and implementation of a performance improvement model to increase CRC screening measures in an Ambulatory Care setting.

Planning
Ambulatory Care will employ a two-pronged strategy of education and documentation to serve as its performance improvement model. The education component will entail provider and patient education while the documentation component will rely on a clinical reminders tool. Both components will utilize Advanced Clinical Access (ACA).

Development
Posters and pamphlets served to educate providers and patients on the importance of CRC screening. In addition to this educational media, nurses provided verbal instruction to patients during admission and discharge. The verbal instruction aimed to educate patients how to prepare FOBT specimens for testing and to reinforce the importance of CRC screening. ACA was also used as an educational medium as it enabled nursing staff to track unreturned FOBT mail-outs. A nurse then calls to inquire and reeducate the patient on the importance of CRC screening.

Clinical reminders, based on accepted clinical practice guidelines, fulfilled the documentation component of the model. Clinical reminders documented CRC screening compliance in the computerized patient record system (CPRS). Aforementioned, ACA was utilized in this strategic component through the use of the provider panel feature. With this feature, a clinical reminder due report is generated. The due report gives a per provider percentage of completed clinical reminders and thereby establishes provider accountability.

REQUIRED RESOURCES

- FOBT mail-out kits with all components (i.e. pre-addressed envelopes with prepaid postage)
- ADPAC resources to generate a clinical reminders due report
- Medical Media to produce educational media (i.e. posters and pamphlets)
- IRMS to develop a clinical reminder tool
- Provider education and training resources

OUTCOMES AND BENEFITS

EPRP performance measures for CRC screening showed considerable gains during the last half of FY2004, primarily due to the implementation of ACA. The model yielded a 50% improvement in CRC screening in that year when comparing the mean CRC screening measures for the first half of the year, 36.3%, to the second half, 54.6%. In FY 2005, improvements continued as VANTHCS reported 66% and 57% CRC screening compliance for the months of October and November, respectively. Financial benefits of CRC screening assume the role of its cost-effectiveness, which is estimated to be less than $30,000 per year of life saved, independent of screening methodology (i.e. colonoscopy, FBOT, sigmoidoscopy). [2]

APPLICATION POTENTIAL

The significance of this performance improvement model is three-fold. First, it highlights the functionality of ACA, clinical reminders, and a clinical reminder due report to assist with the improvement of appropriate EPRP performance measures. Secondly, it draws additional attention to the Institute of Medicine's recommendation of increased quality of care through patient education. This practice may lend itself to be a cost-effective approach for providers to deliver high quality patient care in a cost-prohibitive environment. Finally, this performance improvement model promotes a focus on quality and performance measurement. The emphasis on performance measurement has been reported to have a "spillover effect" of better care spread to similar measures that may, or may not, be measured by the current performance system. [3]

[1., 2.] U.S. Preventative Services Task Force. *Screening for Colorectal Cancer: Recommendations and Rationale.* July 2002.

[3.] Ash, Steven. et al. "Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample." *Annals of Internal Medicine.* 141(12). 21 December 2004.

Armstrong, Brent, M.D. *Improving the Quality of Care Through Improving Colorectal Cancer Screening Compliance in an Ambulatory Care Clinic.* Amarillo VA Health System. 25 March, 2004.

George A. Duthie
214 NE 51st Street Apt #3
Miami, FL 33137
georgeaduthie@yahoo.com

EXPERIENCE:

Miami VA Medical Center: *Administrative Resident*
Miami, Florida
August, 2004 – Present
* Conducted the annual Local Management Review of Fiscal Service
* Researched practices of a Malcolm Baldrige Quality Award winning hospital and presented findings to ~110 senior and mid-level staff
* Coordinated the Miami VA Health Care System Human Resources Self Evaluation

Atlanta Women's Obstetrics and Gynecology: *Manager of Accounting and Personnel*
Atlanta, Georgia
May, 2003 - December, 2003
* Made operations-level management decisions daily; managed a staff of 24 clinical and office personnel
* Managed Accounts Payable and Payroll accounts for 33 FTE's
* Produced Monthly Budgets and Quarterly Income Statements

The MEGA Life and Health Insurance Company: *Independent Senior Agent*
Atlanta, Georgia
August, 2001 - August 2002
* Marketed and sold health and life insurance products
* Promoted to Senior Agent in shortest time possible while consistently maintaining persistency rate above 90%
* Provided quality customer service to existing clients in order to maintain customer base and generate referrals

EDUCATION:

Georgia State University: *Master of Health Administration*
Atlanta, Georgia
August, 2002 – Present
Anticipated Graduation Date: May 2005
* 3.5/4.0 GPA

Georgia State University: *Master of Business Administration*
Atlanta, Georgia
August, 2002 – May 2004
* 3.88/4.0 GPA

State University of New York: *Bachelor of Science in Social Studies Education*
Buffalo, New York
August, 1995 - May, 1998
* 3.21/4.0 GPA
* Vice President of Sigma Phi Epsilon Fraternity (1997-1998)

COMMUNITY SERVICE & INTERESTS:

* Hands on Atlanta - Volunteered to help clean and restore Martin Luther King, Jr. National Historic Site, The Chattahoochee River, and the Dunwoody Nature Center
* The American Red Cross - Assisted with blood donation effort

George Duthie
Administrative Resident
Miami VA Health Care System
1201 NW 16th Street
Miami, FL 33125
(305) 575-3318

Home Based Primary Care Program Process Reengineering

Program Background

As required under VHA Directive 2001-061, all Department of Veterans Affairs facilities must provide or purchase Home Based Primary Care (HBPC) services for all enrolled, eligible veterans in need of such services. VHA Manual M-5, Part V outlines the criteria considered when determining if a veteran needs HBPC services. The general purpose of the program is to provide primary care services to high risk/high resource utilization patients which experience diminished geographic mobility due to a medical condition. The HBPC program attempts to reduce the adverse effects on patient health that diminished geographic mobility can cause by bringing the primary care clinic to the patient.

During FY '04, the Miami VA HBPC program treated a total of 385 unique patients. The current patient panel has been in the program for an average of 747 days, with 21.4% in the program for less than 6 months, and 14.3% in the program for more than 2.5 years. The program cost $8,180,538 to run in FY '04, but only generated $7,921,934 in VERA revenue for the same time period, creating a $258,604 deficit. There does not appear to be a problem with access, as there is no waiting list for the program, and most, if not all, consults are seen within 10 business days. One final note, average productivity for physicians is 17.6%, and average nurse productivity is 27%.

Objectives

Given the vital importance of our community based care programs to our veterans, it is imperative that programs are well organized with efficient work processes and structured to provide for high quality care. The current organization and work processes of the HBPC program are a patchwork of incremental steps taken as it grew and evolved, with an end result that we are not necessarily running as effectively or efficiently as possible.

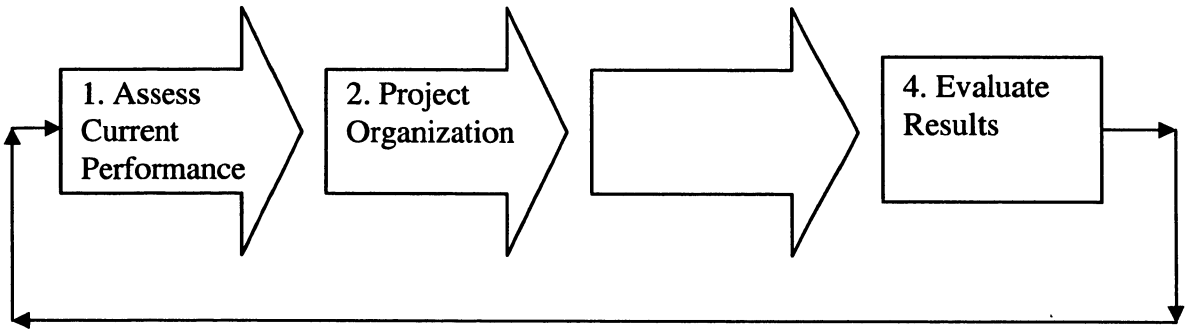
An HBPC Reengineering Team will be charged with reviewing the current program and making recommendations that will enable the most efficient and more effective operation of the HBPC program. In addition, attention must be paid to maintaining or increasing customer and employee satisfaction.

Planning

Consensus and buy-in among clinical and administrative program staff that a reengineering effort would add value for both patients and employees has been obtained.

In addition, the reengineering effort has gained the support of both senior medical center leadership and union representatives. Support from all three groups is critical to the success of the reengineering effort.

Once begun, the entire reengineering effort is estimated to take 8 weeks from start to finish. The plan for the reengineering effort is a cybernetic loop, and will be conducted using a four-step process, with the final part of step 4 reverting back to the first part of step 1:



Application potential to other facilities

Providing healthcare services to veterans is a continuously evolving endeavor. "What", "when", "how", "who" and "where" services are provided are dynamic and ever-changing as evidenced by the shift from inpatient to outpatient settings, advances in medical and information technology, and the slow progression towards evidence-based methods, to name but a few.

For any VHA program or service to remain unchanged in this kind of environment would invite sub-optimal efficiency, effectiveness, or both over the long term. Therefore, a systematic review of programs and services within each VHA facility should be ongoing.

Resource Requirements

There are no significant costs to implement this project. The overwhelming majority of cost can be attributed to the time spent by the HBPC Reengineering Team in moving through the four-step process mentioned above.

Anticipated outcomes, benefits, cost savings

At this point, it is too early to state definitively what benefits are expected, and to what degree. However, the Miami VA does anticipate improving program efficiency, effectiveness, and staff job satisfaction.

MITRA YAEL EFRAMIAN

1824 NW 3rd Place Apt. 38
Gainesville, FL 32603

(352) 335-5980
(352) 871-2669

mitra.eframian@med.va.gov

EDUCATION

Master of Health Administration,
Univeristy of Florida, Gainesville, Florida, May 2004
United States Public Health Service Traineeship Award

Bachelor of Art in Psychology,
Indiana University, Bloomington, Indiana, December 2001
Dean's List and Founder's Day Award

PROFESSIONAL EXPERIENCE

NORTH FLORIDA/SOUTH GEORGIA VETERANS HEALTH SYSTEM, Gainesville, Florida
One year administrative fellowship is based out of the Gainesville VA Medical Center under the Graduate Health Administration Training Program.

5/04 – present **Administrative Fellow**

- Participated in Medical Administration Service Process Review Team of outpatient clinics and completed report to present to administrators of clinic and health system, which became a template for Best Practices.
- Completed business plans sent to Congress to build new community-based outpatient clinics within the health system.
- Worked closely with Service Chiefs on a variety of projects.
- Served as a United Way Loaned Executive for three months for the Combined Federal Campaign.
- Analyzed statistics of physician salary within health system to determine gender equity and presented findings to Executive Leadership Committee.

MANHATTAN EYE, EAR & THROAT HOSPITAL, New York, New York
Voluntary, not-for-profit specialty care teaching hospital and subsidiary of Lenox Hill Hospital.
Internship part of the Greater New York Hospital Association/ Institute for Diversity Summer Enrichment Program.

6/03 – 8/03 **Administrative Intern**

- Created and served as chair of task force focusing on improving outpatient clinics and patient satisfaction.
- Identified key operational issues and worked with the committee to provide and implement solutions.
- Worked with Director of Surgery to conduct utilization reviews for surgeon block time in the operating rooms for both Manhattan Eye, Ear & Throat Hospital and Lenox Hill Hospital.
- Involved in other committees such as: medical records sub-committee, disaster critique committee, and Kathy Ngyuen Memorial Award Committee.
- Attended committee meetings such as: operating room committee, executive committee of the board of surgeon directors, quality assurance/ risk management committee, and the finance committee.

UNIVERSAL BEHAVIORAL SERVICES COMMUNITY MENTAL HEALTH CENTER, Indianapolis, Indiana
The first "fully-licensed" Community Mental Health Center in the State of Indiana in over 25 years.

8/01 – 8/02 **Therapist/Counselor**

- Conducted group and individual sessions with a variety of patients including adult AIDS and elderly patients in nursing homes, children living in poverty, and others.
- Conducted two hour patient intake process including behavioral, physical, and HIV risk assessments.
- Developed treatment plans, and completed all appropriate documentation.
- Coordinated health and social services for clients.
- Submitted entire company's activity logs and revenues into funding information systems (Medicaid and Medicare).

MEMBERSHIPS

American College of Healthcare Executives, Associate
North Central Florida Healthcare Executives, Member
University of Florida Graduate Program in Healthcare Administration Alumni Association, Member
University of Florida Alumni Association, Member

Mitra Eframian
Administrative Fellow
North Florida/South Georgia Veterans Health System
1824 N.W. 3rd Place #38
Gainesville, Florida 32603
(352) 871-2669
Training Start Date: 6/7/04

Medical Administration Service Process Review Team

Description

North Florida/South Georgia Veterans Health System (NF/SGVHS) policy (No. 00-4) states that all care and services will be provided in a manner consistent with established mission, vision, values, goals, objectives, and plans. Teams and work groups are to be formed as needed to continuously improve processes, utilizing the PLAN–DO–CHECK-ACT approach to measure and assess performance. Communication that improves the understanding of the interrelationships of all activities is also to be fostered. Additionally, the NF/SGVHS Operational Plan includes an objective under the Baldrige Category of Leadership to conduct "walk-abouts" at all outpatient clinic sites on a regular basis in an effort to improve overall organizational communications. In accordance with these guidelines, Medical Administration Service (MAS) has committed to conduct visits at all satellite (OPCs) and Community-Based Outpatient Clinics (CBOCs) with the intent of assessing and providing constructive recommendations concerning efficiency of operations related to patient processing and benefits, data quality, and health information management.

Objectives

The Process Review Team was initially convened to evaluate MAS policies and processes of the Tallahassee Outpatient Clinic (TOPC). The clinical director of TOPC had previously identified deficiencies in MAS and initiated the review. The objective of the Process Review Team was to assess and provide recommendations to improve current procedures in patient processing and benefits, data quality, health information management, information security, employee relations, and in utilization of Veterans Health Information Systems and Technology Architecture (VISTA) and Computerized Patient Record System (CPRS) applications. After much was learned and gained from that endeavor, the Chief of MAS believed it was time to reach out to all of the OPCs and CBOCs. She believed that MAS needed to spend more effective time at these clinics with more thorough reviews and training attention.

Planning, Implementation, and Development

The process reviews could be done with a review of data, along with interviewing key employees at each of the clinics. The development of an MAS Process Review Team includes the following:

1. Select a chairperson among the MAS Service Chiefs.

2. Formulate a workgroup of selected participants.
3. Develop an assessment approach.
4. Review and restructure (if necessary) the future MAS Training Team that goes out to the sites to meet all the components of MAS.
5. Organize an intense schedule so that all sites can be reviewed and in-depth training conducted in all segments of MAS functions within timeframe. Then establish a "routine" schedule when all necessary disciplines "jointly" go out for quarterly training at each and every site.
6. Develop a format, such as the Tallahassee format for creating a report following each initial full functional review.
7. Organize a monthly meeting with Chief and Assistant Chief, MAS to update them on the progress of the team and outcomes of the review.

Application Potential in other Facilities

It is recommended that other facilities develop an MAS Process Review Team. This can be implemented by following the development of a team previously mentioned.

Resources Required for Implementation

Resources required for implementation include the manpower to drive the team, a government van to transport the team between VA facilities, and a conference room at the clinic being reviewed equipped with a computer and a speaker phone (used to connect with Chief, MAS for exit interview). MAS service chairs and employees from all facilities, and clinical directors and administrative officers from the clinics must be willing to participate.

Documented Outcomes, Benefits, and Cost Savings

Compliance with applicable VHA directives concerning registration, eligibility verification, completion of means tests, administration of the Beneficiary Travel Program, management of electronic waiting lists, completion of encounters, and management of health information are some of the documented outcomes that have already occurred. It is too early to show all of the benefits that will come from these process reviews. A huge benefit of increased communication between the parent facility and its outpatient clinics has been shown through the many e-mails and phone inquiries by the administrative officers and chief medical officers of the clinics. The site visits have opened a line of communication between MAS staff at the medical centers and the clinics. Clinic staff no longer feels like they are disconnected from the medical center.

Next Steps

All final reports, following the Administrative Board Investigation format, are due to Chief, MAS by February 16, 2005. Once these are turned in, the MAS Process Review Team will meet to look at trends. A matrix will be made to show correlations of findings between facilities. At this point, a follow-up schedule will be created including quarterly calls between MAS and the administrative officers at each facility. The practice of the MAS Process Review Team has been submitted to the national VA Virtual Learning Center and has been accepted and acknowledged as a "Successful Practice."

Kristen P. Fortner
4896 Hunt Road #110
Cincinnati, OH 45242
513.984.3911
Kristen.Fortner@med.va.gov

Education

Xavier University, Cincinnati, OH
Master of Health Services Administration, graduation expected December 2005

Marshall University, Huntington, WV
Bachelor of Business Administration-Healthcare Management, *Cum Laude*

Experience

VA Healthcare Network of Ohio — **Cincinnati, OH**
Administrative Resident — Jan. 2005-present

- Rotated in a variety of employee and management areas across VISN 10
- Created an issue of the Employee Newsletter
- Prepared orientation binder for all Administrative Residents at VISN 10
- Participated in process of establishing VISN 10 Group Appointments
- Attended a wide variety of council and executive meetings

Greater Cincinnati Health Council — **Cincinnati, OH**
Intern — Jan. 2004-Apr. 2004

- Assisted with marketing a community indicators publication

St. Mary's Medical Center — **Huntington, WV**
Administrative Intern — May 2002-Jan. 2003

- Prepared wellness brochure to be distributed to community
- Created wellness assessment forms to be reviewed by Forms Committee
- Completed departmental rotation summer 2002
- Implemented hospital-wide "Whistle Blowing" safety defense program

St. Mary's Medical Center — **Huntington, WV**
Certified Pharmacy Technician — Dec. 2001-Nov. 2002

- Input pharmacy charges/credits in order to achieve accurate billing
- Prepared medications for pharmacist review and delivery

Activities

Member of the Student Chapter of American College of Healthcare Executives 2000-03
VP Community Service, Delta Sigma Pi Co-ed Professional Business Fraternity, 2000-03
Treasurer, Phi Eta Sigma National Honor Society, 1999-2003

Community Involvement

Planned and organized "Toy Drive" for non-profit hospital's daycare, 2003
Organized and participated in Breast Cancer Walk and Diabetes Walk, 2000

Honors

Central & Southern Ohio HIMSS Scholarship, 2004
Xavier University Health Services Administration Academic Scholarship, 2003
The David Montondo Marketing Scholarship, 2003
Monica Lucas Healthcare Scholar, 2002-2003

Skills

Proficient with Microsoft Office applications
Capable of reading Spanish

References

Available upon request

Contact Information
Kristen Fortner, Administrative Resident
Training Start Date: January 10, 2005
Veterans Health Network of Ohio: VISN 10 Office
11500 Northlake Drive, Suite 200
Cincinnati, OH 45249
(513) 247-4638

Title of Project:

Practical Medical Care: Planning for and Implementing Shared Medical Appointments (SMA) in the VA

Description:

VISN 10 Advanced Clinical Access Steering Committee identified many strategies to deal with the supply/demand issues throughout the network. One of the strategies is the use of the innovative concept of the Shared Medical Appointment (SMA). Throughout VISN 10, the implementations of SMAs have begun. Dayton VAMC has been using SMAs for about one year, Cincinnati VAMC facility just started to roll out the appointments in February; the goal is for all facilities to begin this practice this fiscal year. Group appointments stemmed from what is known as a Cooperative Health Care Clinic (CHCC) and derived from the Drop-in Group Medical Appointment (DIGMA). Kaiser Permanente originally developed the idea of CHCC and Dr. Edward B. Noffsinger devised the practical DIGMA. VISN 10 has chosen to use slightly different terminology in naming the group appointments. One facility, in particular, is using the term Scheduled-In Group Medical Appointment (SIGMA), to name the visits. They are doing this so veterans realize they must call ahead and be scheduled into the groups. This will keep down overbooking.

Objective:

Although VISN 10 has been innovative and has expedited the implementation of SMAs throughout the network, this type of patient care is really the wave of the future and could be established as part of a daily appointment routine in ***any*** facility (VA or non-VA). SMAs have many positive results, which are appreciated by both clinical and administrative staff. Group appointments have produced increased patient satisfaction, reduction in no-shows, savings in pharmacy expenditures, lower staffing costs, and better coordination of care across the continuum. So, with certainty that SMAs will glide their way into every health care facility, it is necessary to explore what resources are essential when organizing and formulating the usage of SMAs across the VA (and in other non-VA facilities).

Implementation and Planning:

There are tips most feel are crucial to consider when establishing a SMA. In an article written by Dr. Edward Noffsinger and Dr. John Scott in the *Group Practice Journal,* June 2000 issue, eight "practical tips for establishing successful group visit programs" were cited. These eight tips are advocated for both VA and non-VA health care facilities and are essential to establish successful SMAs. Those tips are: "getting support,

understanding target population and purpose, developing outcomes and measures, facilitating, focusing efforts on patients who want to attend, speaking openly about the program, getting patients involved in achieving the group's goals, and completing the medical chart notes during each session." Each of the eight demonstrated properly will equal a successful SMA. An illustration for each of the eight will be available in more detail on the storyboard poster during the conference.

When it is decided that the time is right to start SMAs, various staff, like RNs, LPNs, documenters, physicians, and administrators will need to collaborate. Collaboration must take place in order to mesh ideas, get buy-in, and produce someone who will be called the "champion" or project manager/coordinator. It might be necessary to have two separate positions set forth as "champion" and "project manager," depending on the facility. Having a physician, as the "champion," and someone who is really enthusiastic about the idea (maybe an RN or PharmD) to be the project manager/coordinator might be the best bet for ideal development; and, of course, for keeping everyone on target.

Anticipated Costs, Benefits, and Outcomes:

Managing the creation of SMAs is like putting together a puzzle; a puzzle that ***must*** remain in tact through the process. It is important to have support from all staff, especially clinicians, who will be involved in the formation and implementation of SMAs. Support from each level of administration is also imperative. For example, as soon as the VISN 10 Network Director learned of the idea of a SMA, he was sold on the idea and decided to provide support for a documenter at each facility that formed SMAs. This illustrated that the Network had secured buy-in from administration and was free to proceed. There are not significant costs that need to be factored into establishing SMAs; only space may be an issue at a facility-level.

Applications/Implications to Other Facilities:

VISN 10 has had great results with SMAs, as demonstrated through the patient satisfaction survey results at the Dayton facility. Nonetheless, the idea of a SMA is definitely not for every physician or patient population. Physicians who do not like to be in a crowd often do not react well to being in front of 15 patients; however, some overcome that fear. Patients who have dementia and/or ones that are hard of hearing are not the type of patients you will want to invite to be in a SMA. Most others patients are fine as long as the facilitator does not let one patient dominate the appointment.

If the facility has enthusiasm, clinicians' buy-in, and administrative support, it can establish a SMA with some planning, staff motivation, and minimal additional staff training. SMA can have significant effects on satisfaction and on other important areas, as demonstrated on the poster. Nevertheless, everyone involved in providing care through the use of this practical, new way to practice medicine, should always keep their ultimate goal in mind: "to serve America's veterans and their families with dignity and compassion and to be their principal advocate in the ensuring that they receive the care, support and recognition earned in service to this Nation."

JOSEPH ANTHONY GIRIES, L.N.F.A.

11915 Corona . Houston TX 77072 . 832-274-0694

OBJECTIVE

To obtain a position in the combined area of Business and Healthcare which will allow the utilization of my education and professional experience while working in a professional environment to achieve growth and advancement.

EDUCATION

January 2000- Present (Part time at night) — University of Houston, Clear Lake
Master of Healthcare Administration

June2003 — San Jacinto College
Nursing Home Administration Program-GPA 3.8
Licensed Nursing Facility Administrator

August 1999 — Houston Baptist University,
Bachelor of Arts Degree
Psychology and Christianity –GPA 3.5

EXPERIENCE

January 2005-Present — Administrative Resident-NTHCS-Dallas

April 2002-December 2004 — Afton Oaks Nursing and Rehabilitation Center
Director of Admissions/Marketing/Administrator in Training

Pre-screen patient eligibility for participation in federal and state assistance programs. Verify HMO benefits and secure any pre-certifications needed. Negotiate contracts and terms of payment between HMOs and the facility. Measure the cost of care versus the level of reimbursement for Medicare and insurance admission to determine specific patients profitability. Conduct quality surveys and participate in the utilization review process to ensure that facility resources were used properly and that the patient received all the care that was needed. Train and lead the facility staff regarding the corporate Continuous Quality Improvement program. Participate in the companies CQI Regional Committee by traveling to other facilities to review facilities compliance with corporate programs. Assist in the daily operation of facility and management. Help the Administrator ensure that each department stays within budgeted labor hours. Developed and implement the facilities marketing plan and projected census. Assist the administrator develop the facility budget using the projected census figures. Review contract with new vendors to ensure corporate compliance. Marketing the facility to the healthcare community and to all referrals. Lead marketing team and conduct weekly marketing meetings. Maintain daily census reports of the facility and log of residents in the hospital

August 2001- February 2002 — The Concierge Care Nursing Center
Director of Admissions

Responsibilities included explaining, verifying and establishing Medicare benefits. Verified HMO benefits and secure any pre-certifications needed. Measured the cost of care versus the level of reimbursement for care for each Medicare admissions to determine if a specific Medicare patient would be profitable. Negotiated contracts and terms of payment between HMOs and the facility. Resolved any all issues with various insurance companies. Insured that all necessary paperwork has been completed. Resolved any issues or concerns regarding the facility and care.

September 2000- August 2001 — CLC- Briarwood Health Care Center
Director of Admissions/Marketing

Responsibilities include researched of all state and federal laws in the area of Healthcare. Determined which sector of the Government would provide aid to families in need of financial assistance. Pre-screened patients eligibility for Medicaid benefits. Verified HMO benefits and secured any pre-certifications needed. Negotiated contracts and terms of payment between HMOs and the facility. Assisted in the daily operation of facility and management.

VA North Texas Healthcare System Dallas
Joseph Giries
Administrative Resident
4500 S. Lancaster Rd.
Dallas, Tx. 75216
214-857-1162

Improving the Congestive Heart Failure Discharge Performance Initiatives

Background

Congestive Heart Failure (CHF) affects an estimated 4.8 million Americans and each year the number of new cases identified in the U.S. ranges between 400,000 and 465,000. The incidence and prevalence of CHF increases with age; with two to three of every 100 people aged 65-74 having a diagnosis of CHF. The prevalence of CHF is expected to increase and the aging of the baby boomers generation ensures that CHF will be a major challenge to American Society. In 1994, CHF was the first listed diagnosis in 875,000 hospitalizations, and is the most common diagnosis in hospital patients age 65 years and older. Within the Veteran population, CHF is both a prevalent and morbid condition as well as costly for the VA healthcare system. In fiscal year 2004, there were 2,100 patients treated/evaluated for congestive heart failure at VA North Texas Health Care System (VANTHCS).[1] In VA, approximately two-thirds of patients die within five years of their initial hospitalization for heart failure.

Project Description

According to the core measures from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), "educating patients with heart failure and their families is critical. Patient non-compliance with physician's instructions is often the cause of re-hospitalization. It is thus important that health care professionals ensure that patients and their families understand the prognosis of heart failure, the rationale, for pharmacotherapy and prescribed medication regimen, dietary restrictions and activity recommendations, and the signs and symptoms of deteriorating condition."[2] At VANTHCS, the Quality Management service identified some compliance issues regarding the VA clinical performance measure for congestive heart failure discharge instructions. In October FY04 score for this measure was only 3%, which was well below the VHA floor of

[1] FY04-2100 discharges of patients with CHF as either primary or secondary diagnosis.
[2] Reference http://www.jcaho.org/pms/core+measures/hf overview.htm

71%. In order to increase the score of this performance measure a special action team was assigned by the Performance Measure Workgroup. It was determined that during the discharge process CHF patients were not receiving adequate information to meet the performance measure requirements. The team identified the need for a template to aid providers in the discharge process. Once education and training was provided to the staff, the template was implemented near the end of FY04. Alterations were also made to the CHF discharge order to better guide the physicians. The patient information regarding appointments and medications were auto imported into the template for each patient. In order to monitor the process effectiveness and provide accurate and timely feedback to providers the External Peer Review Process (EPRP) Nurse Coordinator conducted 'real time' reviews of discharged CHF patients. This occurred while the residents were still on site, and the patients were still very familiar to the providers under their care.

Resources Required

The greatest resources required for this process improvement remains the employee hours. The EPRP nurse coordinator or other designated members of the clinical quality management team must conduct 'real-time' reviews of the effectiveness of the process improvements. A template must also be developed to aid the staff in the CHF discharge process. Once the template is complete then training must take place on its proper use.

Project Outcomes/Benefits

The most apparent outcome of this project was the increase in the performance measure from 3% in October FY04 to 79% in October FY05. The most important benefit from this improvement is the increase in the quality of care that the increase in the performance measure signifies. Based on the 2,100 patients who were treated/evaluated for CHF in FY04 this translates into an additional 133 patients a month who received this life enhancing education during their discharge instructions. This also means lower hospitalization and utilization rates for CHF patients as well as cost savings for the VA Healthcare System.

Application Potential

The CHF performance measure is a priority for every VA facility, therefore, the improvements implemented in this project can be used by other facilities to meet this performance measure goal. These steps are relatively low cost and easy to duplicate at other VA facilities.

Neetu Godhwani

864 Silver Lake Scotchtown Rd. Middletown, NY 10941 * Phone: (845)-692-2699
E-mail: neetu.godhwani@med.va.gov

Education:

Cornell University
Master of Professional Studies in Health Administration, Sloan Program, May 2004
Bachelor of Science, Policy Analysis and Management, May 2003

Work Experience:

July 2004-July 2005

Department of Veterans Affairs, Hudson Valley Healthcare System, Montrose, NY
Administrative Fellow

- Acting as Administrative Officer for the Ancillary Care Line (including lab, radiology, pharmacy, voluntary, recreation, and chaplain services) from January through July 2005
- Spearheading the hospital's Extended Care Quality of Life Initiatives to improve nursing home residents' quality of life, including making site visits, facilitating staff and resident focus groups, and designing a Quality of Life Assessment Form for social workers
- Coordinating the planning, implementation, and execution of telehealth initiatives in mental health for the NY/NJ network (VISN 3)
- Directing and facilitating the planning and implementation of a centralized call center
- Analyzing the feasibility of consolidating pharmacies of both campuses, as well as assessing the cost savings that would result
- Devising and implementing recommendations to remedy the hospital's wheelchair deficiency problems
- Contributing member to the Unapproved Abbreviations Taskforce, Patient Funds Workgroup, HFMEA and Root Cause Analysis Team
- Served as a Narcotics Inspector quarterly and provided input to streamline the inspection process
- Participated in a network wide phone system performance improvement team

December-May, 2004

Auburn Memorial Hospital, Auburn, NY
Consultant, Cornell Sloan Program Capstone Project

- Assessed the need for the hospital to continue to provide inpatient psychiatric services
- Examined the feasibility of building a new standalone inpatient psychiatric unit, constructing a new psychiatric unit in conjunction with a new rehabilitation unit/other revenue generating service, or maintaining the status quo
- Provided recommendations to be considered in planning a new unit

June 2-August 19, 2003

Beth Israel Medical Center, Beth Israel Pediatric Associates, New York, NY
Administrative Intern

- Observed patient flow processes and identified inefficiencies in the system
- Examined and implemented methods of improving patient flow and access
- Analyzed the effectiveness of 'phone room' implementation on reducing phone abandon rates
- Updated managed care grids to facilitate patient flow and scheduling
- Redesigned the practice's phone tree to include a Spanish option
- Closely examined the Citywide Immunization Registry reporting mechanism to identify and correct discrepancies in the number of reported immunizations

June 1-July 26, 2002

Northern Manhattan Community Voices Collaborative,
Columbia School of Public Health, New York, NY
Intern

- Drafted a detailed nutrition curriculum for GW High School educators
- Conducted research, identified potential funding sources, and began an ethnographic study of the local neighborhood
- Collected materials to be used in developing a nutrition curriculum for local pre-schools
- Participated in an Asthma Basics for Children media campaign, a mental health forum, and in organizing a seminar on the epidemic of obesity

Professional Membership: American College of Healthcare Executives; Cornell Sloan Alumni Association

Skills: Understanding of Spanish and Hindi and working knowledge of MS Office

Neetu Godhwani, Administrative Fellow
Facility: VA Hudson Valley Health Care System
PO Box 100
Montrose, NY 10548 Phone: 914 737 4400 x3821

Project Title: ***VA Hudson Valley Extended Care Quality of Life Initiative***

Description:
"What is quality of life for frail elders living in the margin of life, physically, mentally, or socially impaired, facing protracted dependency with sharply reduced odds of returning to life as it once was?" (Bearon, 1997).

The *VA Hudson Valley Extended Care Quality of Life Committee* was established in February 2004 to ensure that the quality of life needs of its 160 nursing home residents were given the importance they deserve. While many positive components to quality of life are addressed at the facility, staff members felt that there was much room for improvement as insufficient attention is paid to the "individual's" quality of life. In addition, the need for such a committee was evidenced by results from the 2003 Long Term Care Satisfaction Survey (n=40) indicating that a statistically significant number of residents, 57 % of those surveyed, were dissatisfied with novelty and variety of activities. With respect to food, 52% of those surveyed did not enjoy the meals they receive, 52% did not feel they receive the food they request, and 61% were dissatisfied with the lack of alternative selections in food choices. This quality improvement initiative required that the committee define quality of life, assess whether or not it exists at the local level, focus on improving problematic areas, and find innovative ways to further residents' quality of life, given budgetary constraints.

Professional literature was reviewed to define quality of life and develop an understanding of current state-of-the-art quality of life initiatives in extended care settings that could be employed by the facility. Various models such as PlaneTree and the Eden Alternative have been identified and are being explored. After a comprehensive review of existing academic literature, key dimensions of quality of life were identified and include choice and autonomy, activity, physical status and health, socialization, spirituality, security, environment, meaningful staff interaction, individuality, nourishment, continuity with previous life, and dignity.

Objectives, Planning, and Development:

1. *Visit settings of excellence in the community and develop ongoing relationships with organizations engaged in the development of quality of life programs.* Visits to facilities revealed the importance of the following in improving residents' quality of life: An emphasis on environmental factors, adaptation of alternative healing methods, personalization of rooms, focus on family activities, implementation of diagnosis-specific activities, employment of enrichment activities such as educational programs and activities incorporating multi-sensory stimuli.

2. *Conduct resident and staff focus groups on each unit to identify needs that are being met and those that have not been adequately addressed.* A series of open-ended questions addressing key quality of life component were developed for this purpose. Some findings include the desire for greater food selection and improved quality of food, greater variety of activities, more weekend and evening activities, and more off-station trips.

3. *Plan and initiate quality of life programs at the facility.* To do so, staff will be surveyed for quality of life initiatives (programmatic, environmental, dietary) that can be accomplished immediately. In addition, they will work to implement residents' individualized quality of life plans. A monthly campus-

based activity-planning group will be developed to plan and execute initiatives. Existing intergenerational programs, in which school children regularly visit with residents, will be expanded to all units on the Montrose campus

4. *Develop tools to assess the effectiveness of quality of life programs (i.e. monitoring of staff, resident, and family satisfaction pre and post- implementation of changes).*

5. *Develop unit based staff quality of life/customer service training.* This will include education on the empowerment of residents, communication skills, diagnosis relevant activities, and other pertinent topics.

6. *Initiate Quality of Life Grand Rounds.* This will be explored with the VISN GRECC to bring in experts who will serve to educate employees.

7. *Develop an extended care Quality of Life Assessment Instrument to assess individual residents' interests/needs* and place these assessments in a *quality of life book* to be created as a reference for unit staff.

8. *Identify resources available through Voluntary, Recreation, and Nutrition and Food Services* as extended care unit staff may be unaware of available financial and program resources that can be used to improve residents' daily living.

9. *Foster a culture that embraces quality of life.* Literature and visits to other sites have revealed that changing the culture of the organization is key to improving residents' quality of life. It requires that management and staff embrace the initiative and emphasize that employees are the guests of the residents, not vice versa.

Resources required for implementation

This initiative has thus far incurred minimal cost, requiring existing staff's time and use of a government vehicle for travel to sites in the community. No additional FTEE are required. The idea is to find resources (i.e. contributed funds) that are available in the facility but are underutilized or unknown to staff. This endeavor also aims to increase communication and foster creativity to improve quality of life within budget constraints. As this initiative progresses, some financial support may be required to establish Grand Rounds and effective unit based training for staff, as well as create a more home-like environment for residents.

Anticipated Benefits, Cost Savings, and Outcomes

Research indicates that people who feel they have a purpose in life and are happy have better health outcomes. We hypothesize that the quality of life initiative will create conditions that enhance residents' lives and ultimately result in better patient outcomes. The Center for Health Design has conducted research indicating that designing health facilities in more aesthetically appealing ways and focusing on humanistic design, while allowing more private space for residents and their families, requires additional expenditures which have a quick return on investment by reducing both staff absenteeism and decreasing the spread of infection (*NYT*, September 2004). Furthermore, this initiative may result in increased attention to resident's (individualized), current and lifetime interests, greater variety and creativity in group activities, increased utilization of current hospital resources, increased multi-disciplinary planning of quality of life programs, and positive resident, staff and family survey satisfaction scores.

Application Potential in other facilities:

Individual quality of life in long-term care is of increasing importance in today's health care industry. Our veterans have a right to good quality of life and the initiative started here is a viable means of ensuring that this is so. Given the budgetary limitations the industry is facing, the *VA Hudson Valley Quality of Life Initiative* is a relatively inexpensive and creative method of tackling a truly worthwhile issue.

JULIE GORHAM, J.D.

VA MEDICAL CENTER, NEW ORLEANS
1601 PERDIDO STREET
NEW ORLEANS, LA 70112
TELEPHONE: (504) 568-0811 EXT. 2526

8600 PONTCHARTRAIN BLVD., #317
NEW ORLEANS, LA 70124
(504) 282-1340
JULIE.GORHAM@MED.VA.GOV

PROFESSIONAL EXPERIENCE

VA Medical Center, New Orleans; January 2005 – Present
Administrative Resident
Training and rotations at the VA Medical Center, New Orleans.

UAB Grant Consulting Project; May 2004 – December 2004
Consultant
Responsible for legal research on tobacco prevention/cessation counseling and physician/dentist liability.

Waguespack & Levine, M.D., P.C; March 2004 – December 2004
Accounts Receivable Representative
Responsible for monitoring accounts receivable, patient contact, collections.

Premiere Credit; December 2002 – March 2004
Research and Collections Clerk/Liaison
Responsible for account research and gathering documentation for medical collectors.

BYL Asset Management; February 2002- December 2002
Research and Collections Clerk/Liaison
Responsible for account research and gathering documentation for medical collectors.

Julie Gorham, Attorney at Law; April 2001-December 2001
Solo Practicing Attorney
Areas of practice included probate, guardian ad litem and domestic.

Law Offices of Hornsby & Associates; September 1999-April 2001
Associate Attorney
Practice areas included real estate, criminal, domestic, probate, and guardian ad litem.

The Honorable Roger Monroe -Alabama Court of Civil Appeals; June 1999-August 1999
Staff Attorney
Responsible for research legal issues on appeal and drafting Judge's opinions.

Gorham & Waldrep, P.C.; May 1998-May 1999
Law Clerk/Associate Attorney
Responsible for legal research and domestic matters.

EDUCATION

MSHA - University of Alabama at Birmingham; Expected December 2005
Gerontology Certificate - University of Alabama at Birmingham; December 2004
B.S. Health Science - University of Alabama at Birmingham, *cum laude*, June 2003
J.D. - Cumberland School of Law, May 1998
B.S. Business Administration - Birmingham-Southern College, *cum laude*, May 1994

HONORS

Recipient, U.S. HRSA, Health Administration Traineeship, University of Alabama at Birmingham, 2003 & 2004
Phi Delta Phi
Alpha Eta
The National Dean's List, 1990-1994; 2002-2004

ACTIVITIES AND PROFESSIONAL AFFILIATIONS

Senator, Health Sciences Program, UAB Student Government Association, 2002-2003
Student Representative to Dean's Strategic Focus Group, 2003
Student Associate, American College of Healthcare Executives, 2003 to present
Student Member, Healthcare Financial Management Association, 2003 to present
Alabama Bar Association, 1998 to present
Birmingham Bar Association, 1998 to 2001

CUSTOMER SERVICE REPORT CARDS

JULIE GORHAM
ADMINISTRATIVE RESIDENT
VA MEDICAL CENTER, NEW ORLEANS
TRAINING START DATE: JANUARY 10, 2005

1601 PERDIDO STREET
NEW ORLEANS, LA 70112
504-568-0811 x2526
1-800-935-8387 x2526

DESCRIPTION OF PROGRAM:

VA Medical Center, New Orleans' Customer Service Report Card program is designed to meet the VHA's Vision 2020 strategic objective to provide excellent healthcare to our veterans. In addition, it is a key component of the Medical Center's Customer Service Program. The Report Cards are primarily a customer service performance measurement designed to allow for rapid notification of veterans' complaints to each Service Line in an effort to quickly correct poor customer service relationships, as well as make process changes in a timely fashion. Veterans' are encouraged to discuss complaints/issues with one of three patient advocates, who then appropriately code and record the complaint in Vista **each day**. **Each morning,** the Customer Service Coordinator pulls the frequency of each complaint from the Patient Advocate Package, tallies the results, and reports those results in Daily Morning Report. In addition to those **daily** reports, the Customer Service Coordinator provides **weekly** reports of all the complaints to each Service Line. On a **monthly** basis, the Coordinator, in conjunction with DSS, compiles all the complaint/issue data for the month, reporting the same to Leadership Team. The result is the Customer Service Report Card that allows each Service Line Director to review trends in veterans' complaints/issues/compliments in easily defined, measurable and actionable terms. This allows each Service Line Director the ability to focus their customer service improvement efforts on critically weak areas in a timely fashion. In the event the Service Line does not make process changes to improve their number of complaints, the Service Line Director is required to submit an Action Plan delineating the steps he/she will take to improve areas of concern. This revised process is a significant improvement over the former reporting process.

OBJECTIVES:

To provide excellent customer service through timely veteran complaint feedback to each service line.

PLANNING & IMPLEMENTATION:

This continuous quality improvement process evolved over a one-year timeframe. Top Management expressed a desire to revise the complaint feedback within the system to make it more timely and effective. Through several meetings that included Top Management, Special Assistant to the Director, Customer Service Coordinators, the Service Line Customer Service Coordinators and Patient Advocates the team arrived at the initial quarterly report. After trial and error, the process was continually improved to comprise of a **daily**, **weekly** and final **monthly** score card for trending purposes. All departments involved provided input to continuously improve the process and report card, gleaning their support of the process.

RESOURCES:

Human capital is the most important resource necessary to ensure the customer service report card is properly done. Leadership at VA Medical Center, New Orleans considers customer service to be such an important goal for the Medical Center that two full-time employees have been dedicated to the process as well as Customer Service Coordinators in each clinical Service Line. Those employees must be trained

not only on how to properly handle complaints, but must also be proficient at logging the complaints in Vista as well as preparing the necessary statistical information in a easy-to-understand format.

OUTCOMES AND BENEFITS:

All of the information contained in the report card is used to make changes within the service lines. It, as stated above, provides rapid feedback on problem areas requiring attention and correction. It allows those Service Line Directors to **make changes within days** as opposed to several weeks or months. Furthermore, it allows the Service Line Directors, as well as Top Management, the opportunity to see if their changes have had a positive impact. In addition, it is an important measure for Top Management to determine whether any measures have been taken to improve areas of concern. The revised Customer Service Report Card has been a positive, best practice for the Medical Center. It has already allowed our Directors to make timely changes within their departments. For example, the revised Customer Service Report Card process allowed Ambulatory and Primary Care to pinpoint an issue with lack of returned phone call complaints, reducing the number of complaints from 14 to 4. In addition, the Customer Service Report Card process allowed us to make changes to our Flu Clinic process, reducing complaints from 20 in one day to 2 within two days.

APPLICATION TO OTHER FACILITIES:

Given the VHA's mission to provide excellent customer service, the Customer Service Report Card Process outlined in this abstract provides an exceptionally efficient method to report areas of concern to each Service Line. It provides timely information on problem areas within each Service Line, allowing the Director to make efficient, timely changes immediately rather than two to three months later. It also allows Top Management and Service Line Directors to trend complaint frequency to see if positive process changes have been made or whether an Action Plan is necessary. Overall, it is an exceptionally proactive way to address complaints, thereby improving customer service and the veterans' satisfaction.

REPORT CARD:

	Surgery Scorecard	O-03	N-03	D-03	Total 1st Qtr	J-04	F-04	M-04	Total 2nd Qtr	A-04	M-04	J-04	Total 3rd Qtr	J-04	A-04	S-04	Total 4th Qtr	Total FY 04
1	Excessive Wait for Scheduled Appt	13	6		25				44				40		2			114
2	Excessive Wait at Facility Unscheduled Appt	1	1		2				2				6					10
3	Excessive Delay in Scheduling or Rescheduling Appts	9	8		19				31				37				18	105
4	Delay/Postponement in Scheduled Test/Procedures	9	4		22				20				16	3				72
5	Delay in Receiving Test Results	0			1				1			1	3					5
6	Delay Getting Pain Medications	0			2				1			2	3					6
7	Phone Calls Not Returned/Letters not Answered	5	5		13				16				10	1				42
8	Dissatisfied with Referral Outcome	1			3				4				7					18
9	Appointment Date/Time Concerns	1	1		8				5				8	8				41
10	Patient/Family Disagrees about Decision on Care	4	2		6				9				7		1			29
11	Lack of Confidence or Trust in Caregiver	0			1				2				1		1			5
12	Patient not Treated w/Dignity & Respect/perceived	2	4		10				4			2	6		2			24

Legend
White - 1st Month Complaints Reported
Yellow - 2nd Month no decrease to 0
Orange - 3rd Month no decrease to 0
Red - 4th Month no decrease to 0

Green - No complaint/ significant improvement
Purple - Action Plan Needed
Blue - Action Plan in Place

CRYSTAL DAWN GREEN

162 Bergen Avenue, Apt. 1F
Jersey City, NJ 07305
(973) 280-9097
cdg9600@yahoo.com

EDUCATION

COLUMBIA UNIVERSITY, MAILMAN SCHOOL OF PUBLIC HEALTH
Masters in Public Health, Health Policy & Management, May 2004.

CORNELL UNIVERSITY
Bachelor of Arts in Biology and Society, May 2000.

EXPERIENCE

Administrative Fellow
NY Harbor Healthcare System, New York, NY June 2004-Present
Serve in a training capacity, learning the appropriate rules/regulations used in conducting Department of Veteran Affairs (VA) business as well as following Graduate Health Care Administration Program guidelines. Apply knowledge gained in this position to hands-on projects. Projects include: acting as the Administrative Officer for Radiation Oncology Department; coordinating the Combined Federal Campaign; performing Local Fiscal Management, Part-time Physician & Pharmacy Inventory audits; assisting Regional Council by helping to review medical records; and conducting a Wait Time Survey.

Intern/ Practicum
Bureau of Finance, Patient Information & Billings System(PIBS)
NYC Department of Health & Mental Hygiene (NYC DOHMH), New York, NY Nov. 2002- May 2004
Working under the supervision of the Bureau of Finance's Director of the Patient Information & Billing Systems (PIBS's), performed the necessary credentialing to allow the NYC DOHMH to bill Medicare Part B for services rendered by the Bureau of TB Control's twenty-seven (27) Chest Clinic physicians. Set up billing (CPT-4) and diagnosis (ICD-9-CM) codes to facilitate Medicare billing as well as directed the bureau's vendor in utilizing the applicable computer file layouts required to bill claims by electronic data interchange (EDI). Developed fiscal reports. Trained TB Control staff to collect accurate billing data prior to a patient's receipt of services and assisted in coordinating operations with the NYC DOHMH's data processing vendor.

Clinical Care Technician
Robert Wood Johnson Hospital, New Brunswick, NJ 2000- 2001
Worked under the direct supervision of RN, conducting basic and indirect patient care tasks including a variety of personal care services for patients. Performed phlebotomy work. Obtained stat EKG's and bedside blood sugars. Prepared and set up primary pressure lines and tube feedings. Performed vital signs, intake, output, and weights. Maintained unit equipment and environment.

Administrative/Research Assistant 2000-2001
Environmental & Occupational Health Sciences Institute, Piscataway, NJ
Assisted in research project testing organic samples from chemical dumping site. Conducted comprehensive literature and information synthesis for legal documentation and maintained records of test samples. Performed basic administrative duties including ordering and maintaining lab supplies.

ACTIVITIES

Community Service Coordinator
Black & Latino Student Caucus (BLSC), Columbia University November 2001- May 2003
Served as the primary liaison between BLSC and the neighboring community; organized and implemented volunteer programs; and worked with minority health programs.

PROFESSIONAL AFFILIATIONS

American Public Health Association (APHA), Member, 2001 – Present.

American College of Healthcare Executives (ACHE), Student Associate, 2001 – Present.

Facility: VA New York Harbor Healthcare System (VA NYHHS)

Contact: Crystal Green, Administrative Fellow
VA New York Harbor Healthcare System
423 East 23rd Street
New York, NY 10010
(212) 686-7500 ext. 3631

Start date: June 26, 2004

Project Title: **Use of the Copy/Paste Function in CPRS- A *Survey***

Background

Introduced in 1996, CPRS, the Computerized Patient Record System, is the medical record component of VistA. CPRS is currently used in all VA medical centers, clinics and nursing homes. While CPRS has virtually eliminated medication errors caused by illegible handwriting, it has introduced many new problems into the system. Among these is the copying and pasting of text from one part of the medical record into another. This phenomenon has prompted the Department of Veterans Affairs to make the elimination of copying and pasting in the electronic medical record a priority.

VHA Handbook 1907.1, dated April 15, 2004, requires each VA facility to develop a policy that eliminates the use of the copy/paste function or ensures its controlled use. In response, in September of 2004, Dr. Michael Simberkoff, Chief of Staff of VA New York Harbor Healthcare System (VA NYHHS), issued a Chief of Staff Memorandum (No. 08-08) that provided guidelines for copying and pasting and template use in progress notes. The memorandum states that Clinical Service Line Managers and Service Chiefs are responsible for compliance in their respective areas. Reviewers of CPRS are responsible for referring any cases of inappropriate use of either the templates and/or copying and pasting to the Executive Chief of Staff and the respective Clinical Service Line Manager or Service Chief for review.

Description of Problem

A review of several patient records in VA NYHHS yielded numerous instances of copying and pasting in progress notes.

Goals/Objective

The purpose of this survey is to assess the prevalence of copying and pasting in progress notes in CPRS in the VA NYHHS, the author's motivations for using the copy/paste function and to discuss approaches to clinician training in the proper utilization of the copy/paste function.

The project is in accordance with VA's mission to monitor the occurrence of copying and pasting in progress notes and to train staff in the appropriate use of the copy/paste function. Furthermore, the survey will be used to assess providers' attitudes about the use of and the potential disabling of the copy/paste function. The survey will serve to measure work satisfaction as well as time usage. The recommendations generated from the survey will be used for performance improvement purposes to guide management in developing an effective training program for providers to appropriately use the copy/paste function.

Methodology

A voluntary, anonymous survey was administered at VA NYHHS. It was posted on the hospital's intranet and paper copies were also distributed. An email was sent to all provides asking their participation.

The survey instrument asked a variety of question types. Data on job title and campus were collected, as well as the number of notes written per day and the estimated percentage of time the copy/paste function was used. There were several questions regarding attitudes about benefits and specific uses of the copy/paste function in note writing, including the nature of the material copied. A number of questions regarding attitudes used the likert scale listed below.

Likert scale table

1-Strongly Disagree 2-Disagree 3-Neutral/Not sure 4-Agree 5-Strongly Agree

There was free text space allowed for comments.

Data were collected using an Excel spreadsheet and analyzed. Not all respondents answered every question. Repeated responses were eliminated.

Results

178 staff from the New York, Brooklyn and Saint Albans (Queens) VA NYHHS campuses responded to the survey. Twenty respondents were allied health staff; 81 were attending physicians; 10 were house staff physicians and 67 were RNs.

The majority of respondents (66.5%) wrote seven or more notes per day, with physicians writing the most notes. 65.3% of physicians reported that they wrote seven or more notes per day compared to 38.9% and 39.7% of other allied health staff and RNs, respectively.

63.69% of respondents reported that they used the copy/paste function less than 30% of the time with physicians using it the most. 31% of physicians responded that they use the copy/paste function sixty percent or more of the time. 22.2% of other allied health staff and 5.9% of nurses reported using the function more than sixty percent of the time when writing notes in CPRS.

The majority of respondents (~70%) felt that the copy/paste function makes writing notes easier.

Of the material most frequently copied, two different data types were considered. One was straight data or lists, the other content or text derived from other providers' evaluations. Overall, respondents copied patient history, templates and lab data the most. In addition to patient history, physicians cited medications, radiology reports and problem lists as the three most copied categories when writing notes. Nurses cited other providers' notes, vital signs and diagnoses as the most copied categories when writing a note. Allied health staff copied notes from consults, radiology reports and vital signs the most.

Overwhelmingly, the majority of respondents (88%) felt that the function should not be turned off.

From the likert scale most people agreed or strongly agreed that copying and pasting text makes it easier to produce notes under time constraints and that it allows more time to devote to direct patient care. Respondents also overwhelmingly believed that copying and pasting notes was acceptable as long as the note was relevant to the specific clinic visit. Interestingly, more than 70% of respondents disagreed that copying and pasting notes made the note more difficult to read by someone else.

From the comments most people believed that if copying and pasting is done intelligently it enhances patient care immeasurably. However, almost all respondents agreed that better staff education is critical to preventing the abuse of the copy/paste function.

The overwhelming sentiment is that the copy/paste function saves time. In some cases, pasting in medication, diagnosis or identifying data referred to in a note being written can make the note more readable. However, frequent errors in the use of the function can make the note less valid, less relevant and less accurate. Typos and inaccurate information often are copied many times, unedited. Notes are entered under the wrong patient. Information that is no longer useful or no longer applies is often pasted in notes.

Conclusion

Better training in the use of the copy/paste function is necessary to prevent abuse of the function. Education in regard to the subjects copied is important and the respondents echoed this sentiment. These results will help us tailor our educational program to alert clinical staff of the potential dangers of inappropriate use of the copy paste function.

10224 Flatland Trail
Converse, TX 78109

Phone (210) 771-0436
E-mail aaron.gross@med.va.gov

Aaron Gross

Summary of qualifications

2004 - 2005 South Texas Veterans Health Care System

Administrative Resident **San Antonio, TX**

- Served as Administrative Officer for Radiology Department. Responsibilities include budget and supply oversight, business plan development and implementation to include construction and installation of equipment, contract oversight, human resource and personnel management, and management liaison for physician and employee relations.

2000 - 2003 Coast Guard Marine Safety Office

Lieutenant, United States Coast Guard **Port Arthur, TX**

- Served primarily as Safety and Occupational Health Officer. Responsibilities included management of independent duty corpsman, occupational medical surveillance program, TRICARE health benefits consultant, hazardous material coordinator, and hearing conservation program administrator.

1999 – 2000 MedTox Diagnostic Laboratories, Inc.

Medical Technician **New Brighton, MN**

- Primary duties included specimen processing, inventory and chain of custody control, customer service and vendor relations, and specific gravity, drugs of abuse, and liquid chromatography testing.

Education

2003 - Present Baylor University Fort Sam Houston, TX

Master of Science/Health Care Administration

1995 - 1999 University of Wisconsin-River Falls River Falls, WI

Bachelor of Science/Biology

Professional experience

Medical training courses:

- Contracting Officer Representative (COR) Course
- TRICARE Fundamentals Course
- IS-195 Basic Incident Command System (FEMA)

Non-medical courses:

- Incident Command System Planning Section Chief Course
- Incident Command System Level 100-300
- Unit Safety Officer Course, USCG

Awards received

Various Coast Guard Unit Commendation and Service awards for counter terrorism, homeland security, and readiness operations. Other awards include Meritorious Team Award, Letter of Commendation (2), National Defense Service Medal, and 9/11 Service Medal.

Facility: South Texas Health Care System (STHCS) San Antonio, TX
Program: U.S. Army – Baylor University
Contact: Aaron Gross, LT, USCG
Administrative Resident
7400 Merton Minter Blvd
San Antonio, TX 78229
(210) 617-5300 extension 5848

Project Title: Radiology Performance Measure: A Strategic Plan for South Texas Veterans Health Care System (STVHCS)

Description/Background:

Radiological findings that are not communicated promptly often result in delayed treatment or a failure to treat at all. When important findings are reported late, the requesting clinician is less likely to provide quality care. In addition, the logistical foundation and continuity aspects of patient care within outpatient and inpatient settings become too arduous to manage successfully. Also, abnormalities and other critical readings that are not communicated effectively often result in tort claims and other radiology related litigations and may create and foster an image of poor quality care among veterans. As a result of these patient safety and quality outcome concerns, the VA added the timeliness of verifying radiology reports as a performance measure.

The verification report is extracted from the Vista Radiology package within each facility and is rolled up to the VISN then to Central Office. The report measures the span of time from the point the patient is registered in the radiology package until the image is verified. Currently, this measure is enforced to a four day standard. However, in the fourth quarter of FY05 the time for verification will be moved to two days, thus leaving little room for inefficiencies.

Objective:

The purpose of this project is to develop a short term and long-term strategic plan for meeting or exceeding the radiology performance measure objectives. Timely verification of radiology reports is based on the premise that each facility possesses state of the art, digital imaging capabilities with a strong information technology infrastructure to support it. Although this technology exists, it is extremely expensive and is not feasible to assume every facility can procure it within the short term. Therefore, it is important to understand the true capital budgeting requirements to obtain this technology and to plan its deployment to each point of care location within STVHCS while simultaneously adhering to patient safety and quality improvement.

Planning Implementation and Development:

The vision at STVHCS is to create a "hub and spoke" model of teleradiology. The main hospital (Audie L. Murphy) will serve as the center and all outlying facilities will capture and transmit images for interpretation. This will allow for the elimination of most

local contracts but will require equipment upgrades that allow for digital imaging. The following is a brief description of the current status for each major facility at STVHCS:

Audie L. Murphy Division (ALMD): Most modalities are digital, with the exception of portable x-ray units. ALMD is using Vista Rad and Talk Technology for image transfer and speech recognition. Image interpretation is conducted through contract with the University of Texas. Kerrville Division (KD): KD has few modalities with digital capability. All verification is done with hard copy film and transcription service. Image interpretation is conducted through contract with one full time VA Radiologist. Corpus Christi / McAllen CBOCs: The capture of images is conducted at VA facilities while interpretation of images is conducted under contract. Each contractor must use VA telephone dictation and transcription services. Victoria / Laredo CBOCs: The capture and interpretation of images are conducted exclusively under contract. Each contractor must use VA telephone dictation and transcription services. VA should negotiate with each vendor to establish hard copy reports to be directly faxed to ALMD and scanned into Vista. No equipment will be needed at these facilities.

Location	FY05	FY06	FY07	FY08
ALMD	-1 Ultrasound -4 Portable x-ray -1 C arm (OR)	-1 CT -4 Portable x-ray -1 Ultrasound	-Upgrade MRI	-1 C arm (OR) -1 C arm (angio)
KD	-1 Ultrasound -Diagnostic workstation w/ Talk Technology	-1 CT	-4 Portable x-ray	
McAllen CBOC			-Diagnostic workstation w/ Talk Technology	-1 Smart CR
Corpus Christi CBOC			-Diagnostic workstation w/ Talk Technology	-1 Smart CR
Costs (Approx)	**$900,000**	**$3,300,000**	**$1,400,000**	**$2,800,000**

Anticipated Benefits and Outcomes

- Improve quality care
- Improve patient safety
- Reduced long term costs
- Improved efficiency
- Provide better systematic continuity of care
- Reduce Tort claims and other legal action

Potential Applications to other Facilities:

Demonstrating the ability to successfully implement the long-term plan of capital budgeting while meeting Central Office's short-term demands of timely verification of reports will be a difficult task that all VA facilities need to face. This project may serve as a blueprint for VA facilities to establish their own short term and long-term approach to timely verification of radiology reports.

ERIN M. GULLICKSON

2301 E Lamar Blvd ▪ Arlington TX, 76006 ▪ 817-385-3784
Erin.Gullickson@med.va.gov

EDUCATION

2004 **The University of Michigan** *Ann Arbor, Michigan*
Master of Public Health
Department of Health Management and Policy
Concentration in Women's and Reproductive Health

2002 **Luther College** *Decorah, Iowa*
Bachelor of Arts in Psychology

EXPERIENCE

5/05-Present **VA Heart of Texas Health Care Network, VISN 17** *Arlington, Texas*
Administrative Fellow

- Rotated through all services at VA North Texas Health Care System
- Interviewed and hired network employees, performed financial indicator and cost-benefit analyses, and investigated allegations of employee misconduct
- Create network policies and assist with Congressional affairs and media relations
- Attend executive meetings, national VA leadership conferences, and site visits to facilities within the network

9/03-12/03 **Detroit Wayne County Health Authority** *Ann Arbor, Michigan*
Student Collaborator

- Participated on a student team to establish benchmarks and opportunities for a new approach to healthcare for the disadvantaged
- Surveyed primary care services in the Detroit area to assess safety-net resources

5/03-8/03 **Mercy Care Community Physicians** *Cedar Rapids, Iowa*
Intern

- Reviewed business contracts, made patient visit projections, and consulted with staff and physicians on patient satisfaction and employment issues
- Assisted in evaluating Heart to Heart, a women's health screening program

5/01-1/02 **Riccolo & Baker, P.C., Attorneys at Law** *Cedar Rapids, Iowa*
Assistant to Attorneys

- Gathered and organized medical and legal research
- Collected expert witness information

ACTIVITIES

American College of Healthcare Executives ▪ Michigan Healthcare Executives Student Association ▪ Women's Leadership Forum, Department Liaison ▪ Psi Chi National Honor Society in Psychology

VA Heart of Texas Health Care Network
Erin Gullickson, MPH
Administrative Fellow
Fellowship Start Date: May 17, 2004
2301 East Lamar Blvd, Suite 650
Arlington, Texas 76006
817-385-3784

Business Office Consolidation and Correlations with Financial Indicators

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Background:

On June 24, 2003, the Secretary of the Department of Veterans Affairs approved the CFO Reorganization, a plan to reorganize business operations within the VA. For the Veterans Health Administration, the plan included creating new positions at the network level that would help centralize Finance, Acquisition and Capital Asset Management activities.

The plan grew from a desire to improve consistency, compliance, and accountability in business practices both within and across networks. The hope is that the reorganization will result in improved financial outcomes through increased standardization of processes. Networks nationwide are currently moving forward with the CFO the Reorganization.

Even prior to the CFO Reorganization, some VISNs opted for a consolidated model. Some networks have chosen to organize some or all of their business office activities under the VISN umbrella, instead of having each facility or system operate independently under a more traditional structure. There is a tremendous amount of variation among networks that consider themselves consolidated. Networks may have logistics, contracting, payroll, travel, coding, and finance personnel consolidated and physically located together, or only some of these services might be part of the consolidated entity. Others may consider themselves to have a consolidated model, but keep some workers connected virtually.

Objective:

The purpose of this project was to find out how many VISNs currently have some degree of business office consolidation, and whether those who are consolidated experience improved financial outcomes, as judged by the Financial Indicators found on the VHA Office of Finance Website.

In order to do this, Finance Office personnel in each VISN were queried as to whether or not they consider their business offices to be consolidated. The VISNs were grouped according to their responses. Then, the two groups were compared based upon the number of financial indicators in the green for Fiscal Year 2004.

Findings:

Out of the twenty-one networks, five indicated that they had consolidated business offices. These included VISNs 2, 6, 7, 12 and 22. These VISNs achieved higher performance, on average, in 13 out of 19 financial indicators. Additionally, five of the six consolidated VISNs ranked in the top ten in terms of overall percentage in the green.

The thirteen indicators that were greater for VISNs with consolidated business offices include:

- Delay in billing – in & out patients
- MCCF – receivable (5287)
- Aging of payables
- Aging of obligations
- Aging of travel obligations (non-PCS)
- Aging of suspense – 3875
- Aging of suspense – 3885
- Asset Accounts – FA & GL diff
- Timely reconciliation and matching
- Approval of card payments
- Outstanding timecards
- Un-matched deposits

The three indicators that were greater for VISNs without consolidated business offices include:

- Agent cashier turnover rate
- Aging of accounts receivable (non-MCCF)
- Analysis of FA subsystem

The greatest differences between the consolidated and non-consolidated groups were seen in the following indicators:

- **Agent cashier turnover rate**: There was an 11 percentage point difference between the two groups. The average percentage in the green for the unconsolidated group was 90%, while the average percentage in the green for the consolidated group was 79%.
- **Aging of travel obligations (non-PCS)**: There was an 11 percentage point difference between the two groups. The average percentage in the green for the consolidated group was 80%, while the average percentage in the green for the unconsolidated group was 69%.
- **Timely reconciliation and matching**: There was an 11 percentage point difference between the two groups. The average percentage in the green for the consolidated group was 87%, while the average percentage in the green for the unconsolidated group was 76%.

Consolidation may improve performance in these areas because of enhanced efficiency through standardization of processes.

Application Potential in Other Facilities/VISNs

Each VISN is responsible for achieving and maintaining healthy financial indicators. This project shows that business office consolidation may be an important factor to consider when working to improve financial performance. Therefore, this project's findings are relevant to all within VHA.

Project Limitations:

Although VISNs with consolidated business offices did show greater performance on 13 of the 19 financial indicators, it cannot be concluded that consolidation is the factor responsible for the difference. A correlation exists, but causation cannot be assumed. Also, the number of consolidated networks was too small to ensure an adequate sample size, so any differences in financial performance between the two groups cannot be considered statistically significant.

LESLEY T. HALL

Address: 121 S. Fremont, #202 Baltimore, MD 21201 **Phone**: (410)685-7695 **Email**: lesley_hall@hotmail.com

OBJECTIVE: Vibrant and talented early-careerist seeking a clinical or financial management position in a health care provider setting

PROFESSIONAL EXPERIENCE

06/04 – Present **VA Capitol Health Care Network**, Linthicum, MD

Outpatient Clinic Coordinator (11/04 – Present)

- Performed general day-to-day management functions for two primary care clinics
- Acted as the technical expert for clinics' Advanced Clinic Access Team; Implemented various data monitoring tools in order to analyze and improve clinic and office efficiency

Administrative Fellow

- Worked with group tasked to implement process improvements for multimillion dollar program; Created agendas, monitored tasks, recorded minutes, researched directives
- Drafted lease agreement for homeless veteran initiative
- Provided program support for national executive leadership search; used excel spreadsheets to organize 300+ application packets, scores, referral letters, and emails

09/02 – 04/04 **Economic Research Initiative on the Uninsured**, Ann Arbor, MI

Research Assistant

- Maintained extensive web-enabled Access database on the economics of the uninsured
- Completed special projects involving literature search & review and data abstraction & analysis

06/03 – 08/03 **NewYork-Presbyterian Hospital**, New York, NY

Intern, Greater New York Hospital Association/Institute for Diversity Summer Enrichment Program

- Collaborated with director of children's marketing and advocacy on components of a national campaign strategy focused on the childhood obesity epidemic
- Carried out statistical analysis of branding and service line marketing efforts on call center activity; Data used to justify addition of $1M to call center operational budget
- Developed and executed several market research studies and call center support projects

06/02 – 08/02 **Pharmacia Corporation**, Kalamazoo, MI

Intern

- Participated in implementation processes of an IT project; enhanced project management skills
- Assisted with various tasks associated with transition into a new laboratory information management system including data migration and validation

06/01 – 08/01 **University of North Carolina**, Chapel Hill, NC

Researcher, Summer Pre-Graduate Research Experience

- Conducted economic research under guidance of prominent preceptor
- Authored paper entitled "Hospital Competition and Quality of Care"
- Presented poster at Minority Undergraduate Research Assistanceship Program symposium

06/00 – 08/00 **University of Michigan Hospital and Health System**, Ann Arbor, MI

Intern, University of Michigan Summer Enrichment Program

- Investigated a new Medicare policy and presented findings and recommendations to appropriate persons including the Chief Compliance Officer and medical center billing staff
- Obtained exposure to senior level management through various shadowing opportunities, meetings, and interviews

EDUCATION

University of Michigan, May 2004
MHSA, Health Management and Policy
Selena D. Brown Achievement Award

Duke University, May 2002
BS Economics, BA Chemistry, Health Policy Certificate
University Scholar

SKILLS

Microsoft Certified Power User (Word, Excel, PowerPoint), Microsoft Access, Simulation Software, Statistical Software, Quantitative Research and Analysis, Event Management, Public Speaking, Case Analysis

LESLEY T. HALL
Administrative Fellow, VISN 5
849 International Drive, Suite 275
Linthicum, MD 21090
lesley.hall@med.va.gov
(410) 691-7765

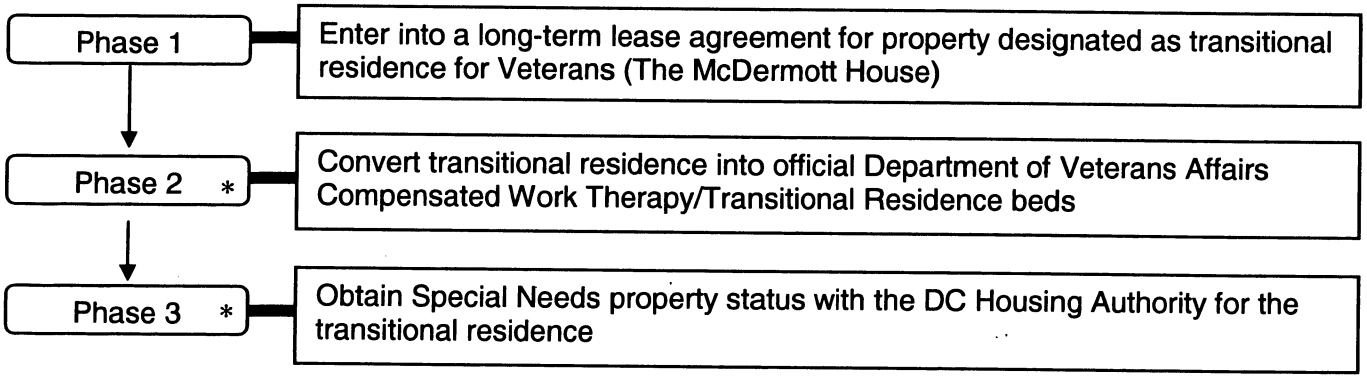
THE McDERMOTT HOUSE PARTNERSHIP:
A Model for Interagency and Community Collaboration

OBJECTIVE

The purpose of this partnership is to help end cyclic homelessness among veterans in Washington, D.C. by providing transitional residence for Veterans enrolled in the Washington, D.C Veterans Affairs Medical Center's (DC VAMC) Compensated Work Therapy (CWT) Program.

DESCRIPTION

The process used to reach the objective consists of three phases. The partners involved in this effort and their contributions (planning and development) are described in more detail on page 2.



*Phase not completed at the time of this report

OUTCOMES

This collaborative is unique because it involves a three-way partnership with a federal agency (Department of Veterans Affairs), a local government agency (DC Housing Authority), and a non-profit community provider (Chesapeake Health Education Program). Although these three entities have been loosely affiliated for several years, the formalization of these relationships will provide benefits for all parties involved, therefore making it a win-win-win situation.

		Phase 1	Phase 2	Phase 3
Partner	DC VAMC	Transitional residence for CWT participants	Increased VERA reimbursement; complex care patients	More seamless transition into public housing after discharge if needed
	DCHA	Efficient use of property	VA money to be used to upgrade furniture and life safety adjustments	Helping to better serve our nation's heroes
	CHEP	Fulfillment of mission	Fulfillment of mission	Fulfillment of mission

FACTS & FIGURES

The DC VAMC CWT program is above the national average in several key performance areas. Below are data from FY04 for the medical center's CWT program. This partnership will add additional support for the continuing effort to provide housing for CWT participants in need.

- Number of patients in CWT in FY04: 176
- Number patients assigned to CWT in FY04: 113
- Number discharged from CWT: 84
- Number/(percent) placed in competitive employment: 39 / (46%) – National Avg. 42%
- Number/(percent) placed in training: 3 / (3.6%) – National Avg. 2.9%
- ALOS in CWT: 8-9 Months

PARTNERS

DC VAMC

The DC VAMC Mental Health Service Line operates many services to help end the cycle of homelessness among Veterans and help prepare Veterans for reintegration into mainstream society. In fact, another relationship with the DC Housing Authority that is separate from The McDermott House project already exists. It is known as the Veterans Administration Supportive Housing (VASH) program, in which 28 housing vouchers are set aside specifically for severely disabled Veterans. In terms of workforce reintegration programs, the medical center operates incentive therapy and therapeutic printing plant programs in addition to its high-performing CWT program. All veterans enrolled in these programs receive quality medical care, preventive screenings, and other benefits that are provided along the VA continuum of care.

DC Housing Authority (DCHA) - *www.dchousing.org*

One of the main functions of the DCHA is the same as all public housing agencies; to provide quality, affordable housing to low-income families and individuals. However, all across the nation, public housing can almost be considered a scarce resource as evidenced by the results of the 2001 Housing Survey-US Conference of Mayors. The statistics are very alarming for the District of Columbia especially. According to this survey, the average wait list for public housing in DC is 30 months and only 31 percent of households deemed eligible by the DCHA are receiving assistance. Current experience shows that this wait time may actually be much longer. This increases the vulnerability for Veterans enrolled at The McDermott House who may need public housing assistance after successful discharge from the CWT program. Fortunately, the DCHA and the DC VAMC have a very good relationship and all efforts, within the law, are used to try to find public housing for Veterans when needed. Phase 3 of the project is to get The McDermott House recognized as a Special Needs property under DCHA regulation. With this designation, all Veterans living at The McDermott House are automatically enrolled in the public housing system, therefore upon discharge would receive a higher priority transfer status and have a more seamless transition into permanent housing.

Chesapeake Health Education Program (CHEP), Inc. - *www.chepinc.org*

This non-profit agency has two missions: (1) provide continuing education for health care professionals and (2) develop programs to break the cycle of homelessness among the Veteran population. Their homeless Veteran initiatives involve partnerships with the VA and other agencies to provide both training and residential opportunities to homeless Veterans and those at risk of being homeless. Their role in The McDermott House Project has been to acquire a long-term lease of this property from its owner, the DCHA. Up to 30 Veterans at a time can reside at The McDermott House. Essentially, CHEP will act as the management company for this transitional residence by providing support activities such as routine maintenance and upkeep. Through use of this property, CHEP is able to provide resources (safe housing) in order to satisfy a need (homeless Veterans) and therefore fulfill their mission.

Acknowledgements: I would like to extend many thanks to the following individuals for their dedicated work with homeless Veterans and for their assistance with information used in this report: Mary Rooney, Sherry Edmonds-Clemmons, Michael Lamb, Martha Valdez, and Ken Backer.

CARIANNE M. JOHNSON

474 N. Lake Shore Drive #4507 (954) 592-3721
Chicago, Illinois 60611 carianne@alumni.nd.edu

Education

Master of Health Administration (M.H.A.) **May 2004**
University of Florida Gainesville, Florida
- Health Services Administration Alumni Service Award
- U.S. Public Health Service Traineeship

B.A. Spanish Major – Preprofessional Studies **May 2002**
University of Notre Dame Notre Dame, Indiana
- Designated Notre Dame Scholar

Work Experience

Administrative Fellow **June 2004 – present**
Jesse Brown VA Medical Center Chicago, Illinois
Network of 209-bed acute care facility and five community-based outpatient clinics
- Managing development and implementation of a new transitional care unit
- Improved the process for monitoring and updating medical center policies
- Served as Member and Facilitator of failure mode and effect analysis (FMEA) teams
- Implemented Advanced Clinic Access, including education of physicians and support staff, outreach, composition of service agreements, and creation of performance measures scorecard
- Created tools to monitor monthly overtime spending and bed days of care
- Extracted facility and service-specific data from an All Employee Survey, disseminated results, and developed strategies for improving key areas
- Actively serve as member of the Employer of Choice and Service Excellence Committees

Project Consultant **December 2003 – March 2004**
ACORN Clinic Brooker, Florida
Rural clinic that provides healthcare services to low-income and uninsured patients
- Collected and analyzed data about unmet healthcare need in the service area
- Organized stakeholder workgroup to evaluate strategic options in CHC approach

Administrative Intern **May 2003 – August 2003**
Catholic Health Services Lauderdale Lakes, Florida
System of 19 post-acute care facilities in Miami-Dade and Broward Counties
- Researched customer service measures for rehabilitation hospitals and nursing homes
- Created a template to graph trends in 24 facility quality indicators (FQIs) for nursing homes
- Adapted a tool to analyze expenses and variances of 15 ancillary charges by payer type
- Developed and organized marketing of a new Spasticity clinic

Research Assistant **Academic Years 2002 – 2004**
University of Florida, Department of Health Services Administration Gainesville, Florida
- Prepared, formatted, edited academic articles, research papers, proposals, and presentations
- Conducted multi-method research, including research design, data collection, and data analysis of pertinent health services research information

Student Assistant **Academic Years 1998 – 2002**
University of Notre Dame, Strength & Conditioning Department Notre Dame, Indiana
- Assisted in planning, organization, and execution of camps and clinics, including marketing, designing brochures, and creating databases and mailing lists

Affiliations

Member – American College of Healthcare Executives (ACHE)
Member – Notre Dame Alumni Club of Chicago
Member – Young Professionals of Chicago (YPC)
Volunteer – The Christopher Zorich Foundation, Chicago, Illinois

Reports

Lemak, C.H., Hall, A.G., Johnson, C.E., Saxena, P., Aftuck, C. & Johnson, C. Evaluation of Florida's Minority Physician Network (MPN) Program: Final Project Report. Submitted to Florida Agency for Health Care Administration. April 2004.

Harper, M. & Johnson, C. Overview of Healthcare Need: Focus on the ACORN Clinic Service Area. Submitted to Florida Department of Health. March 2004.

Facility: Jesse Brown VA Medical Center
Contact: Carianne Johnson, Administrative Fellow
820 S. Damen Avenue
Chicago, IL 60612
(312) 569-6737
Training Start: 28 June 2004

ESTABLISHMENT OF A TRANSITIONAL CARE UNIT (TCU)

Description of the Program

Utilization review data demonstrate that many of our patients at Jesse Brown VA Medical Center do not meet InterQual criteria to remain in medical/surgical acute care beds, as shown in the table below. FY 2004 Continued Stay Reviews indicate that 46% of our patients in-house six days or more did not meet InterQual criteria. The majority of these patients were awaiting acceptance, transfer, or placement in an alternate level of care. Of those, 4354 total patient days had a recommended level of care that could have been met in a transitional care unit. Many of these patients are elderly and do not have the family support to allow them to be discharged to their homes as might otherwise be possible. Patients may also require extended rehabilitation care in a non-acute care setting. The conversion of 15 internal medicine and 10 physical medicine and rehabilitation beds to 25 transitional care beds at Jesse Brown VA Medical Center will reduce our acute bed days of care, while still allowing us to meet the nursing needs of our patients. In FY 2004, our bed days of care were 50,200 days, and the average length of stay (ALOS) was 6.6 days, which makes us an outlier for our medical cost group (MCG 5) for most treating specialties. Our acute bed days of care rate for FY 2004 was 1,131.14. Our FY 2005 target (based on the FY 2004 median within MCG 5) is 741.

	FY 2004	FY 2005 Target
Bed days of care	50,200	39,434
Acute bed days of care rate	1,131.14	741
Average length of stay (days)	6.6	5.5
% of patients not meeting InterQual criteria‡	46%	40%*
Total bed days where recommended level of care could have been met in transitional care‡	4,354	2,177*

‡ According to Utilization Management Continued Stay Review
*Based on full implementation of a transitional care unit in the 3rd Quarter

Transitional care may address both utilization management issues and coordination of multidisciplinary care that is required by our aging veteran population. "Transitional care has been defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care in the same location."[1] Discontinuity and poor communication in our current healthcare delivery system place elderly high-risk patients in jeopardy of poor outcomes and early readmission to acute care.[2] The goal of transitional care is to improve care to these high-risk patients by facilitating the care process from inpatient setting to home or community while improving level of wellness and function. Various studies suggest that transitional care can improve outcomes by reducing subsequent readmissions and bed days of care and, therefore, reduce costs.

The Transitional Care Unit (TCU) at Jesse Brown VA is designed to serve those veterans who do not need hospitalization in the acute care setting and do not meet InterQual criteria but require medical, nursing, rehabilitative, psychological, or supportive services by an interdisciplinary team. The goal of the program is to provide interdisciplinary assessments and treatment toward the improvement and maintenance of the patient's functional levels and to enable the patient to discharge to the least restrictive level of care that is appropriate.

Objectives

- To optimize the highest quality of patient care in the most cost-efficient setting
- To increase the number of patients meeting InterQual criteria and decrease the number of patients placed in an inappropriate level of care
- To reduce bed days of care and average length of stay

Planning and Development

- In accordance with VHA Directive 1000.1, Program Restructuring and Inpatient Bed Change Policy, a request for bed changes was sent to VHA Patient Care Services through the VISN 12 Long-Term Care Task Force and Network Director.
- Research was conducted on relevant clinical literature, VA directives, and best practices at other VA facilities.
- A committee was established to coordinate the implementation of the TCU. Members include the Director's Office, Nursing, Medicine, Performance Improvement, Patient Administration Service, and Social Work. The committee created admissions and discharge criteria based on InterQual criteria and JCAHO standards and developed policies and procedures for the unit.
- The interdisciplinary team (including physicians, nurse practitioner, nurses, social workers, dieticians, dentists, and therapists) was trained in Accu-Care software for documentation of the Resident Assessment Instrument Minimum Data Set (RAI/MDS).
- Providers assigned to the TCU were also oriented and trained in JCAHO standards and unit policies & procedures.
- A mock JCAHO survey will be conducted for the unit by an outside consultant in April.

Application Potential

Application potential at other facilities is high, requiring an internal assessment of the need for a transitional care unit, as well as the authority to convert/establish beds. Other resources and associated costs are listed in the table below.

RAI/MDS software and training (based on five licensed users)	TBD
JCAHO publications: Comprehensive Accreditation Manual for Long Term Care Standards for Long Term Care	 $240 $105
JCAHO consultant mock survey (funded by VISN)	$14,667
Change in nursing mix – cost savings	TBD
Total Costs	

Outcomes, Benefits, and Cost Savings

Anticipated clinical outcomes include reduction in readmissions to acute care within 30 days, reduction in mortality during hospitalization, and increase in functional status as measured by the activities of daily living (ADLs). Cost savings will be achieved through decreased acute bed days of care and a change in nursing mix.

In addition to improved utilization management, we will be able to maximize our VERA reimbursement for patients whose length of stay is greater than 30 days through the use of RAI/MDS for the following patient classifications: Low Activities of Daily Living (ADL), Specialized Care, and Ventilator Dependent.

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[1] Coleman, E.A. and Berenson, R.A. (2004). "Lost in Transition: Challenges and Opportunities for Improving the Quality of Transitional Care." *Annals of Internal Medicine* 141(7): 533-535.

[2] Parsons, P.L. and Gifford, C. (2002). "Characteristics and Outcomes of Elderly Patients Receiving Transitional Care." *Outcomes Management* 6(4): 182-185.

Meredith D. Katz, OTR/L

433 East 56th Street, Apt. 5B
New York, New York 10022
Tel: 212-755-6913
E-mail: MeredithDina@aol.com

Education: **NEW YORK UNIVERSITY** New York, NY
Robert F. Wagner Graduate School of Public Service
Master of Public Administration, Expected May 2005
Health Management and Policy

BOSTON UNIVERSITY Boston, MA
Sargent College of Health and Rehabilitation Sciences
Bachelor of Science: Occupational Therapy, May 1997

Experience: **VETERANS AFFAIRS, NEW YORK HARBOR HEATLHCARE SYSTEM** New York, NY
6/04- Present **Administrative Resident, Executive Office**

- Work closely with Director (CEO), Performance Improvement Manager, Deputy Chief of Staff, Data Manager and other members of senior management on multiple clinical and administrative initiatives including:
  - Conducting performance improvement initiative to reduce the patient missed appointment rates in 8 outpatient clinics.
  - Performing space utilization analysis for Dermatology outpatient practice.
  - Organized and co-coordinated the Combined Federal Campaign and exceeded the facility goal.
  - Participating in Root Cause Analysis (RCA) team.
  - Assisting in developing a new clinic cancellation and rescheduling policy.
  - Acting as a liaison between Performance Improvement leadership and the Medication Management stakeholder team to facilitate JCAHO continuous compliance.
  - Co-coordinating the Employee of the Month Program.

ST. VINCENT'S CATHOLIC MEDICAL CENTER New York, NY
5/98- 6/04 **Occupational Therapist, Behavioral Health**

- Planned and implemented therapeutic discussion groups for mentally ill inpatients.
- Conducted occupational therapy functional assessments.
- Collaborated with multidisciplinary team in assessment, treatment and discharge planning.
- Supervised, trained, and developed educational programs for occupational therapy fieldwork students.

11/01- 5/04 **Fieldwork Coordinator, Behavioral Health**

- Developed and maintained professional relationships with 20 university academic coordinators to provide occupational therapy student internships.
- Interviewed and approved prospective candidates to determine program placement.
- Coordinated and managed meetings with the supervisors to analyze program performance.

11/02- 6/03 **Group Facilitator, Freshstart Program, American Cancer Society**

- Facilitated smoking cessation groups for community members.

Professional Associations: American College of Healthcare Executives
American Occupational Therapy Association

Meredith D. Katz
Administrative Resident
Meredith.Katz2@med.va.gov
Training start date: June 1, 2004

VA NY Harbor Healthcare System
423 East 23rd Street, Executive Office
New York, NY 10010
212.686.7500 ext.3966

Title

Improving Productivity by Reducing Clinic No-Show Rates

Description: The FY 05 VA New York Harbor Healthcare System strategic plan outlines goals and objectives for the shared vision of the organization. Enhancing veterans' access to care is pivotal to improving quality and achieving better health outcomes. The Access strategic target area and FY 05 Access Performance Monitor focuses on reducing the clinic no-show rate to or below 10% in the 8 performance measure clinics. Patients who schedule clinic appointments and fail to keep them have an adverse effect on clinic workflow. The high no-show rate affects clinic capacity, scheduling system productivity, and clinic efficiency.

Objectives:

- Explore the causes behind why patients fail to show for their appointments.
- Recommend and implement effective tools to improve patient no-show rates.

Planning and Development: The New York Harbor Healthcare System consists of three campuses; 2 hospitals, 1 nursing home and 5 community based outpatient clinics. The New York (NY) and Brooklyn (BK) campuses were the primary focus for the project. In collaboration with the Service Chiefs, Administrative Officers, clinic supervisors and clerical staff from 7 of the 8 performance clinics (Audiology, Cardiology, Eye Care, Gastroenterology, Mental Health, Orthopedics, and Urology), patient no-show data was collected from each clinic during a 2-week period. In conjunction with the Deputy Chief of Staff, I developed a survey tool to identify the reasons why patients miss their scheduled clinic appointments. There were a total of 123 patients identified as "no-shows" by clinic staff at both campuses, averaging about 9 patients per clinic. Patient demographic data were gathered from CPRS (Computerized Patient Record System) to contact the veteran at home by telephone. The veterans that were contacted understood that participating in the performance improvement project was voluntary and that the exercise would take 1-3 minutes. Those patients who were unable to be reached by phone were mailed a paper version of the survey to their home address. The patients were supplied with a business reply envelope to facilitate the return of completed surveys.

Data Collection Results: The survey results of the reasons for patients missing their scheduled appointments were compiled and analyzed. Of the 123 patients identified as no-shows from both campuses, 57 patients responded to the survey; a response rate of 46%. Forty-eight patients (39%) responded to the survey by telephone; nine (7%) responded by mail. Of those that did not respond to the survey, only two letters were returned to the VA due to incorrect addresses. Patient reasons for not showing were divided into 3 categories: 'Avoidable,' 'Unavoidable,' and 'Notified/Informed about future appointment.'

Avoidable	Unavoidable
Forgot	Medical problem resolved/no longer need services
Inconvenient time	Change mind about needing appointment
Didn't know who to call	Too sick to come for appointment
Tried calling, no answer	Personal emergency, forgot to call
Clinic schedule too delayed; patient left	Difficult to travel
Can't read the small print on the card	
Appointments are scheduled too far in advance	
Uninformed about cancellation process	
Waiting time too long; doesn't feel the need to cancel	

72% of the responses were related to avoidable factors. Of the 57 responders, 17patients said that they were not notified about their future appointment by telephone or mail; 38 patients stated that they received notification via the automated phone system or by mail. The largest number of respondents stated that they missed their appointment because they "forgot." Published journal articles about missed appointments support the recommendation of telephone reminders as a cost-effective measure to significantly reduce no-show rates.[1] Many patients expressed interest in receiving a reliable reminder call prior to their scheduled appointment.

Recommendations for Implementation:

Phone System Scheduler/Call-in Center

- Address issues related to the avoidable or controllable system failures. The development of a call center would allow for the implementation of an efficient rescheduling procedure, which could result in a reduced no-show rate.
- Reminder phone calls for patients who may forget their scheduled appointments due to the time frame of when the appointment is scheduled.
- Provide accurate telephone numbers for patients to call to cancel and reschedule.

Patient Education

- Produce signage to inform veterans to call in advance to cancel their appointments so that other veterans may use their available slot.
- Make available "call to cancel" information on the VA Internet site.
- Send informational flyers to patients about "calling to cancel" in conjunction with appointment reminder letters.

Advanced Clinic Access (ACA)

- Utilizing ACA principles of "Do today's work today" and balancing supply and demand daily will reduce appointment types and ultimately reduce the amount of patients who miss their appointments.
- Rather than scheduling future appointments, implement a reminder system so that patients call for an appointment when they need it.

Demographic Data

- Reliable demographic data gathering system to ensure that veterans receive appointment information at their correct address.
- Upon arrival at appointment, clerk needs to check with veteran to verify appropriate address and phone number.

Legible Appointment Cards

- Veterans with impaired vision will require appointment cards written in large print to ensure that they are clear and legible.

Application Potential in other Facilities:

The lessons learned from the data collection for reducing the no-show rates are applicable to other facilities. Outpatient clinics with high no-show rates, or clinics that are interested in maintaining a low no-show rate, might benefit from implementing the proposed recommendations to achieve clinic efficiency and productivity.

Resources Required: The primary resource required for the implementation of the recommendations is human resources. Collaboration amongst the providers, clinic supervisors and clerical staff, as well as support from senior management, will facilitate the implementation of the proposed strategy and system changes.

Outcomes and Benefits:

The survey data has been used to develop and support the VA New York Harbor Healthcare System FY 05 Access Goal Sharing Pilot Project to reduce the clinic missed appointment rates to or below 10%. The concepts and recommendations for implementation can be used to improve access, enhance efficiency and maximize resource utilization, ultimately impacting patient satisfaction.

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[1] Oppenheim GL, Bergman JJ, English EC. **Failed appointments: A Review.** Journal of Family Practice. 1979 Apr;8(4): 789-96.

TERRENCE P. KORUPP, MBA
VA Illiana Health Care System
(217) 554-5095 • cell (847) 644-5251
terrance.korupp@med.va.gov

EDUCATION

2001-2004 **KELLOGG SCHOOL OF MANAGEMENT** Evanston, IL
NORTHWESTERN UNIVERSITY
Masters of Business Administration
- Majors in Finance, Health Industry Management and Marketing.
- Member of General Management, Healthcare and Biotech, and Operations Clubs.
- Completed first half of degree while working full-time.

1989-1994 **UNIVERSITY OF MINNESOTA** Minneapolis, MN
Bachelor of Chemical Engineering, Bachelor of Science in Mathematics
- Golden Key National Honor Society.
- Self-financed 100% of education by working.

EXPERIENCE

2004-2005 **VA ILLIANA HEALTH CARE SYSTEM** Danville, IL
Administrative Fellow, 2004-2005
- Actively participate in Executive Management meetings and established committees.
- Trained and managed development of supervisors in new department.
- Audit third party contracts for accuracy of COTR
- Perform cost-benefit analyses of Home Based Primary Care and outsourcing opportunities.
- Analyze sleep studies and MRIs at multiple sites to reduce fee basis costs.
- Participate in JCAHO teams, Root Cause Analysis Teams. Lead various task groups.

1999-2003 **AVENTIS BEHRING, LLC** Kankakee, IL
Pilot Plant Supervisor, 2003
- Coordinated startup and current Good Manufacturing Practices (cGMP) compliance of new product in pilot plant. Successfully passed FDA Pre-Audit Inspection. Biologics License Agreement obtained six months early.
- Trained and managed development of supervisors in new department.

Packaging Supervisor, 2002
- Managed 30 operators in a cGMP packaging operation.

Bulk Manufacturing Supervisor, 1999-2002
- Supervised 15-20 operators, bio-pharmaceutical environment, under FDA consent decree.
- Performed real time audits to ensure compliance with international guidelines.
- Submitted document change requests for SOPs and MPs to comply with cGMPs.
- Clean Room Management Team - involved in developing plant-wide sanitization programs. Coordinated validation within bulk manufacturing areas.

1995-1998 **ECOLAB INC.** Woodbridge, NJ / St. Paul, MN
Distribution Supervisor, 1997-1998
- Directly managed warehouse facility with 2,000 finished good SKU's and four thousand raw materials. Responsible for all aspects of a heavily computerized shipping operation for 250,000 square foot distribution facility.
- Supervised design, implementation, and installation of warehouse rack expansion.
- Implemented computerized inventory control system, decreasing missed shipments by 50%.

Production and Quality Control Supervisor, 1996-1997
- Optimized facility. Improved production rates by 30%, reduced bad batches by 90%.

Roving Industrial Engineer, 1995-1996
- Analyzed manufacturing capabilities of US facilities. Performed facilities capacity planning. Prepared capital authorization requests and implemented capital improvements.
- Oversaw material sourcing and performed physical plant startup in Jakarta, Indonesia.

Facility: VA Illiana Health Care System
Contact: Terrence Korupp
Administrative Fellow
1900 East Main Street
Danville, IL 61811
217.554.5095
Training Start Date: June 28, 2004

Project Title: Mobile MRI Services for Secondary Care Facilities

Description/Background

Providing mobile MRI services at secondary facilities is rooted in giving our veterans superior care. VHA Directives 2002-059 and 2003-062 require the VHA to ensure that service connected veterans receive care within 30 days. Waits and delays throughout the system severely impact the timeliness of care and adversely affect the impression of quality. The VHA System also finds itself financially challenged again. Budgets are extremely tight throughout the VHA system. The Capital Asset Realignment for Enhanced Services (CARES) process is a strategic realignment of capital assets and related resources to better serve the needs of the veterans. The goal is to realign the services of the different centers for optimal efficiency and access. Mobile MRI services is a viable alternative to fee basing patients out into the community or waiting to get them into the related tertiary facility.

VA Illiana Health Care System (VAIHCS) provided care to 30,638 unique patients in FY04. 594 patients received 753 MRIs performed at our tertiary referral facility (Indianapolis, 90 miles away), a local provider (Provena Health Care), or at Open Illini in Champaign, IL. Others with insurance opted to have their MRIs done privately. VAIHCS patients in the western part of our service area travel up to four hours, one way, to have a MRI performed at VA Roudebush (Indianapolis). Current schedule times are twelve weeks out. Provena and Open Illini are able to see our veterans within 2-4 weeks but it takes an additional 3-4 weeks to obtain certified results and another 3-4 weeks for third party billing to complete this lengthy cycle.

Planning/Development

VAIHCS periodically reviews the feasibility of mobile MRI services. With VISN 11's intense financial review of operating expenses, I contacted staff at Battle Creek VAMC, Northern Indiana Health Care System (NIHCS) and VAIHCS to learn what our MRI needs were. Medical records and fee basis reports were analyzed to determine workload, service delays and financial savings. Battle Creek's catchment area requires very few MRIs (~100) and was discounted for contracted services. NIHCS outsourced 562 MRIs during FY04 and is also a possible opportunity for the VA to save by contracting for mobile MRI services.

While reviewing a facility's needs for MRI services, the following considerations must be made:

- Feasibility of performing exams at other VA locations.
- Resources spent facilitating non-VA appointments and collections.
- Travel time of the veteran.
- Construction costs.

- Possibility that some types of MRI scans may be cheaper via fee basis than contracted costs.
- Latent demand (20-30%). Lack of availability of services may lend to underestimating volume. Physicians may also prepare consults too frequently once MRI services are available.

By contacting other VAMCs that have existing mobile MRI contracts, preliminary constructions cost estimates were provided. Combining best practices from other sites with our analysis, a business plan was developed and presented to the VISN 11 Executive Leadership Council. The VISN reviewed the MRI capacity of the tertiary facilities and has recommended, at this time, that VAIHCS continue preparations for on-site, mobile MRI services.

Work continues on the proposal to install a mobile MRI unit at VAIHCS. Currently, the following items are in progress:

- Engineering is preparing cost estimates for multiple locations on site, reviewing costs as well as access to the facility.
- Statement of Work is being developed for the option of having MRI readings performed by radiologists elsewhere in the VISN, as well as contracting them out.
- Anticipated workload is still fluid. Workloads between VA Roudebush, NIHCS, and VAIHCS are being reviewed. VAIHCS may take full control of its workload, allowing additional NIHCS patients to go VA Roudebush. Workload will ultimately determine if VAIHCS needs to contract for service one or two days per week.

Resources Required

- A reinforced cement pad or approximately $40,000 to lay a truck pad capable of parking a fully loaded forty foot trailer.
- Ability to provide electric, data, and phone lines to mobile MRI unit.
- Means to safely move veterans to mobile MRI unit in inclement weather.
- Means to properly store and transfer MRI images within the VA. Have images read, certified and recorded in VISTA and a picture archive communication system for availability to requesting physician.

Benefits

- Reduce waits and delays to have MRIs performed at related tertiary facility.
- Replace high fee basis costs with lower, facility costs. Eliminate issues of transferring images and reports with outside provider.
- Augment one facility, one service image.

Application Potential

For non-tertiary facilities that do not have the workload or expenses to financially defend the high installation costs (approximately $3million) of a MRI unit on station, contracting for on-site, mobile MRI services is a means to ensure:

- Quality of care.
- Reduce waits and delays associated with performing MRIs and the subsequent reporting mechanisms.
- Services are performed within the limited financial resources of the facility.

Aaron M. Love

2515 Center West Pkwy. Apt. 2B
Augusta, Ga. 30909
Cell Phone: (706) 231-4463
Email – aaron.love@med.va.gov

EDUCATION

August 2003 - Dec. 2004 University of Florida (College of Public Health) Gainesville, FL
M.P.H., Concentration: Health Care Management and Policy

Jan. 2001 – Mar. 2003 Wright State University Dayton, OH
M.B.A., Concentration: Project Management

Mar. 1995 – May 1999 University of West Georgia Carrollton, GA
B.A., Psychology, Minors: Chemistry and Biology

PROFESSIONAL EXPERIENCE

January 2005 – present **VA Medical Center Augusta** Augusta, GA
Administrative Fellow, Department of Veteran's Affairs

- Participates as an active member of the executive team

May 2004-August 2004 **University of Florida College of Medicine** Gainesville, FL
Intern, Department of Medicine Accounting and Budgeting Group

- Audited internal payroll and Florida Foundation Endowment Accounts to ensure proper funding usage according to donor intent
- Prepared and reviewed monthly variance reports comparing physicians' budgeted to actual charges and collections
- Used and culminated data for analysis to develop accounting, revenue, and trend analysis reports

June 2002-August 2002 **Miami Valley Hospital** Dayton, OH
Summer Semester Internship (Human Resources)

- Assisted in JCAHO licensure audit ensuring that employees had valid and current licensure
- Assisted in employee demographic reports to be reported to hospital management

Feb. 2000-Dec. 2000 **Fayette Community Hospital** Fayetteville, GA
Medical Records Specialist/ER Registrar/Patient Care Technician

- Registered patients in the ER entering patient information and insurance information
- Ensured the accuracy and confidentiality of patient charts and records by working closely with doctors, nurses, and physician assistants

AWARDS RECEIVED

- MBA Showcase Award (2003); Dean's List-3 semesters (1998); Music Scholarship (1994-1996); HOPE Scholarship (1994-1996); Honor graduate (1994).

PROFESSIONAL MEMBERSHIPS

- American College of Healthcare Executives; (Member) May 2004 – present
- Sigma Iota Epsilon (National Management Honorary and Professional Society) (lifetime member)
- University of Florida Student Public Health Association; (member) 2003-2004

Aaron M. Love
Administrative Fellow
1 Freedom Way
Augusta, Ga. 30904
(706) 733-0188 Ext. 1798

Facility: Augusta, Ga. VAMC

Start Date: January 10, 2005

Project Title: ***A New Era for Patient Scheduling: The Implementation of the VistA Patient Recall System v 1.3 at the Augusta VAMC***

Description/Background:

The Augusta VAMC has a myriad of medical clinics within its two division facility designed to meet the medical needs of our nation's veterans. The Primary Care Clinic Service Line contains four primary care clinics (clinics A, B, C, and D) that experienced over 52,000 clinic visits in 2004. In order for the primary care clinic to schedule and treat veterans in a timely and efficient manner, an effective patient recall scheduling system is being implemented to ensure that patients receive the initial and follow-up care they need. This new scheduling recall system will shift the scheduling responsibilities from nursing staff to six staff employees designated to scheduling appointments. In turn, it will allow the nursing staff to focus solely on their clinical responsibilities. Additionally, it will give physicians more control over their clinical schedules.

In 2004, the average cost per visit at the Primary Care clinic was $143.69. Last year, the clinic experienced over 7,800 no-shows. This equates to a 14.93% no-show rate and as a result the overall cost to the medical center was a staggering $160,405 in fiscal year 2004. The no-show average cost amounted to nearly $21 for every patient that was a no-show.

The main goal of the Advanced Clinic Access Initiative is to build a system in which patients have the opportunity to see their own providers when they choose in a timely manner because an access problem is a delay problem. Instead of dealing with access problems using traditional methods that include controlling the daily patient demand for care, Advanced Clinic Access seeks to predict patient demand and respond to it appropriately. The new VistA patient recall system seeks to achieve this goal. Currently, veterans make their next appointment at the time of their visit. The recall system is designed to send a reminder postcard informing the veteran that he/she is due for an appointment. The veterans can then call and make their appointment with a scheduler. The system will help reduce the level of no-shows and hence, total costs associated with no-shows, as well as provide the clinic with greater control in appointment management. In fact, the new system will shift the process from appointment management to physician panel management whereby the focus of scheduling patients will be based on the physician panels rather than specific appointment time slots.

Objectives:

The main objectives of the system include:

1.) To increase patient accountability and clinic accessibility
2.) To eliminate automatic return visits
3.) To decrease the level of no-shows
4.) To effectively utilize recall for return visits > 30 days
5.) To increase assurance among providers that patients do not "fall through the cracks"
6.) To more effectively manage provider time
7.) To improve data collection and management.

Planning, Implementation and Development:

The recall system software has already been installed. The data for the recall system includes the patient name, the last four digits of the patient's social security number, the return interval, the patient's phone number, the provider, the lab number, the future date of the appointment, and whether the patient is participating in fasting or not.
The medical center will pilot the program in Primary Care Team B to test out the new system and work out any glitches that may arise before rolling out to Primary Care teams A, C, and D. In order to educate the six staff members that will be utilizing the system there will be a one day educational training session in order for those staff members to become informed and trained on the operations of the new system. There are four main steps involved in the recall process. The first step involves entering the patient data into the system. Secondly, postcards are printed with the appropriate information and sent to each respective patient. Thirdly, the patient is removed from the recall system after making the appointment. Finally, the recall list is reviewed and checked for any "fallout" that may have occurred among patients. At checkout, whether a site uses List Manager or the CPRS, a stub record is created in the VistA Patient Recall file. Once created, the site runs an appointment listing for the previous work day from the recall main menu and uses it to complete the required information on the recall record. The postcards are produced from the main menu and sent to the patients via mail two weeks in advance of their scheduled return visit.

Anticipated Costs and Benefits:

The new system has several benefits. The major benefit of the new system is that it will reduce the level of no-shows, which will increase productivity and revenue. It will also create more of an interactive partnership between the patients and the medical center because patients will be more accountable for setting up their appointments and then following through with them in a time frame that is more conducive to their own schedule. With a documented record of the recall postcards of patients and the physicians' requests for return visits, the monitoring of provider return patterns will be easier to assess. Since appointment scheduling will be based on the physician panels the patient workload will be much easier to modify in order to accommodate provider absences. Another advantage of the system includes eliminating automatic return visits. By doing so, it creates availability to patients who call for an appointment in the relative near future. Continuing to schedule patients as they leave their appointments would result in decreased availability. Therefore, the clinic would be incapable of accommodating a patient who wants or needs an appointment "next week." Other benefits include the onset of more balanced work days for providers because of the lack of no-shows, the decrease of patient demands with increased access into clinics and the system supports the goals and objectives of Advanced Clinic Access.

The anticipated costs are expected to be minimal in terms of providing additional financial resources. The software has already been purchased and installed. The main cost associated with the system involves the possible purchase of a high-end printer in order to produce the high volume of recall postcards. Also, there will be an additional cost for the purchase of the reminder postcards but that too is expected to be a minimal expenditure. In terms of reducing staff workload, the system, unfortunately will not reduce the amount of work involved because the process will still need to be managed. Therefore, the costs associated with staffing will not decrease. However, the benefits clearly will outweigh the costs when a cost-benefit analysis is completed.

Potential Applications to other Facilities:

The new recall system certainly is applicable to other facilities within the VA system and has enormous implications for facilities that have clinics that utilize primary care providers and are experiencing high levels of lost productivity and revenues associated with no-shows. In addition, other facilities that are experiencing strains on a provider's time will find the system helpful in more effectively managing the scheduling of patients and the time allocated for providers, which will keep physicians satisfied and more productive and give veterans the care they need in an efficient manner.

ALICIA C. MILLER

EDUCATION

Masters of Health Administration & Policy May 2004
University of Oklahoma Health Sciences Center, Oklahoma City OK

Bachelor of Sciences in Health and Sports Sciences May 2001
University of Oklahoma, Norman, OK

PROFEESSIONAL EXPERIENCE

Administrative Fellowship June 2004- Present
Department of Veterans Affairs Medical Center, Oklahoma City, Oklahoma

- **Conducted** a cost analysis of National Guard Physical Exam Revenue Generating Contract to ensure the contract was a cost efficient initiative for the Medical Center, and **proposed** recommendations to ensure its **viability** and presented findings to the Medical Center Triad.
- **Assessed** the Medical Center's use of **R**elative **V**alued **U**nits in an effort to equate physician productivity with compensation, in order to present findings to Medical Center Triad.
- **Assisted** the VHA High Performance Development Model Program Office with the Executive Career Field Rating Panel by **inputting** and **screening** data used to choose the Executive Career leadership class for the year 2005 and **contributed** in updating current Executive Career Field Tracks.
- **Analyzed** and **conducted** a cost analysis of the Lawton Community Based Outpatient Clinic's radiology services to **ensure** that the most **efficient** and **effective** methods and providers were being utilized. **Determined** if outsourcing these procedure were both **beneficial** and **financially adequate**.
- **Served** as an **Administrative Assistant** in Nursing Service, managing encounters and consults for Nursing, Primary Care, Emergency Room, and Flu Clinics. **Evaluated** the use of overtime throughout Nursing Service to be used by the Nursing Executive team in a service-wide management briefing, and by the Medical Center Triad as an incentive program for nursing associates.
- **Managed** the Offutt Scholarship given by the Medical Center to 3rd and 4th year medical students throughout the country. **Successfully edited** and **published** the second edition of the Offutt Award Book, (a compilation award winning essays writing by the scholarship winners).

Internship Aug 2003-May 2004
Mercy Health Center, Oklahoma City, Oklahoma

- **Developed** a feasibility study of the hospitals' current physician demand for a new physician's building, and the limitations imposed by space and parking on the current campus, which would serve as a new facility for over **50 physicians'.**
- **Evaluated** other hospitals and their campus development, in order to **improve** the use of the space at Mercy Health Center.
- **Proposed** options and recommendations for the building of a new Physician's Building on the Mercy campus to include an economic assessment over the organization's control over assets and the facility.
- **Analyzed** the benefits that a new facility would provide for the organization, such as an **increase** in recruitment**, attrition** of potential and current physicians, **improvement** in continuum of care, provide a **positive** appearance to the community, and the ability to provide **better services**.

PROFESSIONAL AFFILIATIONS/VOLUNTEER WORK/HONORS

- Member American College of Healthcare Executives (ACHE)
- Delta Sigma Theta Sorority Incorporated
- University of Oklahoma, student chapter of American College of Healthcare Executives (ACHE), Vice President.
- Sickle Cell Anemia Foundation of Oklahoma City, Oklahoma
- Mentor Salvation Army North Mabee Center Tulsa, Oklahoma.
- American Heart Walk
- Combined Federal Campaign
- Susan G. Komen, Breast Cancer Foundation
- Dean's Honor Roll
- Who's Who Among America's Colleges and Universities
- National Dean's List
- Article published in the Oklahoma State Medical Association's the ***Journal***

2301 NW 122nd Street Oklahoma City, OK * Phone (405) 751-6321 * EMAIL Alicia.Miller2@med.va.gov

Facility

Oklahoma City VA Medical Center

Contact

Alicia Miller, MHA
Administrative Fellow (OOR)
921 N.E. 13th Street
Oklahoma City, OK 73104

(405) 270-0501 ext. 3605
E-Mail: Alicia.Miller2@med.va.gov
Training Start Date: June 1, 2004

Title

Satellite Clinics: A Proactive Approach to Growth

Background

Adequate space is far reaching within the VA healthcare system, while the ability to increase and improve healthcare access to veterans will continue to be a targeted goal. Similar to other facilities within the VA system, space is truly the last frontier for the Veterans Affairs Medical Center in Oklahoma City, Oklahoma. At the Oklahoma City VAMC, patients are constantly impacted by a lack of parking, the significant driving distance required in order to seek medical attention from their primary physicians, and increased wait times as patients arrive extremely early due to the limited parking on the existing campus. Physicians and administrators however continued to diligently work to manage the care of the growing veteran population under the constraints of limited space allocated within the facility to attend to their patients' needs. The Oklahoma City VA Medical Center is an 882,656 square foot nine story building and accommodates comprehensive healthcare services including ambulatory care, medical sub-specialties, and inpatient bed days of care to veteran patients each day. The Oklahoma City VA Medical Center consists of 169-operating beds; still, the OKC VAMC struggles with having adequate space necessary to provide care for the influx of veteran patients that have entered the system. A long way from its inception as a one-story building located at the Will Rogers Field, the Oklahoma City VA is now located amongst a medical complex in downtown Oklahoma City. However, as construction grew in this area the Medical Center became landlocked with no room to grow. In prior years forecasters predicted an increased number of outpatient visits, with an inversed prediction for the number of inpatient visits. Along with others in the healthcare industry, the VA adapted to this impending change in demographics and inpatient wards were transformed into primary care and outpatient specialty clinics; *however with in the next ten years, this pattern of care is expected to change.* The Oklahoma City VA currently provides care to over 220,000 patients and is expecting significant growth in the next 10-15 years. According to the Capital Assets Realignment for Enhanced Services (CARES), by FY 2010, Oklahoma City will see a 78% increase in Primary Care visits and a 71% increase in Service bed days of care. Due to these significant increases in workload, the Oklahoma City VAMC will be faced with serious space restraints. The inpatient and outpatient patient care areas will need to grow in order to meet this increasing demand for services. The VA Health Care system continues to change in order to provide the highest quality of care for veterans. The inception of CARES was created for all the VA to provide better care in a more appropriate and efficient setting. The CARES mission is to improve quality as measured by access and to improve the delivery of healthcare in a cost-effective manner, while maximizing positive opportunities and minimizing any adverse impacts on staffing, communities and other VA missions. Through CARES, VA is realigning and enhancing its health care system to meet veterans' needs more effectively, now and in the future (VHA Vision 2020).

Project Description

The Oklahoma City VA healthcare system has decided to "outsource" Primary Care Services from the Medical Center to "Satellite Clinics" as a suitable way of managing the impending increase of veteran patients entering the system. This initiative is a challenge that will require extensive resources; however, it is a proactive approach to managing the expected growth that the Medical Center will experience in the future. The ancillary services required to sufficiently support the Satellite Clinics would include nutrition, pathology and laboratory, social work and optometry (with room for the possible growth of radiology services in the future). Primary Care staff would include five Physicians (each with a panel size of 1,200), one Optometrist, one Dietician, one Medical Technician, six Licensed Practical Nurses (to include one as the Telecare Nurse on site), three Registered Nurses (with one to act as the Nurse Manager), one Clerk, and two shuttle drivers to act as couriers and provide transportation to patients.

There will also be several volunteers assisting at the site and serving as patient ambassadors The external operations of this clinic would run much like that of a community based outpatient clinic and both housekeeping staff and the security guards would be contracted services. The pharmacy would run on a voucher system, in which the patient would receive a ten-day supply of medication to be picked up at any participating, publicly funded pharmacy, with the subsequent medication to be sent to the patient via CMOP. A letter explaining the relocation of their primary care provider was mailed to the 6,000 patients treated by each of the physicians (each physician carried their existing patient panel with him to the clinic). Each patient was given the option of opting out of moving with his physician and continuing to be treated at the Medical Center; however, the patient would have to be reassigned to a new physician.

Objective

The primary objectives of outsourcing Primary Care to Satellite Clinics are to maximize access of care for veterans, to provide more convenient accommodations to patients, and to increase the available space within the Medical Center for adequate space reallocation.

Planning

This project required the coordinated efforts of many services within the Medical Center including the Triad, Nursing, Primary Care and Medicine Services, Volunteer Services, Environmental Management, Engineering, Information Management, Fiscal, Medical Administration, Acquisition and Materials Management, and the Office of Performance and Quality Management, who was very instrumental in ensuring that JCAHO standards were being upheld.

Required Resources

In addition to staff time required in the planning and implementation of the Satellite Clinic, capital resources are essential to the overall success of this initiative. The capital resources needed for the implementation of this project include the lease of a 12,000 square foot building, in which the OKC VAMC is the only occupant. This building had to be renovated, which was done by the landlord with some assistance from the OKC VA. Some of the additional capital resources include: a scanner, personal computers, printers, telephones, networking equipment, fax machines, microscopes, centrifuge, refrigerators/freezer, analyzers, van, office systems furniture, exam tables w/ stools, cubicle curtains, locking cart, patient side chairs, seating for waiting areas, T.V., stretcher, scopes w/blood pressure, crash cart, digitals scales, wheelchairs, and ice machine.

Application Potential in Other Facilities; Outcomes & Benefits

The implementation of the Satellite Clinics comes as an extension of the CARES initiative, and furthers the ability to focus on the VA's mission of improving access for veteran patients. This is an alternative that would be beneficial to other Medical Centers within VHA, who are facing the same issue of having inadequate space to provide efficient and effective care to its patients. This method of space reallocation will also provide the Medical Center with adequate space to house the Medical Sub-specialty clinics. In turn, this will create space for the medical inpatient units to grow to meet the increased demand for inpatient bed days of care. The implementation of the Satellite Clinics will relocate approximately 150 primary care visits per day at the OKCVAMC, which will subsequently provide a subsidiary benefit by relieving the strain on parking at the Medical center. This sequentially should have a positive impact on customer service, as parking is a significant challenge at the Medical Center, and one of the most common patient complaints. The adoption of the Satellite Clinics should also have an affect on wait times, as patients are arriving to the Medical Centers hours before their appointed time to ensure they will find a parking space. The Oklahoma City VA will open the doors of its very first Satellite Clinic on February 22, 2005 and is anticipating great success, as patients will be extended increased access to the medical care they deserve!

Kimberly S. Moore

1505 E. 3rd St, Long Beach, CA 90802. Office: (562)826-5228. Mobile: (202)841-6442. Kimberly.Moore5@med.va.gov. kmoor2ep@aol.com

EDUCATION

The George Washington University, Washington, DC
Master of Health Services Administration, management/ acute care
MHSA Candidate 2006

University of Mary Washington, Fredericksburg, VA
Bachelors of Science, Biology, Pre-med
graduate 2001, cum laude

HEALTHCARE-RELATED and LEADERSHIP EXPERIENCE

VA Desert Pacific Healthcare Network (Network 22) — Long Beach, CA, Jan 2005- Present

ADMINSTRATIVE RESIDENT

- A hands-on learning experience under the supervision of Mr. Kenneth Clark, FACHE, in which I will acquire knowledge of significant Network 22 operations and become familiar with the management and administrative activities of the network and it's medical centers

Resource Consumption Initiative Project (RCI) — Washington, D.C., Jan-May 2004

TEAM MEMBER

- Personally worked with the RCI project team members in cardiac care unit of The George Washington University Hospital in attempts to normalize medical supplies and reduce costs
- Collected and analyzed data, observed the cardiac care unit in terms of patient flow, and interviewed those involved with the cardiac surgery process

ISCOPES (Interdisciplinary Student Community-Oriented Prevention Enhancement Service) Bread for the City site — Washington, D.C., Sep 2002-May 2003

FACILITATOR

- All efforts of this organization are for health promotion in the DC Metro Area.
- Arranged and directed meetings made agendas, scheduled meetings, sent reminders, and motivated team members.

Pre-medical Internship — Fredericksburg, VA, Jan-May 2002

INTERN

- Shadowed Philip Casey D.O. in his practice
- Learned about direct patient care
- Gained personal insight into problems physicians face in their practices

Scientific Research — Fredericksburg, VA, Aug 2000-May 2001

UNDERGRAD STUDENT

- Designed, executed, and managed own neurobiological research with the supervision of Dr. O'Dell

Fredericksburg Volunteer Rescue Squad — Fredericksburg, VA, Sep1999- May 2000

ASSOCIATE MEMBER

- High-stress environment involving hands-on patient care, particularly with the elderly

MEMBERSHIPS/AFFILIATIONS

- American College of Healthcare Executives, Member- Congress attendee 2003 and 2004
- Student Association of The George Washington University's School of Public Health and Health Services

SKILLS

- General understanding of oral and written Spanish, conversational ability
- Project Management
- Microsoft Office XP including Word, PowerPoint, Excel, Access, Outlook and Project

VA Desert Pacific Healthcare Network (Network 22)

Kimberly Moore
Administrative Resident
5901 E. 7th Street, Long Beach, CA 90802
Office: (562)826-5228
Training Start Date: January 24, 2005

Community Based Outpatient Clinic Study

Program Description

For the past four years, Network 22 has conducted an annual study to evaluate the performance of their twenty-nine Community Based Outpatient Clinics (CBOC). Various councils of the Network Executive Leadership Board (NELB) including the Strategic Management Council (SMC), the Quality and Performance Council (QPIC), the Service Quality Council (SQC), and the Finance and Business Management Council (FBMC) contribute to the study. The SMC integrates all the of the Councils' findings to produce a report, which the Network uses to monitor the CBOC's workload, cost/utilization, quality, patient satisfaction, and access. With the aid of special software, the Network is also able to ascertain the activity at each outpatient clinic and patient treatment needs. In turn the Network is able to plan where future sites should be located, which sites should be closed, and what improvements are needed. With the help of the Network Planning Committee (NPC), the Councils' then make recommendations to the NELB on the results of the study.

Application Potential in Other Networks

Depending on the network leadership and operational structure, networks should be able to perform a CBOC study rather readily. Networks with a council structure very similar to that of Network 22 should have no difficulty with implementation; even those that manage differently should not encounter too many obstacles. Simply designating current members/committees within the network responsibility for necessary tasks should suffice. However, this study does require the use of specialized Geographic Information System (GIS) mapping software among other recourses to carry out the study.

Resources Required for Implementation

Resources required to conduct the outpatient clinic study include the GIS Mapping Software, trained users of the software, experts in certain fields (ex. finance, quality) to pull and analyze pertinent data and time, not only to perform the study but to train users and delegate necessary tasks. The cost of the basic GIS software is $2,600. Essential additions to compliment the basic software are called Body Viewer and Patient Access and are approximately $1,800 for both. The cost of maintaining the software and access to a helpdesk is $600 each year. (These costs are for a single use license where one person has access to the software at one computer only.) The initial training cost was $1200 for one person. After the initial training, in-network staff can train other staff how to use the software; therefore additional training costs are nonexistent. The time it takes

to train staff totals fourteen hours broken up into two training sessions (i.e. seven hours a session) with the second training session a month after the first. The time it takes for to retrieve data for the study is approximately three months with a team of seven.

Documented Outcomes

Overall: This study not only provides Network 22 insight into the current performance of their community clinics and the ability to make recommendations accordingly, it also allows the Network to be proactive and better project and prepare for the future needs of the veterans. More importantly the study helps fulfill the VHA mission to serve the needs of America's veterans by providing primary care, specialized care, and related medical and social support services.

The study is also a useful resource to have in place for external reviews and audits such as the Joint Commission on Accreditation of Healthcare Organizations and Inspector General.

Below are specific recommendations made concerning CBOC's for FY 04/05.

Workload Assessment: Network SMC

- ...because of the intense pressure to implement mental health services at the CBOC's and because Cabrillo only serves mental health needs, we (now) do not believe it wise to recommend closure of this site.

Cost/Utilization Assessment: Network FBMC Recommendations

- When exploring cost efficiency, each outlier CBOC should look for best practices at other facilities...

Quality Assessment: Network QPIC Recommendations

- Develop an educational program for all clinical staff on the 2005 performance reviews and give providers feedback on their performance...

Patient Satisfaction Assessment: Network SQC Recommendations

- Facilities incorporate real time focus groups targeting areas where scores are less that optimal.

GIS Mapping/Access Assessment: Network SMC Recommendations

- ...we recommend that we meet the needs of San Diego and Loma Linda's growing number of veteran users by leasing off-site space near the parent medical centers...

Continuous contributors of the CBOC studies are the Network SMC, NPC, SQC, FBMC, and QPIC. Information contained in this abstract is from the Fourth Annual FY 04/05 Community Clinic study or from an interview with individuals who conducted the study. Those individuals include Barbara Angus, Sarah Simpkins, Andrew Shaner, MD, Philip Roos, MD, Mike Mahler, MD, Alice Martinez, Rob Johnson, MD, and David Holt

BINTA JANET ODIOR

3446 N. Druid Hills Rd. Apt. D • Decatur, Georgia 30033
(404) 321-6111 ext. 7651 · Binta.Odior@med.va.gov

EDUCATION

12/04 **EMORY UNIVERSITY** **Atlanta, GA**
ROLLINS SCHOOL OF PUBLIC HEALTH - Master of Public Health (Healthcare Management)

- Relevant course work includes: Strategic Management, Operations Management, Human Resources Management, Accounting, Finance, and Marketing
- Served as vice-president of the Association of Black Public Health Students that focused on designing initiatives for minority students, including panel discussions, and targeted career growth and development.

5/02 **UNIVERSITY of ILLINOIS -** Bachelor of Science in Community Health **Urbana, IL**

- Concentration in Health Planning and Administration
- Chairperson of the registration committee for the Women of Color Regional Conference
- Served as search committee Student Ambassador with the responsibility of assessing applicants for the position of associate director of multi-cultural affairs in the office of residential life.

EXPERIENCE

6/04 – present **ATLANTA VETERAN AFFAIRS MEDICAL CENTER** **Decatur, GA**

Emory University/Atlanta VAMC Intern

- Prepared minutes, memorandums, and agenda for task forces and committees
- Oversaw review of service line agreements for seven facilities within the Southeastern Network
- Worked within a multidisciplinary group consisting of medical center leadership and administrative officers in various clinical and operational service lines to implement various local, network, and national initiatives.
- Served on the planning committee for the 1st quarterly clinical summit

9/03 - present **EMORY UNIVERSITY-PROJECT S.T.A.R.S.** **Atlanta, GA**

Database Manager

- Administered a audio computer assisted survey instrument (ACASI) designed to study subjects and ensure accuracy of randomization efforts under the Institutional Review Board guidelines to ensure compliance with HIPAA regulations
- Formulated protocol for medical abstraction charts used by RN staff within the NIH funded study
- Oversaw data management, logistical, and analytical operations to different departments within the research study
- Maintained participant database with monthly influx of up to 100 entries

6/03 – 8/03 **BREAST MAMMOGRAPHY CLINIC** **Carbondale, IL**

Clinical Assistant

- Performed insurance verification and other administrative tasks related to patient administration
- Updated patient medical charts
- Retrieved and filed patient medical records
- Provided customer service and support

1/03 – 5/03 **PROVENA COVENANT MEDICAL CENTER** **Urbana, IL**

Volunteer Services Intern

- Developed guest services system utilized to direct patients and visitors to designated departments within the 270 bed comprehensive facility
- Formulated orientation programs for volunteers from the University of Illinois
- Designed and implemented a staffing model to allocate manpower based upon departmental needs
- Restructured the volunteer program for high school students
- Designed a volunteer and information desk reference manual

ORGANIZATIONS

- American College of Healthcare Executives (ACHE), Student Affiliate 2002-present
- Georgia Public Health Association, Student Affiliate 2003 -present
- Association of Black Public Health Students (ABPHS), Vice President 2003 - present
- Women of Color, Vice President and Core committee member 1999- 2003

Facility Name:
Atlanta Veterans Affairs Medical Center

Contact:
Binta Odior, MPH
Administrative Fellow
Atlanta VA Medical Center
1670 Clairmont Rd.
Decatur, GA 30030

Training Start Date: January 10, 2005

Training Start
Project Title:
Electronic Wait List: Establishing and Managing Compliance

Introduction:
The Veterans Health Administration (VHA) has over 280,000 veterans awaiting care. Many have appointments scheduled six months past their desired date. To address this problem, the VHA established three directives aimed at managing the increasing demand for medical care, **2002-059** (*Priority for Outpatient Medical Services and Inpatient Hospital Care*), **2003-062** (*Priority Scheduling for Outpatient Medical Services and Inpatient Hospital Care for Service Connected Veterans*), **2003-068** (*Process for Managing Patients When Patent Demand Exceeds Current Clinical Capacity*). The directives give priority access to care for veterans with service connected disabilities of 50% or greater and to veterans who are in need of care for their service connected injuries.

It is the vision of VISN 7 to ensure that all facilities maintain compliance with the established directives. Therefore, the Atlanta VA Medical Center (VAMC) continues to provide timely access to care by incorporating the principles of Advanced Clinic Access (ACA) throughout its Primary Care Clinics. However, a growth rate of 11%, as compared to the previous fiscal year, resulted in the placement of veterans on the Electronic Wait List (EWL). VISN 7 and the Atlanta VAMC have aggressively begun an effective management campaign designed to reduce its backlog and increase access to care.

Objective:
"Electronic Wait List: Establishing and Maintaining Compliance" focuses on effective approaches and techniques that can be utilized to eliminate veterans placed on the electronic wait list.

Planning/Development:
Initial planning for the project began by inviting a comprehensive external review from another facility within VISN 7 to provide expertise and guidance with the development of an aggressive action plan. Representatives from each service line (Clinical and Administrative) were asked to take part in the development of the action plan. This resulted in a committee appropriately titled Wait Time Action Group (WAG).

Weekly meetings were then established to report on actions that were assigned with target dates and outcomes clearly identified. Members of the committee were required to provide daily reports to the Medical Center Leadership during morning meetings regarding the status of the EWL and how it pertains to their service line. After several months, the committee rescheduled to bi-monthly meetings and continued its focus on identifying problems throughout the medical center while focusing on compliance and access to care.

Development:
Members of the WAG Committee participated in the weekly VISN 7 Wait Time Blitz conference calls. The calls were comprised of representatives from each medical center within VISN 7. During this time, discussions focused on the sharing of best practices, identification of problems and development of solutions. Additional measuring tools in the form of scorecards were developed by the VISN and initially utilized by the Atlanta VA Medical Center to track and measure our progress.

The SCVA (Service Connected Veteran Appointments), EWL, and Consult reports included quantitative and qualitative data generated daily by our EWL Coordinator. The WAG Committee used the reports to examine the progress and make determinations for each service line and the medical center. The daily reports provided effective management tools that allowed service line managers to monitor their wait list and to identify areas of improvement in which errors were consistently being made in the scheduling process.

In order to minimize scheduling errors, the WAG made the recommendation to standardize the scheduling process, by preparing educational training and materials throughout the medical center. Patient Services Assistants (PSA) and clinical staff receive continuous training on the correct method of scheduling patients. In order to limit access to the scheduling package, access was granted to employees who completed computer based training (CBT) in Synquest. In addition, members of the WAG Committee developed mouse pads for schedulers to use as reference tools in the event important steps in the scheduling process were forgotten. This idea was eventually shared throughout the VISN.

To collect data, it was determined that KLF would be the primary data source in which to extract, analyze and provide information for the bi-weekly scorecards. The KLF database provides the Atlanta VAMC with quantitative information regarding the electronic wait list. Information is pulled to compare and contrast the Atlanta Medical Center amongst other complex tertiary facilities within VISN 7 and throughout the VHA health care system. Gathering, interpreting, and analyzing this information allows the WAG Committee to make recommendations and determine what medical centers should be contacted to obtain information on "best practices".

Application:

As more soldiers continue to return from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), the Veterans Health Administration will see an influx of veterans seeking care from the VA. Most VA Medical Centers will be faced with common circumstances in which the demand for care exceeds that capacity in which services can be provided in a timely manner. With this increase in demand, VA Medical Centers will need to share and incorporate best practices, effective management techniques, engage in process improvement, and establish monitoring control in an effort to manage this enormous demand for services.

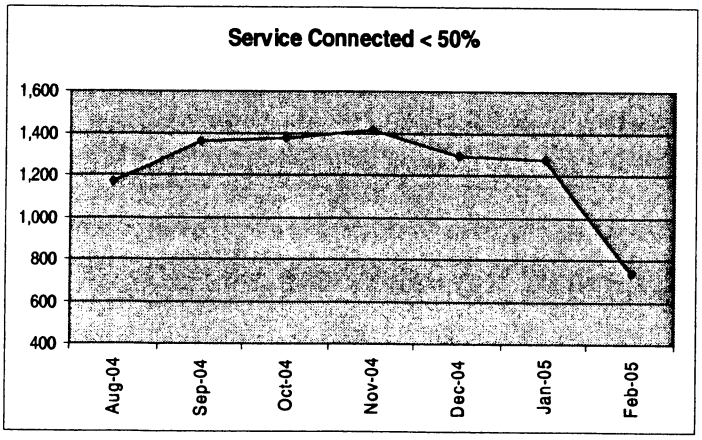
Many facilities will find that by establishing committees that will maintain oversight, track the status of the electronic wait list, and develop an aggressive and comprehensive action plan, they can ensure compliance with all three VHA Directives regarding access to care.

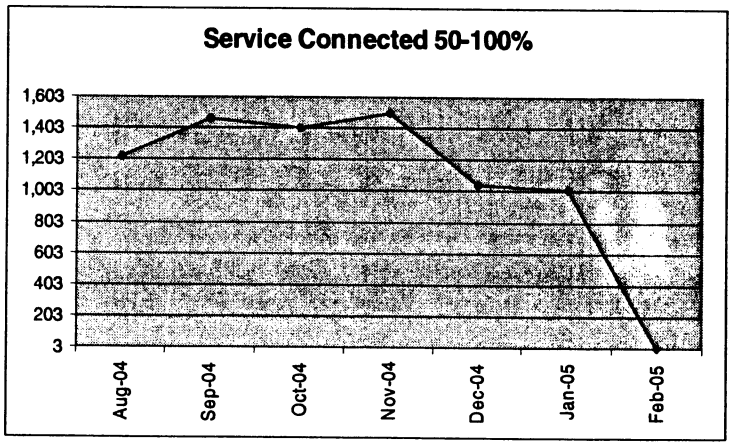
Resources required for implementation:

Support from senior level management and education of the staff is the most important resource. Once support of the Medical Center Leadership is given, educational training on potential changes can be addressed. Ongoing communication and education with the staff is important to ensure overall understanding of the directives and processes being implemented. Once a basic understanding of the strategy is communicated their will be continual participation by staff in the Saturday Clinics and extended hours, eventually leading to a decreasing number of patients on the wait list.

Outcomes, Benefits, & Cost Savings:

Currently various service lines are utilizing Saturday clinics and extended hours to meet the patient demand. In other areas, such as with our Sleep Study, patients are sent to contracted facilities outside of the medical center. Our strategy has been to focus on those who are 50-100% service connected, then 0-50% service connected, and finally non-service connected veterans. The percentage of veterans on the electronic wait list varies weekly, but overall we have seen a significant decrease in the amount of service-connected veterans on the wait list **(A diagram is provided below)**. No cost savings have been associated with the project to date, but savings are possible in the near future. An Advanced Clinic Access (ACA) Committee has been established within the medical center to improve clinical efficiency, which will eventually help in the management of the wait list. It is our hope that in the future we can provide clinical efficiency within our medical center, which will allow greater access for our patients.





Ghazal K. Osman

Michael E. DeBakey Veterans Affairs Medical Center
2002 Holcombe Blvd., Houston, Texas 77030
(office) 713.791.1414 ext. 5536 / (cell) 281.770.9947

EDUCATION:

Trinity University – San Antonio, TX
M.S., Health Care Administration
Dec. 2005, 3.93 Cumulative G.P.A.

University of Houston – Houston, TX
B.S., Biology; Minor, Business Administration
Aug. 2002

EXPERIENCE:

Jan. 2005-Present

Hospital Administrative Resident, Michael E. DeBakey VA Medical Center – Houston, TX

- (Ongoing) Reviewing and maintaining organization's Periodic Performance Review (PPR) for JCAHO survey—includes collecting documentation for each noncompliant standard; developing quarterly reports to the Accreditation Readiness Advisory Council regarding status of compliance; and preparing to meet with JCAHO surveyors during site visit to present evidence of compliance as needed.
- (Ongoing) Conducting critique of ER process in order to decrease wait times and improve patient flow-through—includes survey of physician-patient interaction and length of patient stay.
- Rotated through various medical facilities within the Texas Medical Center, including St. Luke's Episcopal Hospital and the Texas Heart Institute in order to have exposure to different organizational structures and operations.

Aug. 2001-Mar. 2004

Network Infrastructure Team Leader, Human Development Foundation of North America (HDF) – Schaumburg, IL/Houston, TX

- Researched and presented detailed report to board of directors on strategic enabling vision of successful NGOs, to assist in implementing a grass roots model for HDF.
- Appointed Team Leader for Network Infrastructure – youngest team leader within organization. Leading a team of senior doctors to establish an efficient and solid base for expansion.
- Developed business plan for youth club offshoot, which included creating the mission, vision, marketing plan, financial objectives, and organizational structure.

Sep. 2001-Mar. 2004

Senior Editor, Plunkett Research – Houston, TX

- Authored research on over 200 companies; worked chiefly in the *Health Care Industry Almanac 2004* and *Biotech and Genetics Industry Almanac 2003-2004*. Fastest ever promotion to senior editor in the company.
- Utilized MS Access to simplify research process through the development and updating of tables, which outlined trends and statistics for several major industries.
- Trained new members of staff on research tools, as well as customer service protocols.
- Compiled and created marketing manual detailing guidelines for submitting products to wholesale customers. Purpose of manual was to streamline operations by outlining standard procedures, thereby preventing duplication of effort. Manual was adopted by CEO as ultimate source for Marketing department.

HONORS:

- Trinity University Graduate Traineeship, Health Care Administration Dept.
- Texas Woman's University Scholarship/Traineeship, Health Care Administration Dept.
- Magna Cum Laude, University of Houston.
- Dean's Honor List, University of Houston.
- Boston University Scholarship (attended BU from Aug. 1998-Dec. 1999).

ACTIVITIES:

- Preceptor Co-Chair (Officer) – Trinity University's Health Care Student Association.
- Recent Graduate Member – American College of Healthcare Executives.

Ghazal Osman, Hospital Administrative Resident 713.719.1414 ext. 5536
Michael E. DeBakey VA Medical Center 2002 Holcombe Blvd., Houston, TX 77030

Valet Parking: Transporting Our Patient Satisfaction to a Higher Level

I. Description of Project

Objectives/Background

The concept of free valet parking was implemented in January 2004 at the Michael E. DeBakey Veterans Affairs Medical Center (MEDVAMC) in Houston, Texas as a mode to:

(1) increase patient satisfaction and reduce complaints about parking;
(2) increase access by improving the number of on-time appointments and subsequent patient turnover; and
(3) increase patient safety by mitigating the possibility of falls or other adverse events caused by overexposure to inclement weather.

In general, parking has always been a concern at the facility. Though there are 3,154 total parking spaces that span 27 acres around the facility, it is difficult for both patients and employees to find a spot by 8 AM. This translates into excessive time looking for free spaces, as well as parking at relatively long distances from the facility. Such factors compounded with Houston's heat make it all the more important to take action so as to protect our older and more fragile patients who comprise the majority of the service population. Not only did patients complain about the lack of parking through Speak to the Director suggestion forms, but also physicians and employees voiced concerns about patients arriving late to appointments, as well as being out of breath. There was also substantial concern raised by family members/friends who feared that their veteran loved one would wander off or need attention between the time he or she was dropped off at the front entrance to the time it took to park the car and return to find the patient.

Planning/Implementation

Consequently, implementing valet parking became one of the Director's priorities in FY03 and a strategic means to achieve veteran satisfaction. The entire process from planning to implementation took seven months (June 2003 to January 2004) at a cost of approximately $340,000 for the first year. Staff from Facilities Management, Acquisition and Material Management, as well as the VA police were involved to assess how to introduce valet parking. Also, the Parking Committee was utilized as a platform to document the progress of the stages from planning to implementation. Furthermore, a multidisciplinary team was used to assess resource needs and methods for effective implementation.

After working through the logistics, it was established that 237 spaces would be designated for valet and that all veteran patients would be allowed to use the valet service, provided that they have their appointment letter and/or VA identification card. The hours of operation were set as Monday through Friday, from 7:00 AM to 5:30 PM. It is also important to note that apart from parking cars, the valet staff would provide wheelchairs and assistance to handicapped patients arriving at the medical center. Ultimately, the MEDVAMC decided to contract with an experienced company after a cost-benefit analysis revealed several advantages, including no medical center liability in case of car theft and easier termination of contract employees for poor customer service. Eventually, appropriate signage was also developed to redirect other types of traffic and to emphasize the medical center's "no tipping" policy. Additionally, all employees were prohibited from using the valet services for any purposes except medical appointments and were informed of reprimands in case of misuse of the service.

II. Application Potential in Other Facilities

Given that patient satisfaction, access, and safety are key drivers to accomplishing VA goals, valet parking is an ideal service to implement system-wide. It is just as applicable to facilities located in the north as those in the south, with both regions prone to inclement weather that can be harmful to the patient's health. In addition, all VA medical centers have the same type of patients—older and more susceptible to injuries and illnesses—who cannot afford to walk long distances. And though there is no documented evidence, it may be inferred that by having valet parking, patients may avoid being late to appointments, which in turn may have a positive effect on waiting times—another important measure.

Within the Houston community, it is also important to note that there is no other facility in the Texas Medical Center, which includes 42 not-for-profit institutions, that provides free parking to its patients,

much less valet service at no cost. This gesture is not only an effort of goodwill towards the facility's patients, but another opportunity to highlight the MEDVAMC's unconditional focus on patient satisfaction.

Other VA medical centers, including those located in Pittsburgh, Temple, and West Palm Beach, have also adopted valet parking and serve as models for new sites.

III. Resources Required for Implementation

Time—The entire process from planning to implementation took seven months, though the prospects of valet parking had been considered as early as 2002.

Equipment—The project required a self-powered parking arm, in addition to chains to seal off the valet spaces. Also, a reception unit was purchased where the receptionist would manage the intake and disbursal of keys. Other requirements included seating (though the MEDVAMC had this already in place) and signage redirecting traffic.

Financial—The overall costs for CY04 were approximately $340,000. This included a contract, which was initially set at $22,000 per month. However, considering the lack of experience by both the VA and the contractor with regards to valet parking at a government facility, the contract stipulated a 90-day review that would reassess performance and costs. Given the popularity of the service, additional personnel were needed, and so the contract increased the monthly cost to $27,000. While the chains, seating, and signage (mostly provided by the contractor) were at a negligible cost, the parking arm cost approximately $10,000. Whereas the other costs are not recurring, the contract cost is predicted to increase at an annual rate of two to three percent.

Labor—Initially, the contract provided for six attendants, but within three months was increased to 10. There is also one supervisor who oversees the attendants, as well as a receptionist. All individuals are covered under the contract. With respect to VA staff responsibilities, the VA Police keep logs of the parking volume, Facilities Management staff oversees the upkeep of the valet area, and Acquisition and Material Management staff maintain contract obligations.

IV. Documented Outcomes, Benefits, Cost Savings

With valet parking, the main benefits are non-financial in nature, namely increased patient satisfaction and greater patient access. There are several tools that have illustrated the effectiveness of the project, including Survey of Healthcare Experience of Patients (SHEP) survey scores, Speak to the Director program comments, physician and staff observations, National Center for Organization Development (NCOD)-led activity results, and the volume of vehicles being parked over time. According to SHEP survey results tracking satisfaction with parking availability, scores increased 65.5% over a six-month period spanning from October 2003 to March 2004. Also important to note is that in CY2003 (and prior to valet), MEDVAMC received 65 complaints and no compliments about parking through Speak to the Director comment forms. In CY2004, however, there were 41 documented compliments, excluding the numerous commendation letters and thank you cards given personally to the valet staff. In addition, physicians have noted an increase in patient satisfaction as well as staff who can firsthand attest to fewer cars circling the lots in the morning. Other results from a NCOD-led activity also noted that employees were pleased that services like valet parking were being offered to patients. While the first few months drew approximately 250-300 vehicles per day, the current valet daily census totals nearly 700, a 64% increase. And these results ignore the cost savings produced by decreasing the number of documented fall incidences and liability.

V. Conclusion

In conclusion, valet parking at the MEDVAMC has yielded important outcomes—improved levels of patient satisfaction, access, and safety. At a time when patient-centered care seems to be the watchword, all three factors are important in achieving high-quality care. By providing valet services, patients are offered exemplary customer service literally from the moment they step foot onto the facility to the moment they step back to their cars—thus "transporting our patient satisfaction to higher levels".

Christine Palaschenko
2831 Grantwood Drive
Parma, Ohio 44134
(937) 215-7942
Christine.Palaschenko@med.va.gov

Education

Xavier University, Cincinnati, OH
Master of Health Services Administration, graduation expected December 2005

Wittenberg University, Springfield, OH
Bachelor of Art in Management, minor in Spanish, May 2003

Experience

Louis Stokes Cleveland VAMC — Cleveland, OH
Administrative Resident — January 2005-Present

- Observe Senior Management
- Assist on various projects
- Inspect narcotics levels throughout the medical center
- Conduct rotations through all departments

Ann Taylor — Beachwood, OH
Sales Associate — December 2004-Present

- Work directly with customers — Cincinnati, OH
- Resolve disputes with clients — July 2003-October 2004
- Complete transactions using store computer program

Xavier University — Cincinnati, OH
Graduate Assistant — June 2003-December 2004

- Assist prospective graduate students
- Place phone calls to prospective graduate students
- Perform general office tasks

Discover Health! Adventures in Learning — Cincinnati, OH
Data Analyst — June 2003-December 2004

- Enter data into an Excel spreadsheet
- Answer the telephone
- Enter and update computerized donor records

Affiliations

Member, Student Chapter of American College of Healthcare Executives, 2004-Present
Community Service Officer, Xavier University Graduate Program in Health Services Administration Class of 2005, September 2003-December 2004
Alpha Delta Pi Sorority, 2000-Present

Honors

Xavier University Graduate Services Scholarship, Fall 2003
Tau Pi Phi Management Honorary, Fall 2001-Present
Wittenberg University Dean's List, 1999 and 2001

Computer Skills Microsoft Word, Excel, PowerPoint, SPSS statistical software, Results Plus!

Language Skills Intermediate knowledge of the Spanish language
Proficient knowledge of the Ukrainian language
Proficient knowledge of the Russian language

Community

Mentor, Oyler Elementary School, 2003-2004
Volunteer, Discover Health! Healthy Day At Rookwood, 2003

References Available upon request

Louis Stokes Cleveland VA Medical Center
Christine Palaschenko, Administrative Resident
Start Date: January 10, 2005
10701 East Boulevard, Cleveland, OH 44106
(216) 791-3800 x3824
Lorain CBOC Expansion and Redevelopment

The Cleveland VAMC needed to expand services in an already existing CBOC in Lorain, Ohio. Current facilities were unable to match the supply and demand of veterans desiring care. The VAMC placed a solicitation in the community for a new facility and Southshore Community Partners won the bid. It so happened that additional clinical space was available on the first floor of the current facility. The objective was to build a new clinic quickly to meet the demands of the Veterans in this area.

Renovation of an existing radiology department of approximately 22,000 square feet presented numerous challenges. The challenge was to place an existing model clinic in a space with 42 steel beams to work around. While the space would be completely renovated, the layout needed to allow for expanded services to be placed in existing space. Clinic layouts were modified to conform to the space without compromising functions needing to be achieved in order to better serve the demands of veterans and their needs for enhanced patient care, improving clinic access and outreaching to returning veterans.

The plan developed into a 'one-stop shopping' concept for Veterans. They could come to the CBOC and receive the majority of their care in one central location. Care would be comprised of the following services: primary care, laboratory, radiology, women's clinic, pharmacy, mental health, dietetics, podiatry, physical therapy, and optometry. The floor plan was created so that the administrative functions took place in a central location and all the different areas surrounded this one point. The VA interior designer was brought in to make the CBOC have a non-medical feel to the clinic and provide a therapeutic value for patients. The colors were matched to the other offices in the already existing community center. This way, there would not be such a drastic change when walking into the VA's facility. There were steel beams that were part of the buildings foundation that had to be worked around. They were hidden between exam rooms and made into decorative pillars.

The Cleveland VAMC has a formula they use when looking to expand or build a new CBOC. When 1,200 additional or new Veterans are identified in a certain area, the Medical Center realizes the need to expand or build a new CBOC. More staff is added according to this logic. For example, the Lorain CBOC currently serves 5,520 Veterans. They are staffed with 4 physicians and 1 nurse practitioner. If they began to serve 1,200 more Veterans, they would hire one more physician, 1 LPN, 1 medical receptionist, and one more nurse. This staffing model could be implemented at other CBOC's throughout each VISN. It has proven to be very effective and efficient for the Cleveland VAMC. It prevents the CBOC from being overstaffed and ensures a suitable patient/physician ratio. This model also helps to cut down on costs for unnecessary labor. Staffing positions are based on the number of patients seen at each CBOC.

Several resources needed to complete this project included an adequate amount of space, new exam tables, and new equipment for optometry, podiatry, radiology, pharmacy, physical therapy and lab, among other things. Also, the flooring and decorative materials were needed.

The next page is a graph that illustrates the projects outcomes, benefits and cost savings. The staffing model mentioned above is also outlined in the spreadsheet.

PCL STAFFING	TEAM 1	TEAM 2	TEAM 3	TEAM 4	TEAM 5	TEAM 6	TEAM 7	TEAM 8	TEAM 9
Physician	1	1	1	1	1	1	1	1	1
RN	1	1	0	0	1	0	1	0	1
LPN	1	1	1	1	1	1	1	1	1
Clerk	1	1	1	1	1	1	1	1	1
Other* (*1,*2)	1	1	1	1	1	1	1	1	1
	5	5	4	4	5	4	5	4	5
CUM FTEE:		10	14	18	23	27	32	36	41

Note *1 : ** Other = Phlebotomist, Co-op, Nursing, Admin., SW, Pt Rep. Office Mgr., Nurse Mgr. Case Mgr. Also, the addition of ancillary services such as radiology podiatry, optometry, physical therapy, HBPC, MHICM, Audiology, and Mental Health Staff, are in addtion to the template PC FTEE.*

Note *2 : ** Other position is not staffed immediately at all team levels until a specific need is determined.*

EXPECTED WORKLOAD FOR EACH TEAM:

Workload / Team	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Cum Wkld		2,400	3,600	4,800	6,000	7,200	8,400	9,600	10,800

LEVEL OF SERVICES BASED ON UNIQUES SERVED:

	1,200	2,400	3,600	4,800	6,000	7,200	8,400	9,600	10,800
Primary Care	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys
Mental Health	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys
Lab Draw	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys	5 dys
Lab Special Tests						x	x	x	x
Women's Health	Available	Available	Available	Available	Available	Available	Available	Available	Available
Nutrition & FS		1 dy	1dy	2dys	2dys	3 dys	4dys	5 dys	5dys
Podiatry		1 dy	1dy	2dys	2dys	3 dys	4dys	5 dys	5dys
Optometry		1 dy	1dy	2dys	2dys	3 dys	4dys	5 dys	5dys
Radiology								5 dys	5dys
Pharmacy	ADDs	ADDs	ADDs	ADDs	ADDs	ADDs	ADDs	Pharmacy	Pharmacy
Physical Therapy								5dys	5dys
HBPC				x	x	x	x	x	x
MHICM				x	x	x	x	x	x
Audiology								5dys	5dys

SQUARE FOOTAGE PER UNIQUE LEVEL

UNIQUES:	1,200	2,400	3,600	4,800	6,000	7,200	8,400	9,600	10,800
SQUARE FEET:	2,400	4,800	7,200	9,600	12,000	14,400	16,800	19,200	21,600

NOTE 1 : When planning clinics servicing veterans over 9,000 uniques one must add space for ancillary services to clinics, such as patient representative, optical shop, optometry eye lanes, larger lab draw area, pharmacy, supply and services, podiatry, MHICM, HBPC, Audiology, conference rooms, staff break area, and administrative directors office space for resident clinic administrator / director. There are no physician offices even in the largest of clinics.

NOTE 2: All initial space plans include Mental Health Services. Normally, 3 offices and a group room. Plus additionally sharing the CBOC conference room. 25% of pts may require Mental Hlth Svcs.

Jo Anne Parker

OBJECTIVE

Seeking a management level administrative position in a hospital or health care system where I can gain experience while developing a strong foundation in healthcare management

EDUCATION
Expected 2005

MS, Health Services Administration,
The George Washington University

1977

BS, Administrative Services, North Carolina A&T State University

EMPLOYMENT
June 2004 to Present

VETERANS AFFAIRS MEDICAL CENTER, OFFICE OF SPECIAL (OSP) Administrative Resident
Assisted with the following major projects:

PROJECTS

Budget: Managed three fund control points for OSP, including reconciliation of purchases with the budget, forecasting and preparing budget books for inspection.

Affirming the Commitment (ATC): Member, Affirming the Commitment (ATC) Task Force. Participated in the ATC Video Planning Subcommittee.

VATV: Assisted the Program Manager in marketing VATV to PBS stations by developing promotional materials, corresponding with program mangers from PBS, sending out letters to medical center directors and VISN directors informing them of VATV.

January 1995 to May 2004

THE GEORGE WASHINGTON UNIVERSITY. Executive Associate to Dean, School of Business. Coordinated day-to-day activities of the Dean's office including supervising front office support staff. Liaison to senior faculty and central administration for the Dean and worked independently on a busy daily schedule. Assisted in sensitive and confidential personnel issues involving faculty and staff.

August 1989 to December 1994

FEITH & ZELL, P.C. Executive Assistant to Managing Partner. Facilitated day-to-day activities for Managing Partner including: making and confirming appointments, entering attorney time into the Timeslips System, assisted in hiring of support staff. Supervised a support staff of six. Assisted in confidential matters involving the law firm. Rendered administrative support to the managing partner.

PROFESSIONAL AFFILIATIONS

2002-Present	Student Associate, GWU Student Chapter, American College of Healthcare Executives
2002-Present	Student Member, GWU Student Chapter, National Capital Healthcare Executives

References available upon request

Washington, D.C. VAMC
50 Irving Street, N.W.
Washington, D.C. 20422
Start Date: May 31, 2004

Jo Anne Parker
Administrative Resident
202-745-2200

Getting VATV Broadcast on National TV

A. Overview of the VATV Project

VATV is a health program primarily targeted to veterans but in fact very suitable for the general public. This project is in response to a Veterans Health Administration (VHA) objective to maximize the independent functioning of veterans in the least restrictive way. Strategies were developed by VHA to: (1) improve and enhance home care services and develop an assisted living plan; and (2) promote the use of care management in the least restrictive and most efficient way.

To address these strategies, the Office of Special Projects (OSP) developed and produced VATV. VATV delivers health education content and other relevant information to patients in their home. VATV programs are varied in nature and are designed to provide timely educational information to the veteran in his or her residence. Each 27½ minute episode includes fast moving segments revolving around the episode's theme, such as "Medical History Window on Time," The Healing Corner," and "Panel Discussions by Experts." Current VATV episodes include "***Hypertension – Silent But Deadly***" and ***"Healing Corner"*** with Ed McMahon, "***Outsmarting Cancer"*** and "***Healing Corner"*** with Sam Donaldson, ***"Give Life"*** and ***"Healing Corner"*** with Larry Hagman, and ***"Live to 100"*** with Art Linkletter.

To secure the national broadcast of VATV, relationships were established with PBS program managers to arrange broadcast dates. Specifically, contacts made with the PBS program manager in Richmond, Virginia proved most beneficial due to their effecting national broadcasts from two station in Virginia – Richmond and Charlottesville. The contacts established with the Richmond VAMC were in partnership with OSP in a joint marketing effort to broadcast to Veteran Service Organizations and local media outlets as well.

B. Application Potential in Other Facilities

When a televised VATV broadcast is forthcoming, VA facilities can alert their respective service providers and patients via public service announcements, local media and Veteran Service Organizations. This will incline patients to be more proactive in their own health by becoming knowledgeable about medical conditions they may have. More knowledge and understanding about methods of healthier living could assist patients in reducing their need to visit VA facilities

as frequently as before the VATV broadcast, thus potentially reducing patient dollars spent at VA facilities across the country.

C. Resources Required for Implementation

A Statement of Need was developed for VATV, indicating in part that the Department of Veterans Affairs is authorized to accept gifts of money, airtime, etc. for VATV's goal of reaching veterans audiences in their homes. The list below outlines costs associated with national broadcasts. Additional needs for costs associated with production and marketing are not included in this particular Statement of Need.

- $25,000 per thirty minutes of CNBC airtime for upwards of ten such broadcasts between now and September 2005. Each broadcast would focus on a particular subject and could have one or more sponsors.

- $7,000 for distribution to PBS per thirty minute for upwards of ten such broadcast distributions between now and September 2005. Each broadcast would focus on a particular subject and could have one or more sponsors.

Given these two options, the less expensive national broadcast vehicle, PBS, is preferred.

D. Documented Outcomes and Benefits

Through negotiations with the PBS program manager in the Richmond, Virginia area, I was successful in securing VATV's first televised broadcast.

- A milestone was reached when VATV programming was cleared for broadcast on two flagship PBS Stations -- WCVE in Richmond and WHTJ in Charlottesville, Virginia on Sunday, November 7, 2004.

- VATV episodes have been scheduled for monthly broadcasts on WCVE and WHTV PBS Stations through April 2005.

- The Richmond PBS area is known as a "Nielsen Overnight Market," meaning that by 10:00 a.m. every morning, the PBS station manager knows what the viewership levels were for every program aired the previous day.

- With the airing of these broadcasts, a critical need to inform veterans about VA benefits, services and health education has been met and veterans VA visitation expenses will have been optimally reduced.

Mia D. Powers

117 Centre St.
Boston, MA 02119
Home Phone/Mobile: 901-568-0686
Email: LL_UNIT76@HOTMAIL.COM or mia.powers@med.va.gov

PROFILE

Possesses a keen understanding of organizational structure and the ability to develop enhanced management and leadership programs through creative application of data analysis and specialized auditing to improve efficiency, effectiveness, and outcomes. Serves as an advocate for strong employee/patient education and is a skilled participant in such program development to address needs of the organization.

EDUCATION

M. S. Health Administration, University of Memphis, August, 2004.
B. S. Biology, University of Tennessee-Chattanooga, May, 2002.

WORK EXPERIENCE

Administrative Fellow VA Boston Healthcare System, Boston, MA 9/2004- present

- Acting Administrative Assistant to the Chief of Staff.
- Managed the Part-time Physician Audit as required of VA Boston Healthcare System by the VA Central Office.
- Co-Chaired the Combined Federal Campaign, exceeding the monetary goal by 9.2%.
- Performed Local Management Audit of Fiscal Services.
- Co-authored a new Medical Center Memorandum on Time & Attendance for Part-time Physicians.

Graduate Assistant, St. Peter Villa Nursing Home & Rehab. Center, Memphis, TN 1/2004-8/2004

- Interim Privacy Officer; provided continuous education on HIPAA; maintained HIPAA policies and regulations.
- Chaired marketing Committee.

Foods Supervisor, Libertyland/Fairgrounds Inc., Memphis, TN Summers: 1996-2004

- Supervised 100-170 employees in the Food & Beverage Department throughout Libertyland Amusement Park.
- Performed several human resource functions including provided adequate customer service, conducted customer service/ employee training and departmental orientation, managed payroll, provided recruitment/retention tactics, product orders, data entry and other general office duties.

Graduate Assistant, Student Health Services, University of Memphis, TN 1/2003-12/2003

- Assist Health Educator in the coordination of health educational programs/promotions/projects for students.
- Designed and developed pamphlet titled *"101 Things To Do in Memphis Without the Use of Alcohol or Drugs"*.

Administrative Intern, Erlanger Health Systems, Chattanooga, TN 5/2003-8/2003

- Interned through the Tennessee Hospital Association (THA) Minority Program.
- Shadowed Senior Executives, gained knowledge of the Healthcare environment, constructed projects exemplifying administrative and managerial skills (i.e. financial analysis, strategic planning, etc.).

PREP Preliminary Clinician Participant, East Tenn. State University, Johnson City, TN 7/2002-8/2002

- Participated in hospital rounds, clinical office work, and visited patients/ shadowed Internal Medical Physicians.
- Gained knowledge of Medical Terminology.

PROFESSIONAL AFFILIATIONS

Upsilon Phi Delta Honor Society, 2004.
National Association of Health Service Executives (NAHSE), 2003.
American College for Healthcare Executives, 2004-2005.

VOLUNTEER EXPERIENCE

Transformations Rite to Passage Girls Program, YMCA, Boston, MA.

OTHER SKILLS

Proficient computer skills including Windows, Microsoft, Microsoft Excel, PowerPoint, WordPerfect/Trained Pubic Speaking/Acquired knowledge and hands-on experience.

VA Boston Healthcare System
Mia D. Powers, MHA
Administrative Fellow
1400 VFW Parkway
West Roxbury, MA 02119
617-323-7700 x5635

Training Start Date: 09-08-04

Healthcare Failure Mode Effects Analysis on Healthcare Management within the VA Boston Healthcare System for Returning Service Persons from Operation Iraqi Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)

Objective: To conduct a Healthcare Failure Mode Effects Analysis (HFMEA) in an effort to improve the healthcare management process for returning OEF/OIF service persons, to ensure the seamless transition of active duty service persons from active to veteran status, and to emphasize the important avenues taken to provide adequate healthcare to service persons in the greater Boston area.

Project Description: A Healthcare Failure Mode Effects Analysis (HFMEA) is a systematic risk assessment tool used to proactively identify possible failures and successes within a system to improve its overall process. Thus, the tool reasonably ensures safe clinical outcomes and prevents system breakdowns before they occur. As a requirement of Joint Commission & Accreditation of Healthcare Organizations (JCAHO), VA Boston Healthcare System (VABHS) is required to select one high-risk process to evaluate extensively each year. The Healthcare Management process for returning OEF/OIF service persons was selected for study and improvement during the first half of fiscal year 2005.

As of December 2004, over 1,100 returning soldiers were seen at the VA in Boston. As this figure increases with time, VA facilities throughout the country must prepare for volumes of returning active duty service persons and their need for healthcare. Currently a healthcare management process for returning service people is in place. However, several concerns have prevailed that has encouraged the medical center to evaluate the method. The HFMEA flow chart will assess every step in the process; from the time the patient enters the facility to the point of treatment. The primary focus is to identify these steps, predict areas where process failures could occur, and finally modify the process to address possible failures in a systematic fashion.

Implementation: A multidisciplinary task group including representatives from all aspects of the process (i.e. Eligibility, Medical Services, Psychiatric Services, Administrative Services, Public Relations, Information Systems, and Patient Safety) has

been assembled. The group meets on a weekly basis to diagram the process. Once all necessary failures and resolutions have been identified, the modified process is reviewed by members of the task force and concurred by select executive members, the Chief of staff and the Medical Center Director. Subsequently, education and reintroduction of the final process takes place throughout the facility; eligibility clerks at each site will be educated on the process including documentation, identifying urgency of care, treatment options, etc.

Anticipated Outcomes, Benefits, & Cost Savings: A systematic way to streamline transition of service persons from active duty to veteran status will increase patient satisfaction and eliminate some delay of healthcare access. The HFMEA will also encourage returning soldiers to utilize VA healthcare facilities early on, thus enabling the facility to accommodate the growth and change in the VA population and possibly prevent future illnesses because continuum of care has been established. With a process of this nature, it is difficult to identify cost savings in a dollar amount. However, the outcome of the HFMEA has the opportunity of preventing cost that could possibly be generated from legal issues, negative publicity, and patient dissatisfaction. In addition, the process will initiate preventive maintenance programs, which allows the VA to address medical issues before they occur, thus reducing the expense of future healthcare treatment. Furthermore, the process allows VABHS to uphold the mission, vision, and values of the organization while taking a proactive stand to better serve America's veterans.

Application Potential in Other Facilities: The HFMEA on returning OIF/OEF service persons identified several sub-steps regarding the health assessment screening process, which should be performed on each returning soldier. Service men and women may require medical needs that are unique to the veteran population. Therefore, the results of the HFMEA will produce educational tools that can be applied to other healthcare systems as a means to assess returning service persons if they happen to seek care at a non-VA facility. It also allows other facilities to observe the process taken to address healthcare management. For instance, the process can be used to identify healthcare management processes that are unique to a particular organization such treatment of noninsured individuals, charity cases from other states, or insured patients to monitor and improve patient access and satisfaction.

Available July 2004

Katheryn F. Powers
1030 North State Street, Apt 2M
Chicago, IL 60610
(205) 567 - 8334
katheryn.powers@med.va.gov

EDUCATION

2002-present **University of Alabama at Birmingham, Birmingham, Alabama**
Master of Science in Health Administration, expected May 2005
Certificate in Gerontology.
Master of Business Administration, May 2004

1997-2001 **Auburn University, Auburn, Alabama**
Bachelor of Science, August 2001, Cum Laude
Major in Marketing.

PROFESSIONAL WORK EXPERIENCE

2004-present **Edward Hines, Jr. VA Hospital, Hines, IL**
Administrative Resident
Serving as a member of the Director's Office Administrative Team encompassing:
-Strategic Planning for the Hospital and VISN 12.
-Evaluating and making recommendations regarding resource management to include FTEE ceilings, 2005 Hospital Budget, overtime and contract usage, staffing ratios, space utilization and Medical Cost Group 7 benchmarks.
-Performance Improvement and Patient and Employee Safety, including Root Cause Analysis and Prevention of Disruptive Behavior Management.
-Conducting cost/benefit analyses for clinical programs such as Cardiovascular Surgery, Radiation Therapy and Pharmacy.
-Acting as the Special Assistant to the Director and the Administrative Officer to the Police Service.
-Creating performance measures for top leadership and service chiefs.
-Collaborating with Regional Counsel and the Hospital on enhanced-use leases and safety agreements.

2001–2002 **Hirsch Financial Services, Baltimore, Maryland**
Account Representative
Marketed and managed flexible spending account plans on behalf of my employer to various organizations, including George Washington University, National Public Radio, and Mercy Health System.

PROFESSONAL AFFILIATIONS

Associate, American College of Healthcare Executives, 2002 to present.
Student Member, Healthcare Financial Management Association, 2003 to present

LEADERSHIP AND COMMITTEE ACTIVITIES

Serve on Resource Management Committee
Serve on Executive Council of Operations
Serve on Leadership Council
Member, Leadership Retreat Planning Committee
Member of Decontamination Team
Member of Spinal Cord Injury/Blind Rehabilitation Activation Team
Member, Space Management Subcommittee
Participate in Weapons of Mass Destruction Emergency Exercises
Lifetime Member, Golden Key National Honor Society, Auburn, 1999
Recognized in Who's Who among Students in America's Colleges and Universities, 2000
Volunteer, Project Uplift (Big Brothers/Big Sisters Program) 1998 to 2001
Volunteer, Shelby County School System, 1997 to 2004
Volunteer, Campaign for U.S. Senator, Bill Armistead, 1993 to 1994

Edward Hines, Jr. VA Hospital

Katheryn F. Powers
Administrative Resident
Fifth Avenue and Roosevelt Road
Hines, IL 60141
708-202-5628
Start Date: July 26, 2004

Implementation of the Green Environmental Management System

Description:

Executive Order 13148 "Greening the Government through Leadership on Environmental Management" requires all VHA facilities to establish environmental management systems in order integrate environmental responsibility into the daily operations of medical centers. The Green Environmental Management System (GEMS) as titled by VHA must be fully implemented by December 31, 2005. Hines VAH realizes the positive potential of such a program and has proactively begun implementation.

The Center for Engineering and Occupational Health Safety published a guidebook, in which nine steps are outlined, to assist facilities in GEMS implementation. Following this format, Hines appointed an Industrial Hygienist from the Safety Department to be the GEMS Coordinator. Then a GEMS Committee was created and integrated into the existing Hazardous Materials and Waste Management Subcommittee to ensure compliance and eliminate redundancy. The subcommittee, Hazardous Materials and Environmental Management Subcommittee (HM&EMS), is comprised of seven members, including four that were on the existing subcommittee. The makeup of the group includes a Performance Improvement Specialist, an Environmental Management Service Supervisor, Collaborative Duty Safety Officers for Research and Laboratory, the Assistant Chief of Facilities Management Service, a Presidential Management Fellow and Administrative Resident.

The immediate goal of the subcommittee was to create a GEMS policy, program and standard operating procedures to assist employees in improving both the work and community environment. The group reports directly to the Safety Management and the Environment of Care Committees quarterly on issues and recommendations.

Training began for team members with education on the Environmental Protection Agencies' Environmental Compliance 101 course and will continue until all members have been educated on the six parts of this program in February.

Hines' gap analysis was based primarily on the Environmental Protection Agency's Environmental Management Review that was conducted in July 2004. The review identified several areas with opportunities for improvement that the HM&EMS Subcommittee will focus their attention on. In addition, significant environmental aspects, such as energy consumption and radiation, have been identified by examining the environmental impacts for example, natural resource consumption and release of pollutants, associated with services provided at Hines, including patient care, education, research and support. For each aspect identified, the respective services involved will be required to create a standard operating procedure to maintain control of these aspects.

Based on these standard operating procedures, the HM&EMS Subcommittee will set objectives and targets for the facility to reach and maintain. These will be realistic and measurable. The HM&EMS Subcommittee will be responsible for tracking progress towards these objectives. Once the standard operating procedures and objectives are in place all staff will be educated on the processes and the significance of the GEMS implementation. It is important that every individual is aware of his or her responsibility and its significance in the GEMS process.

After training is complete the HM&EMS Subcommittee will coordinate an Environmental Compliance Baseline Audit to address all compliance issues as determined by federal, state, and local regulations. The HM&EMS Subcommittee will conduct an Annual Program Effectiveness Review which will include: status report on the regulatory compliance program, status report on GEMS implementation, review of progress towards goals and objectives and new objectives and targets for the upcoming year.

Application Potential in Other Facilities

Due to the national mandate requiring all VHA facilities to put into practice GEMS by the end of 2005, this implementation process can be used by all medical centers, with slight modifications needed for individual sites. It is recommended that other facilities use some of the same practices in implementation that have been successful at Hines.

Resources Required for Implementation

Depending upon the individual medical centers' budgets, the GEMS Coordinator could be a newly created position. Alternatively a current employee could be called upon to take on additional responsibilities as the GEMS Coordinator. Of critical importance is finding knowledgeable, dedicated staff to place on the GEMS Team since it plays such a critical role in the process. This team should report to a committee that has the authority to act on recommendations. The most costly resource involved is time. However, once the process is implemented, the time commitment required of the staff will lessen and the environmental benefits will outweigh the time constraint. In order for the program to be successful the GEMS team must have the long term commitment from top leadership within the organization.

Anticipated Benefits

The GEMS process was developed to improve environmental performance. With its implementation, Hines and other VA facilities will take the pioneering role in environmental management. Implementation and continuous improvement of this process will ensure that VA medical centers are at the forefront of environmental compliance, creating a safer place to work and live while enhancing the delivery of healthcare to our veterans.

HAYLEY RAYMER

6182 Galloway Lane, League City, TX 77573, Phone (281) 316-9692, Email: Hayley.Raymer@med.va.gov

EDUCATION

UNIVERSITY OF HOUSTON-CLEAR LAKE. Houston, Texas.
Master of Healthcare Administration/Master of Business Administration. May 2005.

LOUISIANA STATE UNIVERSITY. Baton Rouge, Louisiana.
Bachelor of Science – General Business Administration. December 2001.

- Dean's List: Spring 1999-Spring 2000, Spring 2001-Fall 2001

EXPERIENCE

2004 – Present **MICHAEL E. DEBAKEY VA MEDICAL CENTER (MEDVAMC)**. Houston, Texas.
Administrative Resident

- Projects included conducting feasibility study of On Demand Room Service; developing an analysis of nurse staffing effectiveness; and assisting in research for CAREY writing team.
- Served as Director's Office Combined Federal Campaign Keyworker and collected 317% of United Way goal.
- Participated in a successful unannounced JCAHO Survey.
- Developed and implemented scripting for Director's Office and Chief of Staff.
- Led taskforce with Union participation to conduct HR Management Program Evaluation.
- Assisted in developing Strategic Plan goals focused on Resource Efficiency, which was implemented across the MEDVAMC.
- Participated in Leapfrog Performance Improvement Team to assess MEDVAMC's performance of Leapfrog's 30 safe practices.

2002-2004 **GULF COAST REGIONAL BLOOD CENTER**. Houston, Texas.
Administrative Assistant-Business Operations.

- Prepared monthly office equipment report and investment portfolio analysis for Chief Financial Officer.
- Integrated payroll monthly journal entry by mapping accounts to import into accounting system.
- Processed over 300 invoices weekly, and disburse over 800 vendor payments monthly.
- Updated customer database to improve collection rate.
- Streamlined accounts payable process.

1999-2001 **LSU MIDDLETON LIBRARY**. Baton Rouge, Louisiana.
Serials Student Assistant.

- Entered incoming journals into NOLA database.
- Compiled issues to be sent to bindery.

1998-1999 **PARK PLACE HOSPITAL, HYPERBARIC UNIT**. Port Arthur, Texas.
File Clerk.

- Utilized Filemaker Pro to enter daily patient charges.
- Filed patient records.

AFFILIATIONS

American College of Healthcare Executives

- Attend quarterly breakfasts.
- Participate in monthly meetings with ACHE mentor.

Upsilon Phi Delta National Honor Society

- Secretary/Treasurer
- Prepare annual financial statements and collect annual dues.
- Create chapter newsletter that is published each semester.

Youth Fellowship Counselor

- Supervised youth at summer camp.
- Assisted with annual Christmas shopping trip for needy families.

MICHAEL E. DEBAKEY
VETERANS AFFAIRS
MEDICAL CENTER

Contact:
Hayley Raymer
Administrative Resident
2002 Holcombe Blvd
Houston, Texas 77030
(713) 794-7531

Training Start Date: June 2004

Project Title: *Scripting for Improved Customer Service*

Description/Background/Planning and Development:

The Michael E. DeBakey VA Medical Center Veteran Satisfaction Board composed of leadership, veteran representatives, and staff from across the medical center manages the medical center's customer service program. A Service Recovery Subcommittee was established by the Veteran Satisfaction Board to develop scripting in key areas and report the findings back to the Veteran Satisfaction Board. Scripting promotes consistent communication and increases both professionalism and efficiency.

Objectives of Scripting:

- Improve standardization
- Increase efficiency
- Manage patient perceptions
- Encourage professionalism

The first area of focus was to pilot scripting in the Eye Clinic. The Eye Clinic had received many patient complaints and low patient satisfaction scores. The subcommittee developed a general format of patient/staff encounter scripts:

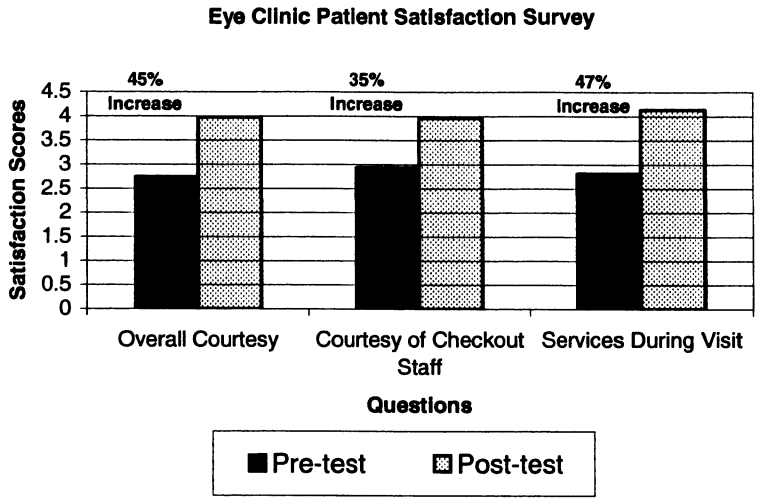
→ Opening
- Introduction with eye contact and facial expressions

→Script
- Delivered with sincerity, empathy, and provides education
- Contingency scripts for special situations

→Closing
- Summary of encounter, thank you

Documented Outcomes:

Scripts in the Eye Clinic substantially improved communication with the veteran population. A pre-implementation survey was conducted before scripting was implemented to gather baseline information. Clinical providers and clerical staff then adopted scripts to better communicate with patients. A post-implementation survey was conducted and found that the number of courtesy issues was reduced and patient satisfaction regarding overall courtesy in the Eye Clinic improved by 45%. The following graph illustrates the improvement of patient satisfaction in the areas of courtesy and services offered during visits to the Eye Clinic.



Because of the success in the Eye Clinic, leadership chose to develop a facility-wide scripting initiative as part of the fiscal year 2004 strategic plan. Customer service representatives were nominated from each care and service line throughout the facility. These customer service representatives were responsible for deploying standardized universal scripts within their respective care and service lines. Employees use the scripts when answering the phone and assisting patients and visitors during a face-to-face interaction. To ensure compliance with universal scripts, certain employees act as "mystery shoppers". Employees who are identified as providing excellent customer service are recognized at meetings such as the Director's Town Hall and Executive Council.

Each care and service line have also identified areas where scripting could improve their customer service and are now meeting to develop their respective scripts. These scripts are channeled through the Service Recovery Subcommittee of the Veteran Satisfaction Board for review and approval. The scripts are then implemented throughout the care and service line. The customer service representatives meet quarterly to transfer knowledge gained from their care and service lines across the organization.

Required Resources:

The two required resources for implementing scripting are time and training. Once the decision was made to implement scripting facility-wide, 40 customer service representatives were trained. These customer service representatives were also responsible for training their respective care and service lines during one hour training sessions. Documentation of results pre and post implementation of scripting along with an oversight body, such as the Service Recovery Subcommittee of the Veteran Satisfaction Board, which approves all scripts and reviews post implementation results is an integral part for successful operations.

Application Potential:

Many other facilities are already using scripting to improve customer service, but they may not be standardized and implemented facility-wide. The key for scripting to be truly successful is to achieve staff buy in by illustrating the improvement in veteran satisfaction. Scripting has also opened communication between care and service lines. In the laboratory, staff considered creating a script for patients who needed to fast before a lab but did not. This script has led to trending providers interactions so they can improve in fully educating patients on the required procedures before laboratory tests.

All-in-all, scripting is not only a low-cost strategy to improve veteran satisfaction, but also an initiative that can be implemented across all service and care lines. It proves to be an effective tool that is sure to bring about positive changes if integrated across all VA systems, thus drawing the VHA closer to fulfilling its focus on patient-centered care.

Charles A. Ritter

1329 NE Hancock apt #4
Portland, OR 97212
503.771.0205
charles.ritter@med.va.gov

Education:

Master of Public Health, *June 2004*
Portland State University
Concentration: Health Administration

Bachelor of Arts in Psychology; *May 2000*
University of Delaware
Concentration: Neuropsychology & Social Psychology

Work Experience:

August 2004 to Current

Administrative Fellow: *Portland VA Medical Center; Portland, OR*

- Received mentored guidance from Medical Center Director for broad, executive-level hospital administration training including strategic planning, budgeting, and project management while rotating through hospital divisions
- Coordinated provision of transitional housing for homeless veterans with community providers
- Organized multi-campus Combined Federal Campaign raising over $100,000
- Guided strategic initiative to expand vesting procedures and workload capture

October 2002 to July 2004

Graduate Research Assistant: *RRTC: Health and Wellness Consortium, Oregon Health & Science University; Portland, OR*

- Assisted Center researchers with health and policy research projects, data analysis, and writing a comprehensive federal grant
- Created and maintained Center's dissemination and budgeting databases and tracking systems
- Developed brief research summaries for multiple audiences including laypersons, academics, and practitioners

June 2003 to October 2003

Co-Investigator: *Portland State University; Portland, OR*

- Co-authored a comprehensive action plan for health providers in Oregon and Southwest Washington, *A Conceptual Map of Children's Mental Health*
- Provided technical support for ongoing grants

July 2000 to July 2002

Psychiatric Social Worker: *Delaware Psychiatric Center; New Castle, DE*

- Conducted psychological assessments of chronically mentally ill clients in both civil and forensic settings
- Performed statistical analyses used in the design and implementation of clinical programming
- Collaborated with Treatment team to generate and modify clinical treatment plans with multi-disciplinary interventions
- Developed curriculum and facilitated various group therapies and psycho-educational trainings
- Appointed as liaison between Delaware Secretary of Health and Human Services and treatment unit staff

September 1999 to June 2000

Research Assistant *University of Delaware; Newark, DE*

- Assisted in research design, and methodology, and analysis for NIMH sponsored grant, "Perceiving and Remembering Scenes"
- Created visual stimuli and graphics for use in research protocol and conference presentations
- Supervised student research assistants

Professional Affiliations:

Affiliate of American College of Healthcare Executives

Facility:	Portland VA Medical Center
Contact:	Charles Ritter, MPH, Administrative Fellow 3710 SW U.S. Veterans Hospital Road Portland, OR 97239 503.220.8262 x54764
Training Start:	August 2nd, 2004
Project Title:	**Advancing Benchmark Effectiveness and Validity through the Analysis of Diagnostic Related Groups**

Description of the Program: Benchmarking, using Diagnostic Related Groups (DRGs)[1] and case-mix adjusted costs[2], is a process-oriented approach that can produce tangible and measurable comparisons across medical centers at multiple programmatic and operational levels. Using DRGs as the foundation of comparison: can quickly highlight operational differences; is flexible enough to suit both long and short-term project requirements; and can potentially lead to a significant reduction of costs. Furthermore, this approach presents an opportunity for a uniform benchmarking approach applicable throughout the Veterans Health Administration.

Objective: The project goal is to isolate all opportunities for programmatic and operational cost savings for the Portland VA Medical Center's (PVAMC) inpatient services. The VHA as a whole and two comparable VA Medical Centers will serve as the benchmarks. Savings potential will be examined through comparative analysis of case mix-adjusted costs and through investigation of the cost patterns connected to specific high-cost DRG outliers. 100% of the identified high-cost programmatic, division, and DRG-specific areas will be scrutinized to determine both the immediate and the long-term savings indications.

Planning: The PVAMC faces the challenge of adapting to an average 12% growth rate in new patients for each of the past three years, reducing costs, and sustaining the delivery of world-class services. In response to this challenge, and in conjunction with the PVAMC's mission to provide services to the eligible veteran population, a collaborative team led by the DSS Manager began to uncover opportunities for improvement in the delivery of cost-effective care to veterans.

The collaborative team investigated savings potential through benchmarking case-mix adjusted costs at multiple organizational levels as well as investigating specific high-cost DRG outliers. Team members consisted of the service chiefs from Medicine, Surgery, and Mental Health. The Administrative Fellow performed the analysis and coordinated efforts alongside the DSS Manager. Frequent team meetings allowed for the development of an informational feedback loop that guided both analysis and communications with clinical staff. Open communication prevented fragmentation of the charge and reduced duplication of efforts.

Development: The charge initiated as an investigation of the overall cost-structure of the PVAMC's inpatient services using data obtained from the Financial and Clinical Data Mart (FCDM). As part of this investigation, the need to benchmark against other VA medical centers was paramount. However, benchmarking using raw numbers from the FCDM proved imprecise, and thus inadequate for tangible comparison. To remedy this shortfall, all data was converted to reflect case-mix adjusted costs. Adjusting for case-mix accounted for the idiosyncrasies and complexities related to each medical center's care delivery model and infrastructure needs.

Through case-mix adjustment, valid benchmarks were identified and measurable medical center-wide, divisional, and programmatic cost-savings emerged. The identification of valid benchmarks not only revealed general, wide-ranging savings potential, but also allowed for more detailed investigation into the root-cause of specific operational costs. For example, in-depth analysis revealed that a handful of high-cost DRGs were skewing the overall cost structure for PVAMC's Medicine and Surgery Divisions. This observation guided evaluation of DRG-

specific cost patterns, chart review, clinical review, and the validation of source data. Stemming from this process, targeted interventions were initiated to improve the cost-effectiveness in the delivery of PVAMC's care.

Application Potential in Other Facilities: Through the recommendation of PVAMC's collaborative team, case-mix adjusted data is now available through the Financial and Clinical Data Mart (FCDM). The availability of this information creates the potential for a standard tool and metric for benchmarking that is applicable across all VA Medical Centers.

Resources Required for Implementation: The recent inclusion of case-mix adjusted data in the existing FCDM package does not require additional cash or capital to implement the benchmarking process. A content expert who is able to analyze large data sets, clarify complex statistical procedures, and facilitate analytical discussion amongst leadership and clinical staff is needed. Furthermore, staff hours are required to investigate all identified high-cost outliers.

Outcomes: The wide-ranging case-mix comparison revealed PVAMC's physician costs for providing attending and resident coverage consult services as considerably higher than the benchmarked institutions. Other wide-ranging areas were also identified in this process summing to a total case-mix adjusted annual savings, relative to the highest performing benchmarked medical center, of $6,409,053 in variable costs alone. When correcting for areas where the PVAMC demonstrated lower variable costs than the highest performing benchmarked institution, total savings potential dropped to $2,493,420 per annum.

Investigation at the individual DRG level also exposed considerable savings. Based solely on the PVAMC's top 25 high-cost DRG outliers, estimated savings ranged from $5,124,000 to $7,690,000 per annum relative to the benchmarks. Upon further review and scrutiny of DRG trends, chart review, source data review, and clinical feedback, the savings potential would more conservatively reflect half the above figure, or between $2,562,000 to $3,980,000 annually. Further investigation is needed to more fully explore additional savings potential. For example, areas currently targeted for improvement include non-indicated chemotherapy, inappropriate admission procedures, data entry problems for particular pharmacological treatments, and case-management needs for cases with high-acuity.

Benefits:

- Case-mix adjusted cost data are more precise than raw numbers for benchmarking
- Operational differences highlighted with enhanced articulation of utilization
- Causal factors identified at the programmatic, operational, and individual case levels.
- Introduces a uniform approach for comparative analysis across VA Medical Centers

Cost-Savings: Adjusting for institutional level of acuity allows for precise comparison of resource utilization in the benchmarking process, and permits analysis of specific DRGs. This breakdown provides comparison at the most specific procedural level that can be defined; provides a process for identifying causal factors contributing to high-costs; and allows for benchmarking precision unattainable by institutions without the sophisticated information systems of the VHA. Specific cost savings for the PVAMC are pending further investigation. Nonetheless, interventions targeting causal factors identified in the analysis would produce conservative projections ranging from $2.5 to $3.9 million in annual savings.

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[1] Each inpatient admission is assigned a Diagnostic Related Group (DRG) based on an algorithm using the principal diagnosis causing the admission, all operations, and significant procedures performed during the hospitalization. Each DRG is assigned a weight that corresponds to the complexity of care and the subsequent costs required to provide that care. The DRG weighting system is normalized to 1.0 and increases as a linear function with the complexity of care.

[2] Summing the weights assigned to each DRG, and then dividing by the total number of discharges determines the case-mix adjusted cost.

Eric Rhodes

1701 East 12th St. Apt. 21J
Cleveland, Oh 44114
(513) 490-3892
Erreigns@hotmail.com

Education

Xavier University, Cincinnati OH
Master of Health Services Administration, graduation expected December 2005

Xavier University, Cincinnati OH
Bachelor of Business Administration, Management, May 2003

Work Experience

Louis Stokes Veterans Administration Medical Center — **Cleveland, OH**
Administrative Resident — *January 2005 – Present*

- Manage departmental projects (Hospital Consolidation, Audiology)
- Inspect Narcotics levels throughout Medical Center
- Observe Executive Management
- Conduct rotations through Medical Center Departments
- Complete requirements of MHA degree

General Electric Aircraft Engines — **Cincinnati, OH**
Sourcing Agent Co-opt — *January 2003 – Aug. 2004*

- Negotiate terms of delivery and prices with foreign suppliers
- Place orders and request for price quotes of engine parts
- Release schedules for delivery of parts
- Utilize Six Sigma methodologies

Tri-Health — **Cincinnati, OH**
Intern — *May 2002 – August 2002*

- Benchmarked competitors for corporate administration analysis
- Calculated compensation figures and sent notifications of adjustments
- Developed a template for a workforce planning model
- Converted Microsoft Word documents to Excel documents
- Performed data entry and internet research

West End Health Center — **Cincinnati, OH**
Intern — *May 2001 – August 2001*

- Conducted productivity analysis
- Developed marketing strategies for new clientele
- Constructed a Strategic plan template
- Initiated zip code analysis program

Xavier University, Student Government Association — **Cincinnati, OH**
Executive Vice President — *June 2002 – May 2003*

- Managed and allocated a $500,000 budget
- Organized and planned Club Day, Fenwick Golf Open
- Led meetings for the Programming branch of SGA
- Interviewed and selected potential SGA aspirants

Activities

President of Alpha Phi Alpha Fraternity, Inc. Sigma Gamma Chapter, 2002-2003;
Special Events chairperson for Student Activities Council, 2001 – 2002;

Honors

Graduate of Fidelity Investments Fellowship Program, State Oratorical Contest
Winner, Xavier Key Achievement Award
Professional Bartender/Mixologist

References

Available upon request

Louis Stokes Cleveland VAMC

Eric Rhodes
Administrative Resident
10701 East Boulevard
Cleveland, OH 44106
216-791-3800 ext. 3825

Consolidation of Two Division Medical Center – Louis Stokes Cleveland VAMC

Project Description:
This project will consolidate and co-locate all clinical and administrative functions of a two divisional medical center at the Wade Park VAMC. This consolidation aligns itself with the Congressional top priority for construction due to the closure of the Brecksville VAMC and achieves the objective of CARES to realign and decrease the amount of infrastructure maintained and operated by the VA by 931,454 gross square feet. This project will require new construction of 268,546 gross square feet at the Wade Park VAMC. The scope of this project includes additional chillers, emergency generators, and boilers as well as the associated incoming utility connection for the new space. Space efficiencies are gained in several ways for the aforementioned items that do not require the new construction of space: 1) There is existing space in the penthouse of the Wade Park VAMC that can accommodate the new chillers and (2) The current energy center is expandable by 1,800 square feet.

This project requires the Enhanced Use Lease of 102 acres at the Brecksville VAMC in exchange for property adjacent to the Wade Park VAMC. Under the Enhance Use Lease agreement, an organization will construct a 120 bed Domiciliary, a 2,000 space parking garage, and administrative space adjacent to the Wade Park VAMC that will provide the additional infrastructure needed for the consolidation of the Brecksville VAMC at the Wade Park VAMC. The consolidation at the Wade Park Division of The Louis Stokes Cleveland VAMC will allow for the complete vacancy and closure of the Brecksville VAMC. The cost savings of this project are anticipated to exceed $23 million annually and the quality of clinical care will be significantly enhanced to the more than 80,000 veterans that receive care at these medical centers annually. Additionally, there is the potential consolidation of VHA and VBA that will promote a One VA through efficient processing of VBA claims requiring medical support from VHA for the more than 500,000 veterans residing in Northern Ohio.

Application potential in other facilities:
The application of this project upon other facilities may be prevalent for any Veterans Administration facility that is experiencing similar problems resulting from operating and maintaining two large facilities. The Louis Stokes Cleveland VAMC has been maintaining two, large, antiquated physical plants that were built more than 45 years ago. The modes for providing clinical care have changed dramatically over the past 40 years and the costs to renovate and maintain two physical locations are very expensive. The result of maintaining two VAMCs, both ill fitting to today's mode of clinical care, results in:
· duplication of services at two VAMCs (e.g., pharmacy, laboratory, radiology, food nutrition, building and grounds maintenance, administrative support);
· decreased operational efficiencies as the result of duplication of services;
· issues with continuity of care between the two VAMCs. (E.g., transfers from the nursing home at Brecksville to acute care at Wade Park, and similar transfers for psychiatric patients requiring acute care);

· patient safety issues that have been reflected in external Inspector General reports and JCAHO citations; and most generally,
· Inefficient use of taxpayer dollars.
The completion of this project will resolve all of the aforementioned problems that currently exist between the two VAMCs; and, most importantly, will allow this medical center to provide, quality, and state of the art care to a very large veteran patient population at the lowest cost per patient in the VHA healthcare system. Any other facility implementing this project should gain similar results.

Resources required for implementation:
Resources that are needed for this project include the expertise, knowledge, skills, physical resources, monetary funding, and participation of the following stakeholder:
-Veterans
-Veteran Service Organization
-Employees of the Department of Veterans Affairs
-The Cities of Cleveland and Brecksville
-Case Western Reserve University (Medical School Affiliate)
-University Hospitals (Affiliate Hospital)
-Approximately 99 affiliates with institutions of higher learning for the training of a wide range of health care professions, including podiatry, optometry, psychology, physician's assisting, pharmacy, social work, dietetics, and others.
-VBA
-Regional Counsel
- Developers/Construction/Architects

Documented outcomes, benefits, cost savings, etc.:
The consolidation of the Brecksville VAMC at Wade Park would improve the operating efficiency of The Louis Stokes Cleveland VA in the following ways:
a) There would be an overall decrease in FTEE due to duplication of services in a two division medical center. This translates to approximately $10.6 Million in operational savings per annum.
b) Avoid approximately $41 Million in Non-Recurring Maintenance and Infrastructure improvements at the Brecksville VAMC over the next three fiscal years.
c) Contract for laundry services that are currently housed at the Brecksville VAMC. This would save approximately $421,000 in operation savings per annum.
d) Elimination of the transportation of patients from Brecksville to Wade Park via ambulance and helicopter for acute medical services and scheduled specialty appointments.
e) Decrease in the amount of nursing time used for preparation of patient transport from Brecksville to Wade Park.
f) Decrease of approximately 569,000 GSF space.
g) Elimination of patient shuttle service between Brecksville and Wade Park for a savings of approximately $325,000 per annum.
h) Total cost savings of over $23 Million per annum due to increased efficiencies and elimination of duplicative service.
i) The scope of this project includes additional chillers, emergency generators, and boilers as well as the associated incoming utility connection for the new space. Space efficiencies are gained in several ways for the aforementioned items that do not require the new construction of space: 1) There is existing space in the penthouse of the Wade Park VAMC that can accommodate the new chillers and (2) The current energy center is expandable by 1,800 square feet.

Training Start Date: 01/10/2005

Asheville VA Medical Center
1100 Tunnel Road
Asheville. NC 28805

Melanie L. Sabik, MHSA

E-mail: Melanie.Sabik@med.va.gov
Phone: (828)-298-7911 Ext. 14160

EDUCATION

MASTER'S IN HEALTH SERVICES ADMINISTRATION (2002-2004)
Graduate Program in Health Services Administration *Little Rock, AR*
University of Arkansas- Little Rock

BACHELOR'S OF SCIENCE IN EDUCATION (1997-2002)
University of Arkansas *Fayetteville, AR*

PROFESSIONAL EXPERIENCE

ADMINISTRATIVE FELLOW (OCTOBER 2004 - PRESENT)
Asheville VA Medical Center *Asheville, NC*

- Represented Executive Office on the Homeless Stand Down Committee
- Coordinating the restructuring of Patient Satisfaction Committee with Staff Assistant to Director
- Researched departmental processes and procedures during facility rotations
- Assisted in planning for Performance Improvement Fair
- Coordinated prize drawings for facility wide Holiday Party Committee
- Promoted the Combined Federal Campaign as Executive Office representative
- Shadowed VISN 6 Safety Manager for annual workplace evaluation survey
- Attends executive leadership meetings and trainings

RESEARCH ASSISTANT (AUGUST 2003 – SEPTEMBER 2004)
University of Arkansas for Medical Sciences/Arkansas Children's Hospital *Little Rock, AR*
Center for Applied Research and Evaluation

- Conducted structured interviews of study subjects
- Managed study participant database
- Generated study codebooks for statistical analysis
- Assisted with other research related tasks

ADMINISTRATIVE RESIDENT (MAY 2003-AUGUST 2003)
Saline Memorial Hospital *Benton, AR*

- Implemented customer service improvement plan for diagnostic imaging services
- Administered licensed nursing staff retention survey
- Created rehabilitation services continuity of care brochure
- Participated in rehabilitation department business planning
- Conducted patient quality of care audits
- Participated in PHO Office Staff and Department Manager's meetings
- Conducted Materials Safety Data Sheet Audits
- Edited press releases for newspaper publication

LEADERSHIP AND AFFILIATIONS

- American College of Healthcare Executives; 2002- Present
- Arkansas Health Executives Forum 2002- 2004
- Health Services Administration Student Association; 2002- 2004
- ACHE UALR Student Chapter, 2002-2004
- Health Services Administration Student Association President 2003-2004
- ACHE University of Arkansas-Little Rock Chapter Secretary 2002-2003
- Association of Health Science Majors Co-President 2000-2001

Asheville VA Medical Center **October 3, 2004**

Melanie L. Sabik
Administrative Fellow
Asheville VA Medical Center
1100 Tunnel Road
Asheville, NC 28805
(828)-298-7911 ext. 14160

Project: Committee restructuring: An opportunity for improving effectiveness

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Description/Background

Service satisfaction is one of VHA's domains of value, and guides all national and network planning as the driving force behind all VHA operations. In 1993, Presidential Executive Order 12862 was released mandating that customer service standards be published and customers surveyed in order to provide feedback to leadership. The intent is to promote quality assessments followed by action plans for improvement to address unmet needs and concerns of patients. Locally, the Patient Satisfaction Committee (PSC) is the center of customer and patient satisfaction information. It supports activities and programs that facilitate excellence in customer service, provides assistance to services and programs, and makes recommendations to the Executive Leadership for improvements or changes.

The Asheville VA PSC has initiated an effort of restructuring to strengthen and improve the focus, function and effectiveness of their team. Recent evaluations from the Asheville VA Committee Process Action Team also recommended some general committee process changes that coincided with restructuring goals made by the PSC. These results indicated the necessity to continue the vision to reorganize the PSC.

Objectives:

To restructure the PSC for higher effectiveness, this project will:

- Evaluate and identify "core" membership versus "consultant" membership
- Develop and implement a committee membership application and interview process based on HPDM and performance based interviewing
- Conduct committee chairperson training
- Identify committee member roles and train members for appropriate responsibilities
- Review and update PSC policy

Planning:

Committee members participated in an external survey to determine team effectiveness of the PSC. Surprisingly, some members were not aware of the goals of, or their roles in the committee. Other results indicated a lack of focus, problems with

timeliness and efficient use of committee meetings. This breakdown in committee member knowledge and action does not support an effective team process. Members rated themselves as 57% on overall effectiveness as a committee. As such, the need for greater vision, structure, communication, teamwork, and organized leadership was demonstrated and supports the concept of restructuring.

Development:

The first step to developing an effective restructured committee is to revisit the mission, vision, goals, and policies that are to drive the committee and update them if necessary. Team and individual competencies essential to being an active member of the committee should also be identified. These steps allow for a clear foundation for the application and performance based interview process to be implemented. Once essential committee membership or "core" membership has been established, training will occur for the members specific to their roles and tasks in the committee. This will enable the committee to act in a clearly defined manner and improve the effectiveness of the team.

Application potential in other facilities:

Every VA has committees that oversee the proper leadership and medical practices of each facility program. Restructuring, or ensuring the structure of committees can assure leadership of highly effective and participatory teams. This practice can be effective for committees other than the patient satisfaction committee. Through training and careful selection of committee membership an energized, organized and focused team may develop.

Resources required for implementation:

Implementation of this concept does not require the use of financial resources, unless an external effectiveness survey is desired. High motivation and a willingness to change the way things "have always been done" are necessary factors for the current committee members and the coordinator for the restructuring. Support from leadership is essential in undergoing this sort of committee reformation.

Expected Outcomes:

This restructuring is a work in progress. To date, no documented outcomes or benefits have been available specific to the project. However, throughout many academic publications, team organization strategies and group development issues have connected performance and effectiveness. Greater understanding of intragroup processes and motivated members can only improve the effectiveness of workgroups. Expected benefits are a more cohesive, knowledgeable committee working together to improve patient satisfaction efforts at the medical center.

Joseph A. Schoeck

2130 University Ave, Apt 8
Madison, WI 53726
Cell: (608) 334-2662
Emails: schoeckj@slu.edu or
joseph.schoeck@med.va.gov

Education

Saint Louis University
Master of Health Administration, May 2004
Bachelor in Health Information Management, May 2003

Experience

June 2004 – Present

William S. Middleton VA Hospital, Madison, WI
Administrative Fellow, Preceptor: Nathan Geraths

- Acting Administrative Officer, Medicine Services, November 2004-present
- Rotated through various departments to observe hospital operations
- VA ACHE project: Case Study VISN 12 Telecommunications
- Participated in various Process Action Teams
- Participated in both VISN and local Strategic Planning Retreats

May 2003 – August 2003

SSM St. Mary's Health Center, St. Louis, MO
Administrative Intern, Preceptor: Ron Tompkins

- Rotated through various departments to observe hospital operations
- Attended and participated in various meetings involving senior leadership
- Participated in strategic planning for two service lines
- Assisted in Joint Commission preparation for September 2003 visit

June 2002 – March 2003

Washington University School of Medicine, St. Louis, MO
Filing Clerk, Department of Otolaryngology

- Assemble, analyze, and distribute charts to departments
- Prepare files for work releases
- Maintain filing system

February 2002 - June 2002

Saint Louis University Hospital, St. Louis, MO
Professional Practice Intern

- Assembled, analyzed, filed charts and loose sheets
- Prepared patient charts for tracking according to compliance regulations
- Generated reports of overdue balances for Pathology Service
- Created database of clients with outstanding patient accounts
- Generated bills based on monthly procedures and tests performed

Honors and Activities

- **American College of Healthcare Executives**, Member, 2004-present
- **Saint Louis "University" Scholarship**, Recipient, 2000-2004
- **Micah House** (organization geared towards social justice and community service in areas surrounding Saint Louis University), Member, 2000-2004
- **Saint Louis University Vision 2000 Scholarship**, Recipient, 2001-2004
- **Dean's List**, Spring 2002

References furnished upon request

Joe Schoeck, MHA
Administrative Fellow, Madison VAMC
2500 Overlook Terrace
Madison, WI 53705
(608) 256-1901 ext. 17760

VISN 12 Telecommunications Consolidation: Did it Work???

A unique and attractive opportunity presented itself to VISN 12 with the installation of unified telephone switches and the completion and activation of their Wide Area Network (completed May 1999). The VISN recognized the opportunity to consolidate switchboard operations to one central location (Madison VAMC) with the goals of saving money and improving customer service. The outcome of the consolidation was reduced costs to the Network, improved reliability in switchboard operations, and enhanced customer service to our veterans and their families, as well as hospital staff. Prior to this study a breakdown and in-depth analysis of the change in costs and quality from the beginning of the project (1999) to present day (2005) had not been completed. The experience of VISN 12 may have application to other VISNs nationwide, particularly with the increasing demand for efficiencies and the future budget outlook for the VA.

Throughout the telecommunications consolidation initiatives in VISN 12, many improvements have been made individually that have led to increased cost savings and improved service. I will quickly list and describe these improvements:

1) VISN 12 has standardized their telephone switches in an effort to create a uniform structure and reduce costs. All large medical center PBX switches were purchased at the same time in order to take advantage of high volume discounts.
2) Interconnecting the PBX switches and sending the voice traffic over Wide Area Network (WAN) has allowed VISN 12 to reduce the costs of calls between Network sites and has enabled "5 digit dialing" throughout the VISN, including CBOCs.
3) These telephone system enhancements have enabled switchboard services to be centralized to one location (Madison VAMC).
4) VISN 12 has moved from contracting out the maintenance of PBX switch equipment to recruiting and hiring "in-house" employees to perform this maintenance.
5) VISN 12 has developed a high volume pricing agreement with the WAN provider and has moved from month to month agreements for T1 and T3 lines to 5-year term agreements.
6) Volume discounts for local phone service have been negotiated with phone service providers yielding significant price savings.
7) VISN 12 off-tour telephone triage activities have been centralized also to one location (Madison VAMC).
8) The funding and tracking of PBX maintenance training has been centralized.
9) The installation of PBX switches has moved from outside contractors to "in-house" staff.
10) Video conferencing is consolidated to the WAN instead of using separate data lines.
11) Implementation of automatic call distribution (ACD), allows multiple agents to answer a given line, eliminating busy signals, improving customer service, and providing workload and performance data to managers.

These improvements have been made over time since 1999. The impending results will be further discussed.

One major impact VISN 12 has realized due to the consolidation of Operator services is an improvement in customer satisfaction. Beginning in January of 2003 an annual 4-question survey has been distributed to staff, patients, and volunteers asking for their input as to the service provided by the centralized operators. One particular question worth noting is, "Overall, I am pleased with the service I receive when I call the hospital operator." Available responses for this question are: Strongly Disagree, Disagree, Unsure, Agree, and Strongly Agree (ranging from values of 1-5 respectively). A higher average score of this question is desirable and VISN 12 has made considerable improvements with an average score of 2.99 in 2003, 3.61 in 2004 and 3.68 in 2005.

Another major impact the consolidation has had on VISN 12 involves improving the performance measures of the centralized operators. With over 150,000 calls a month, performance is of utmost importance to the customer. The average speed to answer (ASA) is one such performance measure that illustrates the improvement of the VISN 12 work unit over time. The ASA for Fiscal Year 2004 was 13.4 seconds, which is a drastic improvement from past year averages which were as high as 19.1 seconds (data on this measure is limited, it was not measured previous to FY01). Another performance measure that illustrates the effectiveness of the operator staff is the Call Abandonment Rate. The 2004 rate was just above 3%, compared to rates of up to 7% in the past.

A major question for VISN 12 leadership was whether or not the consolidation and various improvements to telecommunications resulted in cost savings to the Network. To illustrate this, I compiled information from 1999 (Decentralized VISN 12 Model based on 1999 operational patterns) and compared those costs to the centralized model, which is now in place. Major areas of costs were identified as operator staffing, contracted staffing, PBX maintenance and installation, and phone related billing.

Operator staffing in the Decentralized Model was found to be at a level of $1,807,900 per year compared to $1,606,125 per year for the current Centralized Model. Contracted PBX maintenance was a major expense in 1999, but VISN 12 has made the commitment to hire "in-house" SWITCH and MAC techs to perform this important function. Hiring in-house staff allows for added flexibility among VISN 12 facilities in switch maintenance and installation, as well as significant cost savings over the expensive contract costs. Using the contract PBX maintenance model, VISN 12 would be spending $1,926,000 per year compared to the $1,251,000 which is currently spent per year under the "in-house" technicians model. With these techs now employed "in-house" they have attended specialized training which has allowed them to gain the expertise to install various PBX switches throughout the Network. Installing a PBX switch in a community based outpatient clinic (CBOC) normally costs around $6,000, but with "in-house" employees performing the duty it costs a few hundred dollars associated with per diem and travel. To date twenty-three CBOC phone systems have been installed by "in-house" technicians, saving around $140,000. Yearly maintenance contracts for the CBOC phone switches would cost around $37,000, which is currently accomplished by "in-house" staff. It costs roughly $500,000 to install a large medical center PBX switch. North Chicago is the only site scheduled for a new system and installing it by in-house technicians will save the Network roughly a half million dollars.

Lastly, the VISN has negotiated volume discounts with the local phone carrier that has yielded savings of $240,000 annually. Total savings of the Centralized Model for the major areas examined is around $1.8 million. This figure does not take into account the volume discount savings realized by purchasing the PBX switches simultaneously, or the savings of inter-facility calls currently on the WAN, which previously cost up to 4 cents a minute. Total annual savings of a Centralized Model (minus the one time installation costs) is around $1.13 million a year.

SANGITA S. SHAH

7305 N. Military Trail
West Palm Beach, FL 33410
Home: (561) 242-1131 Work: (561) 422-5747
Email: Sangita.Shah2@med.va.gov

Education

May 2004 **Master of Healthcare Administration and Master of Business Administration**
University of Houston-Clear Lake, Houston, TX

May 2000 **Bachelor of Science in Biology**
Baylor University, Waco, TX

Healthcare Experience

6/04-present **Administrative Fellow**
West Palm Beach VA Medical Center, West Palm Beach, FL

- Prepare Cost-benefit analysis to implement Radiology Voice Recognition System
- Reduced backlog for Audiology Service by analyzing and rebuilding clinical grids
- Develop and implement Advanced Clinic Access plan with Chief of Staff and Audiology Service Chief
- Served as Internal Auditor of Fiscal Service
- Participated in disaster planning, response, and recovery
- Prepared and analyzed clinic workload reports for multiple services
- Participated in preparation of Capital Investment Proposal
- Serve on Advanced Clinic Access Committee which involves developing approaches to reducing wait times, enhancing access, and reducing backlogs
- Participated in DSS workgroup
- Participated in JCAHO and SOARS preparation
- Prepare Congressional correspondence
- Delivered a presentation at West Palm Beach VA Medical Center Strategic Planning Conference
- Review and approve applications for Medical Center's incentive awards program
- Author and editor for monthly facility newsletter (Director's UPDATE)

6/03-8/03 **Administrative Intern**
Seton Northwest Hospital, Austin, TX

- Developed and co-drafted Patient Guide for the hospital
- Collaborated with Director of Patient Services and COO to draft Patient Safety Plan
- Created Cost-benefit analysis for trauma facility designation
- Created reports on quality improvement
- Analyzed clinical/staffing indicators in order to create Staffing Effectiveness Plan reports and run charts
- Rotated through various administrative and clinical departments
- Worked closely with Administrators, Directors, and Managers to understand daily operations of hospital
- Prepared agenda items for various leadership team meetings
- Participated in the JCAHO preparation meetings
- Directed team for determining criteria for rewarding outstanding employees
- Directed team to evaluate staff parking issues

6/01-3/03 **Research Assistant**
Baylor College of Medicine/Texas Children's Hospital/UT Houston, TX

- Organized/Implemented data organization via MS Excel/Access
- Analyzed data research
- Recruited patients for research study
- Evaluated patients and maintained patient database

5/00-4/01 **Intern**
Dentist Office, Houston, TX

- Managed day to day operations of clinic
- Supervised and trained new clinic assistant
- Conducted all financial transactions
- Explained procedures of admittance to patients
- Scheduled procedures/follow up care
- Verified insurance and processed referrals

Activities

- American College of Healthcare Executives (ACHE)
- Medical Group Management Association (MGMA)
- Volunteer work: Star of Hope, Habitat for Humanity, Juvenile Diabetes Research Foundation, LifeGift Organ Donation

Facility Name: West Palm Beach VA Medical Center
Start Date: June 13, 2004
Sangita Shah
Administrative Fellow
7305 N. Military Trail
West Palm Beach, FL 33410
Work: (561) 422-5747 Home: (561) 242-1131

Hurricane Season 2004: How proper planning mitigates the impact of a natural disaster
A Critique of the West Palm Beach VAMC Family Support Services

Introduction:

The West Palm Beach VAMC is situated on the eastern coast of Florida. Due to our location, we must deal with the potential of hurricanes each year. During Hurricane Season 2004, the Medical Center was threatened by three hurricanes within the span of one month, two of which actually hit the hospital. Hurricane Frances was a Category 2 storm with sustained winds of 105 mph, and Hurricane Jeanne was a Category 3 storm with sustained winds of 120 mph.

In an attempt to be proactive with our response to a natural disaster, we begin planning each year for a Family Support Program. The Program's objective is to provide support for mandated employees and their family members who accompany them in the Medical Center during an emergency. The Program is utilized when deemed necessary by the facility's leadership team.

Family Support Program

Problem:
As the 2004 Hurricane Season approached, registration forms were sent out to all employees deemed essential in the case of an emergency. A problem began to develop as the registration forms were sent to employees at a later date than usual. These forms were returned to the Medical Center by mail, or in person, however several were lost in the system. Another issue that emerged during the registration process involved the determination of which employees would be mandated to work during an emergency. A number of employees were hesitant to assist in the event of a hurricane or other emergency, which caused a delay in the development of the official list of mandated employees and their family members.

Due to the problematic registration process, changes were still being made to the number of mandated staff on September 2nd, even though mandated employees were required to report to the Medical Center by noon of September 3rd. Our pre-season registration process was judged to be poorly executed and led to further complications in our emergency operations activities. When the hurricane did arrive, it was quickly realized that the mandated employees brought in many people other than registered family members. With limited space and resources, the Medical Center was not equipped to become a community shelter. However, it was difficult for the Medical Center to turn away people at this point because of the hurricanes fast approach. Additionally, the incomplete pre-registration and identification processes meant that is was impossible to prove that these persons were not registered. Fortunately, the Medical Center did not have to be evacuated, however, this would have been difficult to accomplish in an organized fashion, as there was no clear accounting of people within the facility.

Given that so many additional people were sheltered in the facility, the Medical Center had an inadequate supply of food, space, and resources, such as inflatable mattresses for employees' families to sleep on. With the loss of full water capacity, sanitation and hygiene issues rapidly became a critical concern of the leadership team.

Action:
After Hurricane Frances, a team consisting of the Supervisory Social Worker, Speech Pathologist, Staff Assistant to the Director, and Administrative Fellow reviewed several processes and new procedures were put in place during the hurricane. Clear, specific guidelines were developed to reduce the number of mandated staff to only those required to maintain high quality care for the patients and adequate support for the facility. In addition, an Excel database was developed with the names of mandated staff and their immediate family members, along with color-coded room assignments for each family member.

Security measures were tightened throughout the facility and grounds. All perimeter gates were locked, except for the main entrance. Security guards were directed to check each car as it entered to ensure those entering were on the final approved mandated list. Anyone not on the list was turned away. Everyone entering the building had to check in at the registration desk. Security guards were positioned to deter family members from bypassing registration. For identification purposes, armbands were developed for the family members. Anyone seen without an ID Badge or an armband was questioned by Security.

Outcome:
Opportunity to test the new process arrived with Hurricane Jeanne. Using armbands as identifiers, we were able to determine whether an individual had permission to be in the building. The Excel database, which contained color-coded room assignments and the location of every family member in the hospital, enabled the leadership team to account for all persons in the Medical Center at any given time. With the new registration process in place, the total number of mandated staff and family members was reduced from 900 people (Hurricane Frances) to 439 people (Hurricane Jeanne), approximately a 49% reduction.

Family Accommodation Center

A unique issue developed in the time between Hurricanes Frances and Jeanne. In the wake of the first emergency, a post-hurricane team of employees was identified to provide relief for employees who had worked through the storm. Unfortunately, the pre-planning did not take into account the level of devastation that would exist on Florida's Treasure Coast. Many employees were struggling to repair their homes and take care of their families. Additionally, a significant portion of Florida's Treasure Coast was without power, and many schools were used as shelters. Furthermore, numerous day care centers experienced severe damage and were projected not to reopen for an extended period of time. A large percentage of the relief staff were single parents, or had young children that could not be left alone. Hence, they were unable to report to duty. This caused complications for the mandated staff because they had to wait for their replacement before they could leave.

Problem:
The West Palm Beach VA is committed to both, the delivery of quality patient care as well as supporting employees and their families. The decision was made to open a Family Accommodation Center within the facility where children were supervised, which enabled their parents to return to duty. However, several new problems were created in regards to the staffing of the Family Center, including employees being diverted from their daily work. Another problem was determining which Service would operate the Family Center. A third concern was obtaining approval from Service Chiefs for their employees to volunteer at the Family Center. These problems were exacerbated by the demands of the continued emergency operations and the repairs needed to make the facility fully functional once again. Although the Medical Center volunteers were a valuable asset to the facility, they were not available to staff the Family Center as they did not have a background check completed to safely care for children.

Action:
The decision was made to staff the Family Center from various services, such as Social Works Service, Nursing Service, and the Director's Office. These services were tasked with recruiting employees to assist in staffing the Family Center. The Family Center was open from 7 am to 7 pm, covering all tours of duty, including those on 12-hour shifts. The Family Center accommodated children aged 1-13 years. A child to staff ratio of 4:1 for infants up to 2 years of age, 7:1 for small children, and 14:1 for older children was maintained for safety and regulation purposes. Entertainment was provided in many different forms, including art classes, movies, games, etc. Children were also taken to play putt-putt golf, to bowl, and for walks around the Medical Center (after clean-up). However, because of the unfamiliarity of their surroundings, the children remained anxious. In order to help relieve some of the apprehension, the children were provided insight to the hurricanes and were allowed to voice their concerns. Other educational opportunities were provided, including bringing in a fireman to speak about fire safety, a lecture was given on the harm of drug abuse, and hospital employees volunteered their time to speak about their respective professions. This Family Center operated for approximately two weeks after Hurricanes Frances and Jeanne, with an average of 75 children per day.

Outcome:
The Family Accommodation Center was a key factor in allowing employees to return to work. With their children being cared for in a safe, secure area in the facility, parents were able to focus on the patient's needs. The children also benefited from the Family Center because their anxiety was reduced through discussion groups and entertainment. Money was saved in overtime expenses. In a comparison of the five employees who continuously staffed the Family Center and various employees' salary plus overtime, there was a cost savings in excess of $1,000 per day. Employees who used the Family Center expressed great satisfaction, and appreciated that their Medical Center supported and cared for them when they were in need.

Resources: The following chart illustrates expenses to manage the Family Support Center:

Items	Cost
Arm Bands	$70
Food for Mandatory Employees/Family	$10,000
Bottled Water	$2250
Supplies	$200

**No costs were incurred for inflatable mattresses/cots as they were donated to the VA. No resources were diverted from patient care because VA Central Office reimbursed the Medical Center for operating funds.

Improvements:

Recommendations to improve the Family Support Program are as follows: Mandated employees were distressed because they were not permitted to bring in pets. Future recommendations include implementing a Pet Support Program for mandated employees. A recommendation to improve the registration process includes the development of an electronic registration form. A team consisting of the Supervisory Social Worker, IRM Chief, Speech Pathologist, and Administrative Fellow was established.

Applicability to other VAs:

The emergency operations experience of the West Palm Beach VA Medical Center is applicable to every Medical Center in the Veterans Health Administration. Every facility may potentially contend with natural disasters that impact the delivery of patient care, and the employees that deliver the care. Medical Centers must examine all areas that will be affected by a disaster and have plans and processes in place to handle those situations. Reactive measures are not enough to sustain functioning in the face of an overwhelming disaster.

Desirée C. Snyder

2094 Albany Post Road, Montrose, NY 10548 • 914-736-2143
Desiree.Snyder@med.va.gov

Education:

Cornell University, Sloan Program
Master of Health Administration, May 2004

Cornell University
Bachelor of Science, Neurobiology and Behavior, May 2000, Magna cum Laude

Honors & Awards:

Sloan Student Association Governance Chair, 2003-2004

Sloan Alumni Association Award for academic excellence, 2002 and 2003

Cornell Tradition Fellowship in honor of strong work ethic, community involvement, and academic achievement, 1996-2000

Work Experience:

July 2004 – Present

VA Hudson Valley Health Care System
Administrative Fellow

- Promotion to Business Manager for Medical Services and Rehabilitation
- Planning and implementation of a network-wide telehealth program
- Researching and operationalizing quality of life best practices in extended care
- Assisting in the implementation of JCAHO Tracer methodology
- Contributing member of the Unapproved Abbreviation Task Force and Root Cause Analysis (RCA) Teams
- Investigating possible causal relationship between nursing overtime and medication errors

Aug 2003 – Jan 2004

Department of Policy Analysis and Management, Cornell University, Ithaca, NY
Teaching Assistant, Epidemiology

- Conducted study sessions and tutored students individually
- Responded to students' questions and concerns via written and verbal communications
- Graded homework, exams, and final projects

June 2003 – Aug 2003

Marion Regional Health Care System, Marion, SC
Administrative Resident

- Researched and developed specific initiatives to improve case management
- Designed surveys and developed strategies to increase constituent satisfaction
- Fostered an interchange of learning, inquiry, and development of ideas among myself and senior managers

June 2000 – Aug 2002

Department of Molecular Medicine, Cornell University, Ithaca, NY
Technician

- Optimized lab protocols to meet financial constraints
- Led initiatives to meet OSHA and EPA compliance standards
- Purchased equipment and supplies
- Trained and supervised employees

April 1996 – May 2000

Wilson Synchrotron Laboratory, Ithaca, NY
Computer Operator

- Provided technical support for physics laboratory with over 100 collaborators
- Organized and maintained data library of several thousand tapes

Research Experience:

2001 – 2002

Cornell University, Department of Molecular Medicine
Cancer Research

Professional Membership:

Member, American College of Healthcare Executives

Additional Skills/Interests:

- High level proficiency with MS Office applications, Internet
- Volunteer work as ER Assistant (Cayuga Medical Center), Office Support Staff (Cortland Chamber of Commerce), Counselor (Ithaca Offender Aid and Restoration), Activities Planner (Groton Nursing Home), and Tutor (Boynton Middle School)
- Personal Trainer and enthusiastic about empowering people to manage their health

Desirée C. Snyder
Administrative Fellow and Acting Business Manager for Medical Services and Rehabilitation
VA Hudson Valley Health Care System
2094 Albany Post Road • Montrose, NY 10548 • 914-737-4400 x3820

Abstract: Implementation of Facility-Based Telemental Health Programs for VISN3

Care Coordination Overview
The VA is implementing care coordination in response to the changing health care needs of veterans in the 21st century. As an in creasing proportion of veterans live longer and healthier lives, they are seeking alternatives, when feasible, to hospital and institutional-based long term care in managing their chronic disease. The Care Coordination Home Telehealth (CCHT) is an important element of the care coordination initiative to meet changing veteran needs.

VISN3 Facility-Based Telemental Health Programs
In response to the CCHT initiative a team of three (3) key members, including myself, another Administrative Fellow, and the VISN3 Mental Health Care Line Business Manager, began implementation of facility-based telemental health programs for the VISN3 veteran population in August 2004. Involved facilities include VAMC Hudson Valley, Lyons, Northport, and Manhattan. The technology utilized for this project is the Health Buddy®, provided by Health Hero Network, Inc. via national contract.

Health Buddy® Technology
The Health Buddy® is a small, lightweight, handheld appliance that plugs into a telephone line and an electrical outlet. Each day, the patient user is prompted to answer a series of questions regarding their medical condition. Based upon the responses given, the Health Buddy® prompts the patient with tips for better managing their health. In fact, Health Buddy® offers a strong educational component regarding disease management. Patients are instructed to contact their health care provider if clinically indicated.

The Health Buddy® appliance automatically transmits patient responses to vendor servers located in VA facilities at Austin and Hines during the hours of 1-2 am, via the Plain Old Telephone System (POTS). After data is transmitted, VA providers are able to log into the iCare Desktop to see new patient data. The iCare Desktop is a website that allows them to monitor and track patient progress. Adequate physical and data security protections are in place to safeguard the personal health information and privacy of veterans.

Program Goals
Fitting with the mission of VHA Care Coordination, each facility is expected to adapt their specific telemental health program to satisfy the unique needs of the patient population served. For example:

- VA Hudson Valley: The telemental health program enrolls domiciliary graduates who may desire continual monitoring/contact with health care providers to insure their success and sustain their ability to live in the community.
- Northport: The telemental health program will enroll residents of Community Residential Care homes (CRCs) to support their transition into a less structured, community environment.

Development of the VISN3 Telemental Health: Health Buddy®Implementation Plan
Upon initiation of the VISN3 Telemental Health project, it became apparent that a plethora of materials exist on the CCHT initiative. Sorting out relevant and necessary information proved to be a large barrier to implementation. As a result, my team developed a packet entitled *VISN3 Telemental*

Health: Health Buddy®Implementation Plan. This packet provides only information relevant to implementation and directs staff members to other materials for further reading as needed.

Application Potential in Other Facilities

Our *VISN3 Telemental Health: Health Buddy®Implementation Plan* has greatly simplified and facilitated the implementation process; we have used this packet for implementation at three sites within VISN3 and expect it to be a useful tool at the fourth facility as well as at facilities within other VISNs.

The following key elements are part of the VISN3 Telemental Health: Health Buddy® Implementation Plan (a sample packet is available upon request):

Implementation Plan: Key Elements

- Review Conditions of Participation
- Develop Mission Statement and Standard Operating Procedure (SOP)
- Select Care Coordinator, Backup Care Coordinator, and Administrative Point Person
- Complete CCHT Training on Employee Education System (EES) website
- Care Coordinator and Backup Care Coordinator: Review training materials for iCare Desktop
- Choose Health Buddy Dialogues
- Establish Coding Structure
- Select and Enroll Patients
- Assess Outcomes: Patient Function and Well Being, Patient/Provider Satisfaction, Cost Savings

Utilization of VA Resources

Each Health Buddy® appliance is procured at a rate of $500 as set by national contract. No additional FTEEs are required to implement or run the program. All duties are manageable within current job assignments. Avoidable admissions and unnecessary visits are expected to be reduced, resulting in overall cost savings.

Expected Outcomes

The VISN3 Telemental Health program is expected to engender a number of positive outcomes. Qualitatively, we expect the following:

- Decrease health care costs while maintaining a high level of satisfaction with health care
- Keep patients non-institutionalized and functioning in the community
- Allow providers to monitor patients and be proactive in preventing a health care crisis
- Provide patients with a greater sense of security with their health status
- Provide patients with increased emotional support from their providers
- Empower patients to manage their own health needs

We will quantitatively assess changes in patient and provider satisfaction, as well as patient functionality and well-being, as patients are enrolled in the program.

Testimonials

Here are some statements from patients enrolled in Health Buddy® programs:

- *I feel like somebody is watching out for me… and I like that.*
- *It's become a quick little daily routine – just like brushing my teeth.*
- *It has raised my awareness about the things I need to do to stay in good shape.*
- *It gives me something to look forward to. And it is very educational.*
- *sAt first I thought it would be inconvenient. Now I find myself looking forward to my Health Buddy sessions every day.*

Katherine Steinberg

katherine.steinberg@med.va.gov 11301 Wilshire Blvd. Los Angeles CA 90073 (310) 702-2807

HEALTH POLICY EXPERIENCE

Hospital Operations, VA Greater Los Angeles Healthcare System, *Administrative Fellow* July 2004 – Present

- Led the evaluation of workflow and throughput of Triage, Urgent Care, and the Emergency Department
- Currently implementing recommendations arising from evaluation of workflow and time study
- Manage the Network Nursing Recruitment and Retention Committee and provide oversight for contracted advertising firm developing an employer brand for the Network
- Direct task force charged with enhancing the integration of Psychiatric Emergency Services and the Emergency Department through the development of new structures and processes

Health Policy Analysis, University of California in Los Angeles, *Graduate Student Researcher* Sept 2003 – June 2004

- Conducted research and analysis for Policy Studies Department Chair, for upcoming book, *Stalemate: Opportunities, Gambles, and Miscalculations in Health Policy Innovation*

Children's Health Initiative, Los Angeles County Department of Health Services, *Intern* June 2003 – Sept 2003

- Evaluated monthly reports from community organizations contracted with LA County
- Monitored and audited grantee compliance with program funding requirements
- Managed outreach efforts for launch of Healthy Kids Program
- Coordinated collaborative grant writing process to successfully compete for federal money for LA County

Drug Abuse Control Policy, University of California in Los Angeles, *Teaching Assistant* March 2003 – June 2003

- Managed all administrative and technical components of undergraduate course for 100 students

Health Care Research, The Healthcare Advisory Board Company, *Analyst* Aug 2000 – Aug 2001

- Played integral role in mapping direction of start-up health information web portal
- Translated physician-level information into clear patient-level explanations for web content
- Created customized research projects for hospitals and other health care organizations
- Conducted interviews with clinicians, as well as hospital and health plan administrators

Health Marketing Analysis, UCLA Robert Wood Johnson Clinical Scholar, *Research Assistant* Summer 2000

- Collected and analyzed news for paper, "What Makes a Medical Story Newsworthy"

Psychology of Health Communication, University of Pennsylvania, *Independent Researcher* Fall 1998 – Fall 1999

- Analyzed how the popular press and the medical community understand and report the French Paradox: low rate of heart disease relative to similar developed countries

EDUCATION

UCLA School of Public Policy and Social Research, Los Angeles, CA June 2004

Master of Public Policy (Relevant Coursework Includes: Health Care Policy and Finance, Privatization Regulation & Public Finance, Decision and Cost-Effectiveness Analysis, Statistical Methods of Policy Analysis)
Thesis: Aging Gracefully: Recommendations for Addressing the Health Needs of the Elderly in Los Angeles County

University of Pennsylvania, Philadelphia, PA May 2000

Bachelor of Arts *magna cum laude* with Honors in History and Sociology of Science
Concentration in **Bio-ethics**, Dean's List Junior and Senior Years.
Thesis: National Cholesterol Education Program: A Case Study on the Promotion of Public Health Initiatives

SKILLS

Extensive presentation, research, writing, and analytical skills. Knowledgeable in Microsoft Word, Excel, and Powerpoint, LexisNexis, Dow Jones Interactive, STATA, Siebel, VISTA, and CPRS

Facility: VA Greater Los Angeles Healthcare System
Contact: Katherine Steinberg-Bluth, MPP, *Administrative Fellow*
11301 Wilshire Boulevard
Los Angeles, California 90073
(310) 478-3711 x.49804
Start Date: July 26, 2005
Project Title: Optimizing Joint Emergency Department and Urgent Care Centers: An Examination of the Process for Providing Medical Care to Veterans without an Appointment

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Description of Project:
In order to optimize patient satisfaction and throughput in the VA Greater Los Angeles Healthcare System (GLA) Urgent Care and Emergency Department, a spatial analysis and throughput time study were undertaken which identified numerous low cost efficiency gaining improvement opportunities. This project utilized a program of patient satisfaction surveys, one-on-one interviews, process flow analysis, and detailed time motion surveys (all described below) to generate compelling recommendations for change.

Background:
Recently, GLA Urgent Care (UC) service and the Emergency Department (ED) began numerous efforts to improve the quality and efficiency of its Triage practices. Historically, veterans that arrive at GLA seeking medical care without an appointment have found it difficult to locate the appropriate station for their care. A number of different medical services including primary care appointments, urgent care, emergency department registration, blood drawing lab, clinical pharmacy services, and social work services are offered in one large atrium area of GLA. It is unclear to veterans that arrive in the atrium seeking medical care without a scheduled appointment where in this atrium they should go for the medical service they need. Once veterans find the appropriate window to begin their care process, they often experience long waits, fragmented care, and unnecessary shuttling back and forth across the atrium for different components of their care. GLA is committed to streamlining the patient intake process and has begun a comprehensive study of the patient flow process to determine the appropriate corrective actions.

Objective:
The purpose of this project is to facilitate a better understanding of the experience of veterans that arrive at GLA seeking medical care without an appointment and provide recommendations for low cost ways to make improvements to the process. In order for GLA to succeed in its promise to offer high quality medical care and excellent customer service, the health system must make health care more easily accessible to those veterans coming to their facilities.

Development:
A work group consisting of key ED and UC leaders dedicated to defining and resolving these patient flow concerns determined that it was necessary to conduct a comprehensive analysis of the physical layout of the atrium and conduct a patient satisfaction survey. Accordingly, GLA policies that impact the process were studied, patients who came to GLA without an appointment were shadowed through their care process, sixty veterans completed a patient satisfaction survey, and one-on-one interviews were conducted with clerks, nurses, and physicians who serve these veterans. Combining an outside view of patient flow with the feedback from the veterans and employees, a spatial and process flow chart were developed that illustrates the current flow of unscheduled veterans in the atrium.

Finally, the workgroup developed a time motion survey that allowed GLA to quantify the timeliness of the care they provide. Gaining buy-in and ensuring that the survey was reflective of the process was critical to its success, as the study necessitated that the care providers were motivated to participate in it. Therefore, the survey was reviewed multiple times by the UC and ED physicians, nurses, clerk leaders, and other employees that would be completing it. Once consensus had been reached on the scope and measurement process, the time study was scheduled. For a five-day period in January, GLA staff recorded the timeframes that spanned each stage of the care delivery process. The GLA ED Registration triage nurse began this process by compiling a data collection sheet for each patient that approached the ED Registration window, noting their time of arrival and duration of their assessment. The data collection sheet was provided to the patient who passed it to each member of their care team, who would subsequently document the wait times and assessment durations as they unfolded. Compliance was approximately 40% of patient volume during that period.

Findings:
This program confirmed many of the assumptions related to patient throughput and customer service in the GLA triage process and identified numerous improvement opportunities. The interviews confirmed that there are opportunities for greater coordination and the reduction of certain duplication of services. The flow charting elucidated examples of where the design of the environment can better support efficient processes and improve patient satisfaction. One example of this was elucidated during interviews with UC physicians who expressed frustration with the time it took to identify the veteran they are ready to evaluate. Due to the large size of the waiting area, veterans waiting to be seen by an UC clinician may be seated far from the UC area and physicians report regularly spending 15 minutes trying to find their next patient. Finally, the time motion study concluded that there is wide variation in the time veterans are required to wait before receiving medical care. This study provided a variety of data points, such as average wait time from patient arrival until their triage was completed.

Recommendations:
As a result of the findings, GLA is considering a number of enhancements. In order to facilitate patient movement, the atrium area can be colored coded to create a more intuitive flow and signage can be improved reducing veterans frustration and confusion with the care process. The waiting area can be divided according to service in order to make divisions obvious to patients and thus their care providers can identify quickly when they are ready to see the patient. These adjustments to the design of the atrium area are minimal in cost and will improve both the efficiency of care provision and veterans' satisfaction with their visit to GLA. Also, patient education materials can be developed to help guide patients through their care process. Informational materials can be provided to patients as soon as they enter the atrium area. In addition, physicians can offer patient education about the appropriate use of the ED as part of discharge orders. Moreover, the time study results are being closely analyzed to determine the most appropriate corrective staff training and overall policy improvements.

Application to Other Facilities:
As VA medical centers across the country work to evaluate their patient processes and spatial flow for the purposes of improving patient satisfaction and care efficiency, the methods and ideas used by GLA for this project are easily adaptable to the specific needs of other facilities.

David Jesse VanMeter
2978 Frankfort Rd
Georgetown, Kentucky 40324
DVanMeter@QX.Net
1-859-536-3665

Education:

University of Kentucky, Lexington, Kentucky
- -Martin School of Public Policy and Administration, Masters in Health Administration, May 2005
- -Gatton College of Business and Economics, Bachelor of Arts with Majors in Finance and Management, May 2001

Professional Experience:

Administrative Resident, 2004-Present
Director and Acting Director, Louisville Kentucky VAMC
- Created tracking process for the High Cost Prosthetics Committee
- Compiled and co-presented the FY05 budget proposal for the Director's Office and Budget Hearing roll-up
- Provided logistical support for the VISN 9 Health Systems Council meeting
- Researched the implementation of advanced clinical access principles to the ophthalmology clinic
- Participated in the FY05 Strategic Planning Retreat
- Provided support for special projects, investigations, OIG depositions, and congressional meetings for the Director

Budget Analyst, 2003-2004
Director of Budget and Planning, Kentucky State University (KSU), Frankfort Kentucky
KSU is a Historical Black College and Land Grant Institution specializing in education and aquaculture degree programs
- Investigated misappropriated state and federal grants
- Supervised the construction of annual budget plans
- Compiled detailed monthly financial reports
- Conducted mainframe financial data analysis and created databases from financial reports

Executive Intern, 2002-2003
CEO and COO CHA Health, Inc., Lexington, Kentucky
CHA Health, Inc. is a statewide health management organization that provides health coverage to over 250,000 KY residents
- Created Five Year Strategic Plan and Corporate Goal reporting tools and guidelines
- Supervised annual Department of Insurance (DOI) Market Conduct Audit and DOI Information Services Audit
- Directed company wide committees on managed care market trends and new consumer driven health care products
- Conducted research on outpatient costs within the organization
- Proposed a restructuring of internal data warehouse query guidelines for ad hoc financial reporting

Executive Intern, 2001-2002
COO University Physicians and COO Kentucky Clinic, Lexington, Kentucky
University Physicians is the largest multi-specialty group practice in the state of KY and is affiliated with the University of Kentucky Chandler Medical Center via the Kentucky Clinic, the states largest outpatient clinic.
- Constructed demographic study of service locations and payer mix
- Researched site location for new clinic construction
- Supported facilities management in resource allocation model
- Created policies and procedures for vendor advertisement in clinical and non-clinical settings

Treasurer/Director of Operations, 1998-2001
McCurry Trucking, Road Fleet Services, Lexington, Kentucky
McCurry Trucking is a regional carrier of bulk petroleum products to distributors and retailers in KY, IN, IL, OH, and TN
- Contracted with vendors for multi-state operations
- Conducted day to day operations for regional carrier
- Directed the purchase and lease of capital equipment
- Created financial reports for monthly/quarterly/yearly Accounts Receivable and Accounts Payable

Technical Skills:

Access Database (Mainframe Data Analysis)	Outlook	Word
Excel (Complex Formulas and Analysis)	PowerPoint	

Professional and Civic Affiliations:

ACHE, Student Affiliate
Martin School for Public Policy ACHE student chapter treasurer
Lexington Habitat for Humanity, Michigan Street Project
Toys for Tots, VFW Post 680

Louisville Veterans Affairs Medical Center
800 Zorn Avenue
Louisville, KY 40206
1-502-287-4580

David VanMeter
Administrative Resident
Start Date: 6/7/04

Implementing Shared Medical Appointments: Increasing Efficiency and Patient Satisfaction

Description

The Louisville VA Medical Center (VAMC) experiences around 400 new requests or inquiries about care and veteran status per month. In order to provide care to those who are newly enrolled veterans, during a budgetary downturn, efficiencies must be found within existing programs. New efficiencies for primary care can be created through the introduction of a new type of clinic appointment.
Shared Medical Appointments (SMAs) are a complete paradigm shift from the traditional patient and provider appointment dynamic. This new type of appointment concentrates the efforts of one provider across the aggregate needs of the patients while providing the individual with high quality care. Due to the provider focusing time and energy away from multiple individual patient appointments, economies of scale can be reaped from the removal of repetitive actions. One provider can see six newly enrolled veterans and supply them with a level 3 appointment, a physical exam, prescriptions, and treat their primary care needs in 90 minutes, as opposed to 180 minutes. The move away from 30 minute appointments marks a dramatic change in the way that providers look at the where, when, and why of patient care, but also the how of patient care delivery.

Objectives

The committee formed to implement SMAs at the Louisville VAMC described three main objectives to the project. The first objective was to test the validity of the model. The best choice for a test model was a Community Based Outpatient Clinic (CBOC). Here the model could be tested and implemented on a small scale before a total facility rollout. The second objective is to increase efficiency in primary care. The amount of patients being seen would be measured against total staffing needs and standards for the provider to determine any increases or decreases in efficiency. The third objective of the implementation of SMAs is to increase patient satisfaction. The collection of patient satisfaction surveys for veterans exiting a SMA would be measured against patient satisfaction numbers for the provider and the CBOC to determine any increases or decreases in patient satisfaction.

Planning

Individuals from the Louisville VAMC traveled to the Lexington VAMC to watch a presentation by Dr. Edward Noffsinger on the topic of SMAs. Clinical and administrative personnel who watched the presentation agreed that these practices would be beneficial to the Louisville VAMC. Soon afterwards a committee was formed to develop, test, and evaluate the process. The committee contacted facilities within, and outside of, VISN 9 to compile information concerning all aspects of the process involved with developing the program. The committee traveled to the Memphis VAMC to observe two shared medical appointments. Here the committee determined that the concept was viable, working, and generating economies of scale and efficiencies not currently realized at the Louisville VAMC.

Development

Through teleconferences, emails, letters, site visits, and faxes the committee compiled a working knowledge of the process involved with implementing the first SMA at the Louisville VAMC. Before the first appointment could be made all logistics had to be in order. The committee developed the following facility specific documents from those received from other facilities conducting SMAs:

- Patient Consent Forms
- Patient Health Questionnaire
- Preventative Health Screening Form
- CPRS template for Shared Medical Appointments
- Patient Satisfaction Survey
- SMA Reminder Letter
- SMA Thank You letter

The development of the CPRS template, the patient health questionnaire and the preventative health screening required the most time and attention. Providers gave feedback to the committee on the forms and changes were made to reflect additional medical history, layout concerns, and to alleviate ease of use. The CPRS template was developed in conjunction with the providers and clinical managers to ensure that no clinical information was inadvertently left out and that the flow was appropriate.

Application

The application potential for this project in other facilities is tremendous. Each of the documents that the committee developed is in Word or Excel format. The template created in CPRS for use at the Louisville VAMC can be used anywhere. The process by which the SMA takes place should be the only thing that differs from facility to facility, except where an individual provider or regional counsel would like to make changes. The most exportable application from this project is the concept. Once there is a firm grasp on the concept and the paradigm shift, it should be only a matter of finding clinical space, working out flow issues, and identifying veterans for the SMA.

Resources

This project required no additional resources. Increasing efficiency is one of the three objectives of this project and any additional resources would contradict the spirit of the project. All committee members who participated in developing the program and all facility spaces used for the SMA are collateral duties. The time provided by the clinicians for the SMA would already be used for patient visits and any support staff would already be providing the same services in the CBOC.

Outcomes

By the deadline for submission of this abstract there has been one trial run SMA with Louisville VAMC staff and committee members. This trial allowed errors in flow and process to be corrected before the first SMA. There are two more trial runs scheduled before any veterans will be seen. By the time of publication the Louisville VAMC will have two SMAs completed. The first SMA will be conducted 2/24/05 with an outside observer from the Memphis VAMC. The committee expects there will be process changes and recommendations before the second SMA. The second SMA will be held on 3/10/05. From these two SMAs the first patient satisfaction numbers and efficiency numbers will be recorded. Historically there is a 200% increase in efficiency and the committee expects the same level of growth for the first two SMAs.

Lessons Learned

The committee changed the depth of the new patient physical exam to allow for this visit to be recognized as a billable event. Although this was not the objective of the committee when this project started, it is an unintended consequence and a bonus for the facility. Other lessons learned came through the trial run. Space issues, placement of forms, talking notes, and flow were all modified after the first trial run. The committee learned a great deal about the process from the mock runs and hopes to learn more and more as the process continues.

K. Wade Vlosich

2301 East Lamar Blvd Suite 650, Arlington, TX 76006-7435 · (817) 385-3785 · Wade.Vlosich@med.va.gov

Education

Texas Tech University, *Lubbock, TX*

- Master of Business Administration and Health Organization Management — May 2004
- Bachelor of Arts in Psychology and Business Management — Aug. 2002

Work Experience

VISN 17, *Arlington, TX* — May 2004- Present

Administrative Fellow

- Coordinated and performed a review of patient Internet usage at all three systems within VISN 17; wrote a VISN-wide policy on Patient Internet Usage
- Facilitated and acted as VISN 17 liaison for outsourcing 3rd party billing within the Central Texas Veterans Health Care System (CTVHCS)
- Acted as Research Compliance Officer July- October 2004 by auditing research studies in preparation for the National Committee for Quality Assurance visit
- Completed a cost assessment for starting a Bariatric Surgery Unit at VA North Texas Health Care System (VANTHCS)
- Compiled a Performance Improvement Log and Root Cause Analysis log over the last 3 fiscal years for VANTHCS; presented findings at semi-annual Management Briefings
- Created a Brachytherapy cost analysis for the Radiation Oncology and Surgery Services at VANTHCS; coordinated discussions between the VA and the University of Texas Southwestern Medical School pertaining to the project
- Audited the Emergency Room business operations at VANTHCS; identified best practices and opportunities for improvement in registration, documentation, coding, and billing processes
- Rotated through all program areas of the VISN 17 office and administrative/clinical services at VANTHCS

***Advances in Health Care Management* (Elsevier),** *Lubbock, TX (London, England)* — Jan. 2004- Present

Assistant Editor

- Author of an article in Advances in Health Care Management, Vol . IV pertaining to the negative implications on the healthcare industry by allowing pharmaceutical companies to advertise prescription drugs through various media outlets
- Wrote, revised, and proofread copy for *Advances in Health Care Management, Vol. VI*
- Communicated and acted as key stakeholder with the authors about editorial specifications, deadlines, and review processes

Center for Healthcare Leadership & Strategy, *Lubbock, TX* — July 2003- May 2004

Project Coordinator for the Bioterrorism Studies Group

- Aided in creating the Center's visions and goals for 2004-2006
- Strategically managed all key stakeholders involved in the creation of Vol. IV of *Advances in Health Care Management*
- Aided in creating the annual report for the Center pertaining to the 2002-2003 academic year

The Center for Orthopedic Surgery, *Lubbock, TX* — May 2003- Aug. 2003

Senior Administrative Intern

- Acted as a consultant on ways to lead organizational change through the addition of information technologies
- Implemented change in the Medical Records Department by showing ways to increase production time and save on lost production hours through a cost-benefit analysis; saved the office 10 hours of lost production a week
- Produced an analytical report which led to the implementation of digital x-ray technology
- Added features to billing reports to increase accuracy and efficiency involving current cash flows
- Wrote the office internet usage policy; assessed and implemented HIPAA requirements involving IT security

James Houston, DDS, *Amarillo, TX* — Jan. 1995- Jan. 2003

Dental Assistant/ Administrative Assistant (Holiday/ Part-time)

- Prepared billing and paperwork in regards to insurance claims
- Negotiated payment arrangements with patients
- Assisted in dental operations ranging from tooth extraction to orthodontics

Professional Affiliations & Publications

- *American College of Healthcare Executives Affiliate Member* — Mar. 2003- Present
- *Medical Group Management Association Member* — May 2003- Present
- *Dallas Junior Chamber of Commerce Member* — May 2004- Present
- *Dallas/ Fort Worth Local ACHE Chapter Member* — May 2004- Present

Blair, J., & Vlosich, K.W. 2003. "Cocktails, Deceptions and Force Multipliers in Bioterrorism," *Advances in Health Care Management*. Elsevier; London.

Blair, J., Keel, R., Nix, T., & Vlosich, K.W. 2003. "Modeling the Environmental Jolt of Terrorist Attacks: Configurations of Asymmetrical Warfare," *Advances in Health Care Management*. Elsevier; London.

Facility: VA Heart of Texas Healthcare Network, Arlington, Texas

Contact: Wade Vlosich
Administrative Fellow
2301 East Lamar Blvd Suite 650
Arlington, TX 76006-7435

Training Start Date: May 17, 2004
Phone: (817) 652-1111
Cell Phone: (817) 313-9428
Email: wade.vlosich@med.va.gov

Project Title: *Best Practices for Revenue Improvement in the Areas of Patient Intake, Medical Documentation, Coding, and Accounts Receivable*

Background: With many facilities facing operational budget shortfalls, management must make the paradigm shift in regards to revenue. The Veterans Health Administration, in April 1986, was authorized by the enactment of Public Law 99-272 to collect reasonable charges from third party health insurers for medical care provided to non-service connected veterans whose injuries or illnesses were not incurred during military service. Since that time, the Department of Veterans Affairs (VA) has made great strides in its collection of third party insurance. However during Fiscal Year 2005, VISN Directors voted on a 10.53% increase over prior year collection goals in order to meet the growing demands of patient care. This action demands that the VA enhance its efficiencies of the revenue cycle.

Patient intake is a vital area of the collection process that begins with insurance identification and verification. The process for the identification of third party insurance is a problem in many VA facilities. It has been shown through numerous CAP reviews of VA facilities that some patients who have third party insurance are never identified, and the facility does not get reimbursed for the care given to these non-service connected patients. The problem stems from lack of responsibility, training, and collection of insurance information.

The *medical documentation* process occurs by properly documenting all care provided to the veterans by physicians and other health care providers. Documentation problems are rife throughout the VA as a whole, which causes a decreased reimbursement rate and certain legal or certification issues. Through various internal VA studies, it has been shown that much of the care or diagnostic services provided are not documented correctly or are missing from the medical record.

The *coding* process assigns the appropriate diagnosis and/or procedure codes, such as ICD-9 or CPT-4 codes, based on provider documentation. In order for accurate coding to occur, proper medical documentation must be implemented. In some VA facilities, coding inaccurately has lead to repayment of money to the insurance companies and/or fines and penalties. Coding pools within some facilities tend to be understaffed and have many non-certified coders.

The *accounts receivable* process includes processing payments collected and following up with insurers on outstanding or denied bills. The account follow-up function exemplifies the most challenging and time consuming AR-related activity. Many facilities do not have the resources to effectively perform accounts receivable follow-up, an example being the difficulties created by the increased volume of bills where no additional staff or contracted help are introduced. Recent CAP reviews continue to show the need for VHA to improve processing and collections of accounts receivable in such areas as unbilled and delinquent accounts receivable, coding for medical services, and to ensure timely follow-up of accounts receivable.

Objectives: The purpose of the study is to explore best practices in the revenue cycle in order to help VISN 17 enhance collections. The project focuses specifically on the areas of patient intake, medical documentation, coding, and accounts receivable.

Development and Implementation:
Centralized Check-in Process – In the area of patient intake, VISN 6 was referred by both Central Office and other VISNs as having implemented a best practice for their centralized check-in process to improve the accuracy and timeliness of insurance information. This follows the model of many private sector hospitals in

terms of patient flow and best practices for retrieving patient insurance information. Veterans check in at one centralized area before going to clinical appointments where intensive screening of demographics, insurance information, and future appointments are discussed with the patient.

- The centralized check-in resulted in the identification of over 68,000 new insurance policies, resulting in an increase in over 154,000 bills processed when comparing FY 2002 results to FY 2003.
- The project was implemented at the VAMCs in FY 2003 and was fully operational by FY 2004. The process contributed to revenue improvement in FY 2003 by increasing collections by 16.61% ($67,084,519 total MCCF), and FY 2004 by increasing collections by 57.94% ($105,954,509 total MCCF).

Extensive Physician Documentation Training Programs – In the area of medical documentation, VISN 8 received high marks on revenue generation and physician training in regards to medical documentation. VISN 8 has Assist Teams (groups with specific knowledge areas for best practices) within the individual facilities that help to train coders on working with providers for proper documentation. When errors are found within the medical record, immediate meetings between coders and physicians occur to correct the inaccurate documentation. This follows the practice of private hospitals in terms of training medical staff in regard to medical documentation.

- After FY 2003 ($103,436,498 total MCCF) when the Assist Teams were fully functional, the revenue collection of VISN 8 increased 59.90% in FY 2004 ($165,390,201 total MCCF), some of which can be attributed to the extensive training of health care providers.

Certified Coders & Training Programs- In the area of coding, VISN 23 was identified as implementing coding programs that can be attributed to the increase in collections. The VISN set down policies that insured that coders are regularly trained and kept updated on the latest coding changes. Most of the coders within the VISN are certified through either the American Health Information Management Association or American Association of Professional Coders. They have identified revenue coordinators that are engaged in the coding operation by comparing coding patterns, analyzing downcoding and upcoding, and relaying coding information to physicians. In addition, coding software, Quadramed, is being utilized to augment the coding process.

- Since the more aggressive use of monitored coding practices, VISN 23 has increased FY 2003 ($87,384,565 total MCCF) collections by 43.03% in FY 2004 ($124,984,974 total MCCF).

Outsourcing Accounts Receivable Follow-up – In the area of accounts receivable, the Central Texas Veterans Health Care System was identified as implementing programs that contributed to an increase in collections and a decrease in the cost to collect. Central Texas began outsourcing its accounts receivable follow-up for those accounts over 90 days to OSI in order to meet the demand of an increased number of bills. Subsequently, Central Texas saw a greater increase when OSI follow-up began occurring for those accounts over 30 days.

- The outsourcing of the follow-up to OSI helped increase Central Texas FY 2003 ($10,688,755 total MCCF) collections by 40.62% in FY 2004 ($15,030,176 total MCCF).

Resources Required for Implementation: Many of these best practices would require additional capital, both human and monetary, in order to execute specific action plans. Although, best practices can analytically show that the costs associated with these programs will be offset by the additional revenue received. Space alteration and construction at the facilities may be required to streamline the patient intake process.

Benefits and Outcomes: Enhanced revenue will allow for better and expanded patient care services. With additional monies funneled into operations, the facilities would not have to rely on capital dollars to offset the operational shortfall. Through the establishment of best practices, the VA would be able to create a more lucrative revenue cycle.

Potential Application in Other Facilities: With the growing demand on VHA to supplement care through collections, many facilities could benefit from the lessons learned and best practices at other locations. Communication is the key relaying these new ideas, and this can only lead to better patient care backed by additional revenue from collections.

TERESA M. WHITLEY

5011 Kenton View
San Antonio, Texas 78240
210-392-9349
Teresa.Whitley@med.va.gov

EDUCATION:

Trinity University, San Antonio, Texas
M.S., Health Care Administration
December 2005

Texas A&M University, College Station, Texas
B.S., Kinesiology, specialized in Exercise Physiology
Minor in Business Administration and Psychology
May 2003

EXPERIENCE:

1/05-Present

Administrative Resident, South Texas Veterans Health Care System

- Participate in various projects assigned by senior management and rotate through administrative and clinical services within STVHCS

4/00-8/03

Server/Trainer, Christopher's World Grille – Bryan, Texas

- Waited tables at a fine dining restaurant and served as head trainer
- Helped with the hiring and auditing of new employees
- Assisted in writing and organizing employees' training manual
- Catered several functions for former President George Bush and other world dignitaries at the George Bush Library

5/99-8/99

Office Assistant, Action Contractors – Port Arthur, Texas

- Managed relationships with purchaser and prospective clients
- Provided support to all office activities and managed payroll

9/98-5/99

Counselor, Just Drop In Childcare Center – College Station, Texas

- Tutored children with homework
- Maintained open communications with children's parents

VOLUNTEER ACTIVITIES:

Emergency Children's Shelter – San Antonio, Texas, 9/04 to 12/04

- Prepared and assisted in daily activities (art projects, outdoor sports)

Project S.A.V.E – San Antonio, Texas, 2/04 to 8/04

- Worked with a non-profit community organization, devoted to providing relief for the homeless population of downtown San Antonio
- Assembled information and hygiene packs and encouraged substance abusers to get tested and treated for diseases.

AIDS Services of Brazos Valley - Bryan, Texas, 9/02 to 8/03

- Assembled information packs and assisted in case management
- Staffed information booths and assisted in several outreach projects
- Organized and participated in community events

Aggie Buddy Program - College Station, Texas, 9/99 to 12/99

- Mentored underprivileged grade school students

SOUTH TEXAS VETERANS HEALTH CARE SYSTEM

Contact Information
Teresa Whitley
Administrative Resident

7400 Merton Minter Blvd
San Antonio, Texas 78229
210-617-5300 Ext 4065

Training Start Date
January 9, 2005

Project Title
Patient Safety: Using Information to Affect Change

Description/Background
In response to a growing importance of patient safety, The Department of Veteran Affairs (VA) established the National Center for Patient Safety (NCPS) in 1999. The primary goal of NCPS is to promote a culture of safety throughout the Veterans Health Administration (VHA) by focusing on the reduction and prevention of adverse events to veterans. In 2005, JCAHO expanded its criteria for accreditation to include a significant focus on patient safety and a reduced risk of patient harm resulting from falls. A fall is a sudden, uncontrollable, and unintentional event, excluding those resulting from violent blows or other intentional occurrences. Possible consequences of falls includes: hip fractures, brain injury, prolonged hospitalization, and death. Falls are one of the most common adverse patient events in the VHA and the consequences can be life threatening, especially to our elderly patient population. South Texas Veterans Health Care System (STVHCS) responded to this initiative by participating in the NCPS program and forming its own falls prevention and management team. The main principle is that veterans seek care to improve their health and should not get hurt while under our care. With this in mind, STVHCS is diligently working to reduce the number and severity of these falls.

Objectives
- Improve patient safety by reducing the most frequent adverse event in hospitals: patient falls.
- Improve accuracy and timeliness of the current patient fall data collection method, and translate the data into practical information that can be used to affect change in each individual unit.
- Increase awareness of patient falls by providing informational feedback to individual patient care units in the form of graphs and educational materials to educate employees about the devastating effects of falls.

Planning/Development
Historically, each unit would document and report to the patient safety officer all patient falls regardless of injury. Although the patient safety officer kept track of these falls on a monthly basis, there was no system in place to ensure the information was reported back to the units to track performance and initiate improvement.

The NCPS produced several toolkits to assist hospitals with improving patient safety. STVHCS used the NCPS "Falls Toolkit" as a guide in implementing its new patient fall prevention and management team. The purpose of this project was to assist in expediting a critical part of its execution. The first step involves using the reported data on falls and converting it into information that is useful in accomplishing the patient safety goals. The reported data is separated by unit and then plugged into a measuring formula, known as a fall rate. The fall rate is a measurement of risk and tells how many falls one can expect for every 1000 bed days of care (BDOC). The formula used to find the fall rate is:

Fall Rate = (number of falls/bed days of care) x 1000

Once the data analysis is complete, the information is then presented as run charts. A run chart effectively presents information because it easily illustrates data that is tracked over time. After this step is complete, the informational graphs are dispersed among the units.

Target Outcomes

Analysis, action and feedback are crucial in making this initiative a success. Patient safety must become an integral part of the care we provide to our veterans and must be defined in our culture. Ultimately, we need to have a clear understanding of our patient safety goals. Initially there were concerns with a lack of coordination, inadequate follow-up and lost opportunity with the previous method. In order to promote this culture change, the patient fall management and prevention team must provide all services with the tools that will help modify existing behaviors. The data analysis resulting from this project on patient falls will provide the units with the appropriate information. The graphical representations will serve as a tool to show where each unit stands and where they need to evolve. This also creates a perfect opportunity for the service chiefs to educate on why change is essential in providing the highest quality of care for our veterans.

Benefits/Cost Savings

The prevention of falls is important because it will not only save lives but it will also save money. With regards to saving lives, falls are the leading cause of injury, hospitalization due to injury, and death due to injury among the elderly population. Significantly reducing the number of falls will help to eliminate the deaths relating to patient falls. This fall collection method also promotes awareness of patient safety and reassures that falls are properly reported, investigated, and appropriate follow-up action is taken. This added awareness and improvement will save money through fewer lawsuits and a decreased length of stay.

Potential Applications to other Facilities

With a recent focus on patient safety in the accreditation process by JCAHO, VA facilities across the nation must make sure they are improving their own internal adverse event reporting system. Collecting data and receiving reports is only the first step in the process of improving patient safety. Sufficient attention must be devoted to analyzing and understanding the standardized information and causes of errors in order to make improvements. NCPS has timeline standards that organizations must abide by. Implementing this method of data analysis will ensure that the information is complete, accurate and comparable.

Next Steps

STVHCS finds its largest obstacles stem from the timeliness of adverse event reporting and the accuracy of the data. In order to improve the collection method, we want to stray away from an all paper reporting process to electronic reporting. With the original process, incidents could easily go unreported. Electronic reporting will not only make performing a data analysis easier, but it will also automatically track patient falls. For instance, when a fall occurs the witness will enter the incident into the patient fall database, which will later be thoroughly investigated by the service chief. By reducing intermediates in the process, patient falls are less likely to go unreported and can also make the data analysis more accurate because the database will show which incidents are still awaiting investigation.

Health System Management Trainee Individual Projects

Deepa Agusala
1West Superior Apt# 813 Chicago, IL 60610
(Work) 708-202-2199
(Home) 312-371-2732

Objective: To obtain an executive management position in which my knowledge and experience can significantly impact patient care, and ultimately serve in a capacity geared towards meeting and improving the goals of the organization.

Experience:

June 2004 to Present — **Edward Hines Jr. Veterans Administration Hospital** Hines, IL
Health Systems Management Trainee

- Served as Acting Business Manager of Mental Health
- Managed a budget of approximately 1 million dollars
- Co-chaired the Strategic Planning Council for the hospital
- Restructured the Mental Health Clinic to decrease wait times and increase access for patients
- Served as the team leader to revamp the consult process for the Service Line
- Member of the Employer of Choice Committee
- Formulate short- and long-range plans for personnel, equipment, space, construction, and fiscal needs.

Feb 2003 to May 2004 — **Edward Hines Jr. Veterans Administration Hospital** Hines, IL
Supervisor, Fee Basis

- Serves in a supervisory capacity over 6 clerks, as the key administrator for the Fee Basis department; responds to Congressional inquiries; investigate patient complaints
- Decreased the back-log of claims and minimized the average processing time from 100 days to 4.5 days
- Served as a team member to tackle the back-log of consults by utilizing Fee Basis in other clinics
- Oversees the State Nursing Home Program

Jan. 2002 to Jan 2003 — **Edward Hines Jr. Veterans Administration Hospital** Hines, IL
Administrative Resident

- Actively served as a member of the Director's Office Administrative Team encompassing Strategic Planning, resource management, Performance Improvement, community relations and clinical issues
- Served as Administrative Officer to Pharmacy
- Managed a hospital-wide Narcotics Inspection program
- Participated in the development of an Enhanced use Agreement concerning Catholic Charities of the Archdiocese of Chicago.
- Work on various projects for Chief of Staff such as Resident Allocation report, performed cost benefit analysis of specialty beds, and coordinated Office of Inspector General site visit

Education:

Jan. 2003 — **Master of Healthcare Administration and Business Administration (MHA/MBA)**
University of Houston – Clear Lake Clear Lake, TX

Dec. 1999 — **Bachelor of Science of Respiratory Care (BSRC)**
Southwest Texas State University San Marcos, TX

Special Events/ Committees

- Member of American College of Healthcare Executives (ACHE)
- Completed Baldridge Training (Beginning and Advanced)
- Member of Executive Council of Administrative Staff (ECAS)
- Member of Executive Council of Clinical Staff (ECCS)
- Member of Network of Indian Professionals
- Member of Hybrid Rhythms Dance Company (2001-2002)

Facility: Edward Hines Jr. VA Hospital

Contact: Deepa Agusala
Health Systems Management Trainee
1 West Superior #813
Chicago, IL 60610
(708)- 202-2199

Start Date: June 2004

Project Title: Faith-Based Initiative – Catholic Charities and Edward Hines Jr. VA Hospital

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Background:

The U.S. Department of Veterans Affairs realizes the problem of homelessness facing our country. Our governmental leadership, as well as homeless service providers across our nation perceives this to be a national tragedy. The formula for success must include partnerships between partnerships between departments of government, faith based organizations, community organizations and recipients of homeless services.

In an effort to accomplish this goal, The Edward Hines Jr. VA Hospital in collaboration with the Office of Asset and Enterprise Development conducted a study to determine the potential of enhanced-use opportunities for the underutilized portions of the campus. This was followed by an appraisal of the subject property at highest and best use. This business plan builds on the real estate market research and financial analysis produced by previous reports which also includes a study conducted by Economics Research Associates in July, 2001.

Objective:

The purpose of this new initiative is to assist Hines in strategically enhancing its mission linking primary and long-term care with advanced tertiary care, while emphasizing outpatient and preventive services. The commercialization of these properties is in concert with VHA directives to pursue enhanced-use initiatives that supplement VHA costs by utilization of outside resources. The Edward Hines, Jr. VA Hospital would utilize their financial returns from the commercialized property to support the mission of VHA.

Implementation of this initiative:

- supports a definitive unmet need for affordable transitional living for veterans and residents in the surrounding community.
- meets the Millennium Act objective to develop community partnerships that would benefit our veterans.
- assists the Edward Hines, Jr. VA Hospital in operating as a veteran-focused organization that provides high quality, accessible, and timely information and service through the development and maintenance of a high-performing workforce, the application of state-of-the-art technologies, the continuous improvement of processes, and the effective allocation of dollars.
- re-directs funds from maintenance of the enhanced use site to providing high quality, safe, and reliable patient care thereby improving the overall health of enrolled veterans including special populations of veterans.
- utilizes the unused portion of a hospital building for revenue to support patient health care needs that restore the capability of disabled veterans to the greatest extent possible and improve their quality of life and that of their families.
- Establishes a long-term sharing agreement with resource or revenue benefits that reduce the impact of inflationary growth on the hospital's budget, thus allowing VA Hines to continue to provide comprehensive, effective service to veterans and their families

Planning Implementation and Development:

To improve veteran access to the continuum of services, VA Hines is proposing to use the Department of Veterans Affairs' Enhanced Use leasing authority to develop an existing building for commercialization purposes. Catholic Charities of the Archdiocese of Chicago is interested in converting Building 14 for the development of a transitional living center (40-45 single room occupancy units). Future plans also include converting Building 51 and 53 into an assisted living center and a senior housing/ transitional living center. Each building is identical in structure and size (58,000 square feet each, all currently unused VHA space on the eastern section of the Hines campus). Building 14 will have 100% vet priority while Building 53 will have 50% vet priority with admission being offered to spouses and children of our veterans.

These vacant buildings all have excellent access to the main hospital. Through the enhanced use authority, VA can offer long-term use of VHA's assets in order to accommodate the scope of the project. Catholic Charities of the Archdiocese of Chicago is agreeable to finance the renovation of one of these buildings and in supporting at a minimum a 30-40 year lease agreement of the building.

The developer/operator selected will be required to finance, design, construct and operate all site improvements in accordance with State of Illinois regulations and local building codes. Hines Facility Management Service project engineers will collaborate with Catholic Charities of the Archdiocese of Chicago contractors to assure building renovations are completed appropriately. In return for the long-term use of the asset the lessee will be required to provide veteran priority for admission to the facility.

Anticipated Costs, Benefits and Outcomes:

The proposed enhanced-use development will potentially yield considerable benefits for the hospital.

- Provide an alternative revenue stream(s) for the hospital.
- At the end of the enhanced-use lease there is the potential transfer back to the hospital of a property with a potential residual value.
- Operating and maintenance cost savings related to the subject property.
- Increased economic activity and job growth for the local community.
- Increased market value for adjacent property owners.
- The program operated under the Enhanced-Use lease will be an innovative new service option that can meet the demand of a veteran population with psychosocial rehabilitative needs.
- The proposal will provide cost efficient transitional living in a residential environment that increases the quality of life for our veterans.

Catholic Charities Cooke's Manor/Hines residence will be a Veteran transitional living program in an alcohol/drug free environment for recovering men who have completed an inpatient treatment program or have had a successful period of sobriety. Cooke's Manor enables a resident to rebuild his life; become responsible and disciplined; become financially stable; and renter society and the working world as an independent and respected citizen. There will be 40 private rooms available in the facility. The common area will consist of a communal kitchen, recreation room and laundry facilities.

Potential Application to other Facilities:

No up-front VA capital investment is required under this business plan. Hospital operating costs are expected to decrease, while revenues are expected to increase. To undertake this enhanced use effort, an evaluation and market analysis should be performed to determine what commercial use would bring the highest value and best return to VHA in concert with its mission and objectives. In summary, the analysis found that residential real estate is healthy, especially for the consumer and that the current market can be classified as a "buyer's market." It is noted in the analysis that the parcels identified for enhanced use initiatives are conducive to future development for a variety of uses.

Randa Attum
6315 Innisbrook Drive
Prospect, KY 40059
502-802-1452
Rattum1@aol.com

EDUCATION:

Spring of 2002 – March of 2004
Sullivan University, Louisville, KY, Masters of Science and Information Technology

1994 – 1998
Bellarmine University, Louisville, KY, Bachelor of Arts with a major in Psychology,

WORK EXPERIENCE:

2004 – Present Health Systems Management Trainee
Louisville Veterans Affairs Medical Center, Louisville, KY

- Health Systems Council
- IT Specialist
- Training residents and nurses CPRS (Computerized Patient Record System

2000 – 2004 Office Manager, Pathology and Laboratory Medicine Service
Louisville Veteran Affairs Medical Center, Louisville, KY

- Develop and update manuals relative to the Pathology & Laboratory Medicine Service Standard Office Procedure.
- Provide continuing education to the Clinical Staff.
- Promote a sense of pride in the workplace, conflict resolution and staff scheduling.
- Coordinate interdisciplinary educational activities for the Pathology Department

8/2003 – 12/2003 Loaned Executive, Combined Federal Campaign
Louisville Veterans Affairs Medical Center, Louisville, KY

- Build a healthy community by raising awareness for nonprofit organization in collaboration with Metro United Way from various Regional Federal Agencies

10/2002 – 11/2002 Key Worker, Combined Federal Campaign
Louisville Veterans Affairs Medical Center, Louisville, KY

- Build a healthy community by raising awareness through monetary contributions from the Pathology & Laboratory Medicine Service

10/2001 – 11/2001 Employee Coordinator, Combined Federal Campaign
Louisville Veterans Affairs Medical Center, Louisville, KY

- Build a healthy community by raising awareness through monetary contributions for various local agencies within the Louisville Veterans Affairs Medical Center

PROFESSIONAL MEMBERSHIPS, HONORS AND COMMUNITY SERVICE:

- American College of Healthcare Executives (ACHE)

BOARDS AND COMMITTEES

Present Blitz Team
Louisville Veterans Affairs Medical Center, Louisville, KY

- Implementing new resident training program on the computerized patient record system

2003 – Present Sullivan Advisory Board
Sullivan University, Louisville, KY

- Designing, establishing and monitoring Computer Science curriculum to prepare students to succeed in the current job market

2002 – 2004 Administrative Coordinator, Kentucky State Commissioner for the College of American Pathologists Louisville Veterans Affairs Medical Center, Louisville, KY

- Organizing mandatory inspections for all Kentucky hospitals

2003 – Present Tissue Review Committee
Louisville Veterans Affairs Medical Center, Louisville, KY

- Data Mining

2004 – Present Succession and Planning Committee
Louisville Veterans Affairs Medical Center, Louisville, KY

- Decision Support Coordinator

2004 – Present My HealtheVet Committee
Louisville Veterans Affairs Medical Center, Louisville, KY

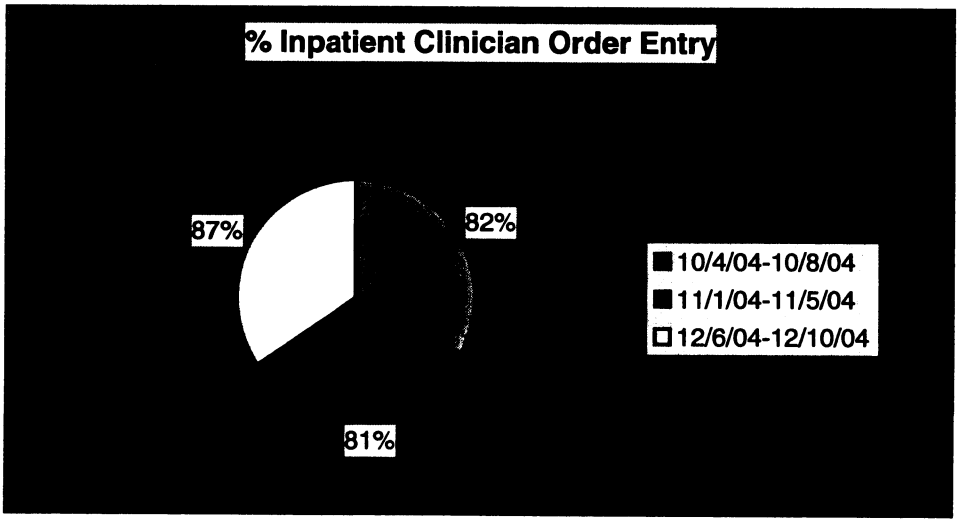
- Promote and evaluate online access to veterans to review medical information and benefits

Louisville Veterans Administration Medical Center
R. Attum
Health System Management Trainee
800 Zorn Avenue
Louisville, Kentucky 40206-1499
502-287-4090
Training Start Date: June 6, 2004

Computerized Patient Record System (CPRS) Training for Residents

Description of the program or project including objectives, planning, and development: According to Louisville Veterans Affairs Medical Center (LVAMC) Memorandum No. 00-38 Computer Usage and Information Security Training, all users of the computer systems at the LVAMC will be provided computer usage and information security training in depth enough to create the skills necessary to adequately perform assigned duties.

Problem: Residents attend a weeklong orientation program prior to their rotation every year beginning July 1. During this time, residents receive computer access to CPRS. Some residents undergo a one to two-hour training course on the basics of CPRS. Unfortunately, other residents do not attend a training course on CPRS. The residents who do not receive training in CPRS will have access to patients' medical records without a clear understanding of the computer system. For example, residents could enter orders or progress notes in the patients' medical record without knowing if they are doing so correctly.



(Pie chart showing within a specific time period the number of inpatient tests actually ordered by providers)

Incomplete CPRS training can result in a lower standard of care for veterans as a result of the timeliness in the delivery of prescriptions and turnaround times with laboratory orders. Lack of CPRS training also gives the residents an opportunity to request from a clerical nurse to enter an order, such as discharge summary, resulting in order entry errors.

Solution: To eliminate the inconsistency with CPRS training and to improve patient standard of care, the Strategic Management Service at the LVAMC organized a Blitz Team (consisting of the Clinical Applications Coordinator, Automated Data Processing Area Coordinators (ADPACs), IT Specialist and chief physicians) to create a mandatory training program for new residents. Beginning January 2005, the Blitz Team will be responsible for structuring the CPRS training program for new residents at the LVAMC. The course outline will consist of either a two-hour overview course or a four-hour detailed course. Upper Management will make the final decision on the time of the course.

Objectives: The Blitz Team's objectives are threefold; first to create an effective CPRS training program for new residents, second, to ensure that one hundred percent of new residents will be trained in CPRS prior to their rotation at the LVAMC and third, to have the CPRS training program implemented by July 1, 2005.

Resource Requirements:
The implementation of a CPRS training program does not require funding. The only resource required is time used by the IT Specialists (trainers), clinical applications coordinator (CAC), residents, attending physicians, clinical service ADPACS, and cooperation from the University of Louisville.

Application Potential in Other Facilities:
Other VA facilities have implemented a CPRS resident training program, but there is no known performance measure being monitored. The LVAMC will monitor physician orders entered incorrectly.

Documented outcomes, benefits, cost savings, etc:
Costs: There are no costs involved in implementing a CPRS resident training program.
Benefits: By implementing a mandatory CPRS training course for new residents, and mandating that providers enter their own orders will overall reduce user errors. By spending either two or four hours with the residents prior to their rotation, more time will be spent on patient care rather than fixing errors.

Amjed Syed Baghdadi

OBJECTIVE

- To contribute my experience and education to the ongoing improvement of a complex healthcare organization

EDUCATION

- **M.H.A./M.B.A.**, Healthcare and Business Administration, May 2004, Univ. of Houston – Clear Lake, Houston, Texas
- **B.S.**, Biochemistry and Genetics, May 1995, Texas A&M Univ., College Station, Texas

ADMINISTRATIVE EXPERIENCE

- **Health Systems Specialist**: South Texas Veterans Health Care System, 2004-Present

  Initiated and chairing the Wayfinding Taskforce to study navigation issues for patients and visitors. Functioned as a critical contact person for three external review surveys: SOARS, OIG-CAP, and Mock JCAHO. Provided technical support for the Primary Care Contract Management Database. Co-taught a course on Quality Data Management. Co-founded the local Employee Association. Worked with consultant to establish an electronic process for entering and monitoring peer reviews. Participated on two Root Cause Analysis teams as well as CFC steering committee.

- **Administrative Resident**: South Texas Veterans Health Care System, 2003-2004

  Started the Excellence Program at South Texas Veterans Health Care System. This program is designed to focus on employee satisfaction as a means for achieving organizational excellence. Participated on a TQI team studying overtime usage. Assisted in the development of Advanced Clinic Access implementation policy and procedures for Primary Care Product Line. Rotated through several administrative services.

- **Consultant Administrator**: Mohamed O. Jeroudi, MD, PA, 2001-2003

  Facilitated many of the administrative tasks associated with expanding a solo cardiology practice to a group practice. In particular, negotiated the lease and construction expenses for moving to a larger office, executed and monitored the credentialing of a new physician at several hospitals, and prepared necessary documentation for contracting the new physician with an array of third party payers. In addition, redesigned the flow of several weekly functions involved in patient coordination and billing.

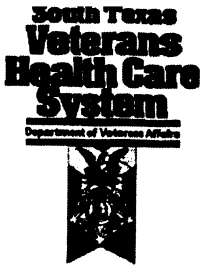
PROFESSIONAL AFFILIATIONS

- **American College of Healthcare Executives**: National and South Texas Chapter, Member since 2000, Board Member of South Texas Chapter since 2004
- **Toastmasters International**: Audie's Orators Local Chapter, Member since 2003, President since 2004
- **Healthcare Financial Management Association**: 2002 - 2004
- **Upsilon Phi Delta**: Healthcare Administration Honor Society, Member since 2002
- **Beta Gamma Sigma**: Business Administration Honor Society, Member since 2003

RESEARCH EXPERIENCE

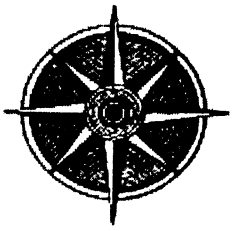
- **Research Project**: Immunoparasitology of *Schistosoma* infection, 1997 – 2000
- **Research Project**: Basic Immunology, 1996 – 1997

134 Agency Oaks, San Antonio, Texas 78249
Mobile: (210) 392 – 9327 • Phone: (210) 617 – 5205 • Fax: (210) 949 – 3670 • E-mail: Amjed.Baghdadi@med.va.gov
References available upon request.



WAYFINDING

INCREASING CUSTOMER SERVICE THROUGH NAVIGATION



SOUTH TEXAS VETERANS HEALTH CARE SYSTEM

AMJED S. BAGHDADI

Quality Management (002), 7400 Merton Minter Blvd., San Antonio, Texas 78229
Office: 210.617.5205 Cell: 210.392.9327 Email: amjed.baghdadi@med.va.gov

BACKGROUND

A patient's first experience with a healthcare facility is the environment. From the moment the patient and his/her family drive onto the premises until they drive off, they will use what they experience to characterize not only the facility but also the quality of care they receive; most patients will interpret flaws in the environment as flaws in care. Paramount among the experiences with the environment is a patient's success at "wayfinding". In essence, **wayfinding is the ability of a visitor to navigate an unfamiliar environment**. In addition, wayfinding includes all the environmental clues that augment the visitor's ability to "find the way". Recently, the South Texas Veterans Health Care System was approved for $42.1 million in construction projects that are expected to result in renovation of over 90% of the hospital in the next two years. Unfortunately, the extensive construction in the facility has made navigation difficult for patients, visitors, as well as employees. Further complicating the issue, the construction often results in temporary relocation of essential areas/units in the building. Amidst the chaos, patients are faced with greater wayfinding challenges each day.

OBJECTIVE

To increase customer service and access to care by improving wayfinding at the Audie L. Murphy Hospital.

EXPECTED OUTCOMES

Although there are several obvious negatives associated with getting lost in a large building, medical issues often compound the problem for patients. Due to the nature of their visit to a hospital, patients usually arrive already anxious. Improved wayfinding for the patients can have several positive outcomes as fewer patients get lost while trying to find their way around the building. The expected outcomes are:

- Fewer patients who are late for or miss their appointments (increased access)
- Fewer patients who get angry and violent (less workplace violence)
- Reduced patients' stress levels (more accurate medical test readings)
- More patients will find the facility accessible (increased use of care)
- Staff will spend less time giving directions (increased staff efficiency)
- Fewer patients who become highly fatigued from repetitively traversing incorrect paths (less liability)
- Patients will develop an improved opinion of the facility (increased customer service)

MULTIDISCIPLINARY TASKFORCE

Considering the involvement of several roles with patient wayfinding the following were identified as key players in the taskforce: 1) information desk, 2) voluntary service, 3) interior designer, 4) sign shop, 5) clerk, 6) nurse, 7) Medical Administration Service's analyst responsible for appointment letters, 8) Office of Information Technology's Clinical Application Coordinator, 9) representative from Decision Support Science, 10) patient educator, 11) representative of blind veterans, and 12) patient advocate.

Veterans Administration Hospital FY05

Taskforce Subgroups

Although the taskforce identified several areas of wayfinding needing attention, the group decided to focus on three main areas needing improvement: 1) appointment letters, 2) maps & directory, and 3) signage & nomenclature. To enhance coordination between the groups, the chair of the taskforce has been working closely with all three subgroups.

Appointment Letters

To address these problems, the subgroup on Appointment letters is currently working to standardize the letters and replace over 2000 templates with less than 10 form letters that meet patient needs. In addition, the group is working to eliminate unnecessary verbiage from the letters and make them more user-friendly.

Maps & Directory

This group is working to develop comprehensive, easy-to-use maps with color coding that will eventually coincide with the redesigned interior of the hospital. In order to be most useful, these maps must be flexible so as to be adjusted quickly to reflect construction changes in the building over the next two years.

Signage & Nomenclature

To address these issues as well as to enhance overall signage in the building, the group is looking to ways of introducing color, landmarks, and simplified nomenclature. Second, the group is studying the practicality of naming major corridors in the building for ease of remembrance by patients and staff. Finally, the group is working to develop a transition plan to eliminate unnecessary signage during the upcoming two years of construction.

Measurement Tools

To establish methodology for measuring progress of the taskforce initiatives, two measurement tools were developed. Both tools are simply log sheets designed to track patient concerns. The first was given to the information desk at the front entrance. This tool primarily measures confusion caused by the appointment letters as patients enter the building. In addition, a measurement tool was needed to monitor difficulties that patients have with reaching a particular service or unit. Therefore, a log sheet was given to volunteers to track the number of patients who had difficulty finding the outpatient surgery waiting room on the second floor and the Cardiology clinic near the back of the building on the first floor.

Financial implications & Resources Required

Several facilities in the private and public sector turn to vendors to purchase expensive wayfinding solutions. With the current budget situation, we looked for other more cost-efficient solutions to our wayfinding needs. The establishment of the multidisciplinary taskforce greatly reduces the need for expensive companies. Through literature review and cost neutral approaches to implementing changes, we have been able to develop strategies to improve wayfinding without huge costs incurred at the planning phase. To date, the only cost incurred has been employee time used by the Taskforce and subgroups to work on this initiative. Future expected costs involve the following: 1) reprogramming the appointment letters (12 hours employee time), 2) cost to reproduce colored maps and directories (recurring cost), 3) cost to mount large scale maps and directories at key decision points throughout the facility (8 floors), and 4) cost to phase in the new signage plan (included in approved construction budget).

Work:

VA Stars and Stripes Healthcare Network
U.S. Department of Veteran Affairs
Delafield Road
Aspinwall, PA 15240
412-784-3939
Matthew.Funke@Med.VA.gov

Home:

45 Acorn Drive
Elkton, Maryland 21921
410-398-9364
Matthew.Funke@comcast.net

Matthew G. Funke, MS

Education

1988
West Chester University, West Chester, Pennsylvania
M.S. Health and Physical Education

1984
West Virginia Wesleyan College, Buckhannon, West Virginia
B.S. Rehabilitation

1982
Harford Community College, Bel Air Maryland
A.A. General Studies

Professional Experience

2004 - 2005 Health System Management Trainee
VA Stars and Stripes Healthcare Network

- Administrative Assistant Network Education Council
- National LEAD program participant
- Member National LEAD Grants and Awards Committee
- Administrative Assistant to the Network Health System Council
- Administrative Assistant/Liaison to the VISN 4 Unified Union Partners and Executive Leadership Council
- Assisted with VISN 4 Behavioral Healthcare and Homeless initiatives.

2001 - 2004 Adjunct Instructor
Community College of Baltimore County, Essex, Maryland

- Wellness educator

1997 - 2004 Kinesiotherapist
Perry Point VA Medical Center, Perry Point, Maryland

- NHCU Team Representative
- Cardiac Rehabilitation Coordinator
- EEO Disability Manager
- EEO Executive Board
- Provided Wellness instruction to SARRTP and Outpatients.

1993 - 1997 Physical Therapy Assistant
Perry Point VA Medical Center, Perry Point, Maryland

- GEMU Team Representative
- EEO Disability Manager
- Provided Rehabilitation Services to Patients in an acute and long term care setting.

1989 – 1993 Exercise Physiologist
Cardio-Kinetics, Inc. , Newark Delaware

- Cardiac Rehabilitation/Exercise Testing

Licensure and Certification

Certified Drivers Rehabilitation Instructor; Healthcare Provider Certification, American Heart Association; Advance Life Saving Certification, American Red Cross.

Publications

A Kinematic Analysis of the Long Snap in Football, copyright 1989

Professional Memberships

American College of Healthcare Executives (ACHE), American Alliance for Health, Physical Education, Recreation, and Dance (AAHPER).

Honors

EEO manager of the year; Director Service Award; Outstanding Performance Rating; Phi Theta Kappa

Interest/Hobbies

Biomechanical Analysis of Motion; Coaching Football; Antique Automobile Restoration

VA Stars & Stripes Healthcare Network
Matthew G. Funke
Health System Management Trainee
John Heinz II VA Medical Center
Pittsburgh, Pennsylvania 15415
412-784-3939
Training Start Date: June 28, 2004

A Comparative Analysis of the VA Stars & Stripes Healthcare Network's Homeless Programs Scope to Standards Developed Nationally

Description of the Project:

This was a program evaluation and quality improvement initiative of the VA Stars & Stripes Healthcare Network, VISN 4. The VISN 4 Homeless Program was initiated as a component of the Behavioral Health Strategic Planning process. The two primary objectives of this quality improvement project are 1) determine how successful the programs have been in providing services to homeless veterans utilizing what are recognized as best practices, evidence based treatments, and the intent of the Veteran Affairs policy on Homelessness, and 2) identify where there are gaps in services with in the VA Stars & Stripes Healthcare Network's Homeless initiatives as well as make recommendations that can be implemented as part of the Network's Strategic Plan for Homelessness. Benchmark criteria utilized in this evaluation included the report from the President's Interagency Council on Homelessness, ICH, and the President's New Freedom Commission on Mental Health. A literature review was performed using the documents listed above and then comparing core clinical elements associated with eliminating homelessness to actual practices within the VA Stars & Stripes Healthcare Network. Strengths and gaps where identified within VISN 4's current continuum of care and suggestions were made to improve the current VISN 4 Homeless initiative.

The VA Stars & Stripes Healthcare Network Homeless Initiatives

The VA Stars and Stripes Healthcare Network serves veterans in Pennsylvania, Delaware, South New Jersey, North West Virginia, portions of Ohio, as well as portions of New York. VISN 4 includes 10 medical centers, 42 Community Based Outpatient Clinics, CBOC, and 10 Vet Centers. VISN 4 provides approximately 115 FTEE and 10 million dollars in resources for homeless services. In the last fiscal year, FY 2004, VISN 4 significantly expanded its services for the homeless as well as crossing services lines with in the VISN to better meet the needs of the homeless population it serves. Additionally, the network has been actively working with the Region III, ICH of the Mid Atlantic States and is participating in the 10 year planning process to end chronic homelessness for the city of Philadelphia and for Allegheny County, PA.

Program Strengths

The Stars & Stripes Healthcare Network has considerable resources and a clear plan that is coordinated with the goals and objectives of the VHA and the ICH. It has embraced the new goals of ending homelessness. Strengths of the VISN 4 Homeless program now includes outreach at each medical center and a recent addition of 195 Grants and Per Diem Beds; 30 of these beds are targeted to meet the specialty needs of women veterans. VISN 4 has also begun to focus on issues related to assessment and retention in both behavioral health and primary care

services as well as develop partnerships with community providers in an effort to expand opportunities related to prevention and longer-term housing. VISN 4 is an active participant in the regional ICH, and each medical center actively participates in the Community Homeless Assessment Local Education and Networking Groups, CHALENG, project. The homeless programs have developed a close working relationship with the network's Mental Illness Research Education Clinical Centers, MIRECC, in an effort to improve the competency of its staff and to implement more empirically based best practice treatment services for the veterans that are homeless and who have either Serious Mental Illness or a substance use disorder. Finally, the network has begun to more actively work with the State of Pennsylvania Continuum of Care Group to better plan and coordinate services.

Program Gaps

The Homeless services within the Stars & Stripes Healthcare Network have 5 important enhancements to implement in order to comply with the intent of the benchmarks set by the President. The 5 enhancements are as follows: 1) Outreach teams need to use a Critical Time Intervention Case Management approach. This approach will be very practical for the homeless teams to implement and it should have a positive impact on improving access and engagement to both VA and community based behavioral health and primary care services. 2) Rural regions of our network are deficient in having access to VA supported transitional housing and long term housing. The Department of Health and Human Services indicates that transitional housing can decrease the annual healthcare of each chronically homeless person by $11,161. Therefore, a priority for the network's homeless program needs to include the development of community partnerships in our rural regions to coordinate outreach and to develop services for both transitional and long term housing options to homeless veterans. 3) There is a need for "real time" data collection and monitoring systems. A key element to implementing best practices is to have program decisions driven by accurate and timely data. As a network we need to be able to provide our medical center leadership and our community partner's pertinent information related to cost and productivity for our programs. 4) There is a need to increase partnerships with state and local providers in order to extend our continuum of care. VISN 4 needs to improve its partnership with the community to develop early intervention and long-term housing options in both rural and urban areas. It is critical for VISN 4 to incorporate successful new models used in the community such as "Safe Havens" and "Housing First", into its new homeless initiative while utilizing existing housing programs such as HUD-VASH and Section 8 vouchers. 5) A partnership needs to be created with other Federal agencies. Federal partners needs to include those who are named by the President in the benchmark documents. The Department of Housing and Urban Development, the Department of Health and Human Services, the Department of Labor, Department of Justice, Department of Transportation, and Social Security Administration need to be included to address the unmet clinical, transportation, judicial, and monetary needs of our homeless veterans. Additionally, VISN 4 must enhance income and benefit opportunities using the VA's own Veteran Benefits Administration.

The Stars and Stripes Healthcare Network has considerable resources and a clear plan that is coordinated with the goals and objectives established by the President. VISN 4 has made significant progress to comply with the Presidents goal of ending homelessness within 10 years and is strategically positioned to be a leader within the VA.

Jennifer Griffin

13150 Mill Stone • Austin, TX 78729 • (512) 336-3962

EDUCATION: **Trinity University**, San Antonio, TX
M.S., Health Care Administration, December 2002

Trinity University, San Antonio, TX
B.S., Biology, May 2000

EXPERIENCE:

Central Texas Veterans Health Care System (CTVHCS) Temple, TX

1/05 to present ***Health System Management Trainee, Acting Strategic Planner***

- Liaison between CTVHCS and VISN 17 Network office on issues related to Strategic Planning.
- Develop, implement, and monitor the Strategic Plan for CTVHCS.
- Create business plans for various sites within CTVHCS.
- Working to expand services in the Austin submarket.
- Assist in the CARES process at the local and national level.
- Work on various projects for the Director's Office.

5/04 – 1/05 ***Health System Management Trainee, Acting Administrative Officer, Primary Care***

- Responsible for performing, providing, obtaining or advising on a variety of management services essential to the direction and efficient operation of Medical Service.
- Served as the local Advanced Clinic Access (ACA) POC for CTVHCS.
- Developed and maintained budget for Primary Care.
- Member of VISN 17 Primary Care Council.
- Addressed patient concerns and complaints
- Ensured adequate clinic coverage across CTVHCS
  - Initiated resource requests
  - Developed recruiting ads
  - Worked with locum companies

1/03 – 5/04 ***Clinic Coordinator - Cedar Park Outpatient Clinic***

- Member of the Activation Team that coordinated the opening of the Cedar Park VA Outpatient Clinic.
- Worked independently and collaboratively with the CBOC physician-in-charge in the management of the administrative and business practices of the CBOC.
- Responsible for planning, organizing, initiating and directing administrative and program functions, which impacted the patient care processes within the CBOC.
- Built and maintained good public relations and contacts with many persons at the local, state and congressional levels.
- Assisted and trained front line HSA staff to effectively manage distraught patients and difficult situations in a stressful clinic environment.
- Worked with contracting to address legal agreements involving the clinic.

VA North Texas Health Care System Dallas, TX
Central Texas Veterans Health Care System Temple, TX

1/02 –12/02 ***Administrative Resident***

- Rotated through the administrative and clinical departments to gain an understanding of the facility at a granular level.
- Completed special projects such as analyzing satisfaction surveys, creating a PR award entry, interviewing patients in an attempt to improve the access of care, and creating presentations for use during the JCAHO Survey.
- Briefed management on current issues.

Facility: Central Texas Veterans Health Care System

Contact: Jennifer Griffin, MHA
Health System Management Trainee
1901 Veterans Memorial Drive
Temple, TX 76504
254-743-2369

Start Date: July 2004

Group Clinic Visits:
Can Group Clinics Change the Way Health Care is Provided?

Description/Background

Central Texas Veteran's Healthcare System (CTVHCS) implemented two pilot group clinics for a Primary Care clinic and a Lipid clinic. The group clinics allowed care to be given to 15-20 patients in a 90-minute group appointment. The Primary Care group clinic utilized a Nurse Practitioner, a Psychologist, a Clinical Pharmacist, an RN, an LVN, and a clerk. The Lipid group clinic initially utilized a Clinical Pharmacist, a Psychologist, an RN and two Clinical Technicians. Unfortunately, the psychologist retired and the role has not been replaced.

Objectives:

Like many VA's, CTVHCS struggles to provide timely access to patient care. Because of this, the main objective of implementing the group clinic concept was to improve patient access to care.

Planning, Implementation and Development:

Edward Noffsinger, PhD is the creator of the Drop In Group Medical Appointment (DIGMA) concept. Dr. Noffsinger came to CTVHCS and held seminars and group clinics to illustrate the concepts of the DIGMA model. CTVHCS clinicians worked with him in planning our group clinics.

The Lipid group clinic began in April 2004 and was able to immediately start with a clinic of 13 patients. The average group clinic size for 2004 was 13.8 patients for each clinic. The traditional lipid clinic handles 14 patients per day, but with the implementation of a Lipid group clinic, the clinic is able to see 15-20 patients in a 90-minute clinic.

The Primary Care group clinic began in July 2004. Typically, patients are referred from a physician provider for follow up on a new or revised course of medication for diabetes, hypertension, or cholesterol problems. However, patients may self refer. The clinic initially saw 2-4 patients, but by the end of December 2004, that number had grown to 12-16. Without overbooking appointments, providers are able to see 14 primary care patients/day. The group clinic allows them to see the same amount in one 90-minute appointment.

Outcomes

In addition to increasing patient access and increasing provider productivity, patient satisfaction scores from both clinics were very positive. 99% of patients in the primary care group clinic and 100% of the patients in the Lipid group clinic were satisfied that their medical needs were met. 97% of the patients in the Primary Care group clinic and 92% of patients in the Lipid group

clinic said they were as involved in the decisions about their medical care as they wanted to be. One big difference in the satisfaction scores came when patients were asked if they would have preferred an individual appointment over a group appointment. While only 35% of the Primary Care group clinic patients said yes, 78% of those in the DIGMA clinic would have preferred an individual appointment. This is most likely because of the fact that the Lipid clinic was unable to replace the physiologist who was key in maintaining the clinic flow and group interaction. Without this behaviorist, the clinic has become much more like a class where the Clinical Pharmacist is lecturing to the group instead of fostering a group dynamic.

Benefits

The benefits of group clinics are multifold. Patient satisfaction increases when access improves and patients tend to become more open in a supportive group setting where they learn about their problems and the problems of others.

In addition, provider satisfaction increases as well due to increased efficiency, improved patient-physician relationships, and more time to spend with patients

From a system perspective, an additional benefit from the group clinic process is increased provider efficiency. In addition, seeing some patients in a group clinic setting allows providers to spend more time with patients needing or desiring individual appointments.

While further analysis is needed, one study done at Colorado Permanente Medical Care Program reported that group clinics accounted for:

- An 18% decrease in ER visits
- A 12% decrease in hospital use and readmissions
- Delayed entry into nursing facilities
- Fewer visits to sub specialists
- More calls to nurses and fewer to physicians

Financial Impact

A well-run group clinic will utilize a medical clinician, behaviorist, pharmacist, nursing staff, and clerical support. This will make for an expensive 90-minute clinic. However, each of the clinicians is able to work with 15 or more patients, which is a significant increase in efficiency. In addition, because of the benefits mentioned above, the Colorado Permanente study found that they experienced a $14.79 decrease in the cost of caring for each patient/month.

While the implication is that facilities will either decrease their costs, or remain cost neutral, it is critical not to cut staffing levels to ensure costs are saved. Group clinics only function well when adequately staffed.

Potential Applications to other Facilities:

The group clinic concept has wide ranging potential. Group clinics can be used for primary care or for specialty appointments. Group clinics have flourished in the private sector and many other VA facilities, such as Loma Linda, Dallas, and Bay Pines. The Kansas City VA has done considerable work in developing group clinics for diabetes, renal diseases, CPAP, and PTSD. They are planning on rolling out-group clinics on Parkinson's, Hypertension, and New Patient Screenings.

David Harden
9 Ridgeview St. Apt. 101
Danville, Illinois 61832
Phone (217) 442-8512
E-mail davidhardensr1@aol.com

Professional Experience

- Twenty years of military Service.
- Strong educational background in training and management.
- Proven supervisory skills and record of accomplishment.
- Naval Instructor and Curriculum Development Specialist.
- Training Coordinator for private industrial cooperation.
- Case Manager/ Counselor/ Addiction Therapist.

Educational Background:

1999- 2001	**University of Saint Francis** Masters in Health Services Administration
1992- 1995	**Georgia State University** Bachelor of Science in Sociology/ Psychology
1990- 1992	**Atlanta Metropolitan College** Associate of Science in Business Management
1986- 1988	**Mississippi State University** Earned 42 hours towards B.A. degree in Business Management
1984- 1985	**Northwood Institute**
1965	**G.W. Drake High School** Graduated

Relevant Experience:

1995- 2004	Atlanta VA Medical Center Case manager in the Mental Health substance Abuse program. Addiction Therapist, Group Counselor.
1990- 1995	Full Time Student Atlanta Metropolitan College ▪ Georgia State University
1988- 1989	Served as Training Coordinator for DynCorp Aerospace
1986- 1988	School Teacher (secondary) West Lauderdale High School, Lauderdale County School System.
1965- 1985	United States Navy ▪ Developed and taught Leadership Courses. ▪ Supervised and trained Naval Instructors. ▪ Wrote and conducted Hazardous Material Training Program at Naval Air Station, Meridian, Mississippi. ▪ Coordinated the Human Relations Management Support System for Naval Air Station, New Orleans, Louisiana.

David Harden, MSHA
Health System Management Trainee
VA Illiana Health Care System
1900 East Main Street
Danville, Illinois 61832
(217) 554-5092
Training Start Date: June 28, 2004

Managing Fee Basis

Project Description:

The VA Illiana Health Care System (VAIHCS) is a dynamic system that services Central Illinois and West Central Indiana. It is comprised of a medical center at Danville, Illinois, and 5 Community Based Outpatient Clinics (CBOC). These CBOCs are located in Peoria, Springfield, Decatur, Effingham, Illinois and West Lafayette, Indiana. VAIHCS has a catchment area that serves more than 30,000 veterans. The demographics are rural with a heavy concentration of World War II Veterans, who present with more complex symptoms and higher acuities. It is anticipated that the demographics will experience further changes with the returning OIF/OEF Veterans. These veterans are presenting fresh from a combat area, and are requiring more complex and unique services.

VAIHCS is anchored by the medical center at Danville, Illinois. The Medical Center provides primary and secondary care to a largely rural service area. As the ages of the catchment population increases, the cost for services increases. This area has a higher than normal fee for services population which necessitate close monitoring and management of the Fee Basis Program. One management tool that is in use is funds control points. These fund control points are the accounting system for the Fee Basis Program. Exacting management of this control point is absolutely essential for overall budget management and forecasting. Budget management is extremely difficult if the projections aren't accurate or meaningful.

With an extremely tight budget, inaccurate budget projections, poor tracking of rendered services, the fund control point can become problematic. The lack of predictability of fees to be paid will create possible shortfalls that must be compensated for from other sources. Reactive budget management does lead to inefficient administration which negatively impacts patient care.

Objective:

The purpose of this project is to develop an operational model that will assist in the management of the Fee Basis Program's budget. This model requires a cooperative effort across several services, and the employment of the latest VA technologies.

Methodology:
This project began as an investigative research of business practices and management of fund control points. The research involves 2 separate VISNs, interviews with 3 Business Managers, 1 Case Manager, and 1 Care Manager. The primary purpose of these interviews was to develop some operating procedures. Business practices and contract development were also areas of discussion.

Proposal:
This research proposes that a multi-facet approach to the management of the Fee Basis Program be undertaken. The first is Case /Care Management. The second is Disease Prevention, and the third is Coalition Building. This research found that these approaches will add manageability and waste reduction to the Fee Basis Program.

Discussion:
During the research and many discussions, it was discovered that there is no central control point for community service requests. This research holds that when a veteran obtains a consult for community services, they should also be assigned a Case Manager. This manager will be able to follow the process and progress of the veteran. The combined case loads of the Case Managers will give accurate data concerning service requests. The already existing disease prevention program can be adapted to the Fee Basis Program. This program brings with it Telehealth, Telemedicine technologies and also the expertise of Care Managers. The Case/Care Manager's case loads will form an accurate document from which valuable data can be extracted. The last facet is coalition building. The first 2 concepts discussed are driven by tangible evidence such as data, or resources that can be inventoried. The end result of good coalition building is data that show a positive outcome. The concept here is that the Administrative Officer or Business Manager should work on building a relationship with community providers. This new relationship fosters accountability, and affords an opportunity to seek better contracts for services. These coalitions can promote healthy competition for VA business.

Outcomes and Benefits:
Care management and Telehealth technologies are proven tools for identified chronic patients to self manage their diseases. This self management is already showing a reduction in the progression of their diseases, which lessen the duration need for hospitalizations. Preventive Medicine was the original premise of the Fee Basis Program, and with VHA's cutting edge technologies, excellent service can be realized, with added cost benefits.

Business Managers and Administrative Officers could begin work on gathering data on community service providers. This data is most beneficial for contract considerations. The VA is a significant revenue provider in any community, and can negotiate for better service contracts. This model has a proven positive outcome in one VISN 7 facility. When used in a combination, these methods can benefit a Fee Basis fund control point, create positive health outcomes, and provide excellent customer satisfaction.

SHELLEY HAYNES

115 Meadowbrook Moore, OK 730160 (405) 270-0501 ext 3961 EMAIL: Shelley.Haynes@med.va.gov

EDUCATION

May 2003 **Master of Public Health**
Health Administration and Policy
University of Oklahoma Health Sciences Center Oklahoma City, OK

August 1994 **Bachelor of Science in Radiologic Technology**
Radiography
University of Oklahoma Health Sciences Center Oklahoma City, OK

LEADERSHIP EXPERIENCE

July 2004 – present
Health Systems Management Trainee
Oklahoma City VA Medical Center, Office of the Director, Oklahoma City, OK

- Establish equipment purchasing steps for VISN 16 Equipment Advisory Group.
- 100% responsibility as Acting Administrative Officer/Chief Technologist for Radiology.
- Successfully organize the implementation of a film-free radiology facility

June 2003 – July 2004
Administrative Fellow
Oklahoma City VA Medical Center, Office of the Director, Oklahoma City, OK

- Direct administration of projects that improve current medical practices.
- **95%** completion of administrative projects as assigned by the Medical Center Director.
- Demonstrate the ability to effectively manage and enhance professional relationships in the **largest** health care system in the United States.

June 1998 – June 2003
Corporate Appreciation Specialist
Radiologic Technologist Coordinator
Norman Regional Occupational Medicine, Norman, OK

- Developed marketing program and implemented corporate satisfaction surveillance.
- Implemented the process of satisfaction surveillance to corporate clientele.
- Maintained a **95% improvement** rate in Occupational Medicine performance indicators.
- Conducted **100%** of the training for non-radiologic staff.

October 1995 – May 1998
Office Manager
CenOk Home Health Services, Lexington, OK

- Directly **supervised 89%** of employee payroll and **95%** of Medicare billing.
- Responsible for employee training, orientation, hiring and benefits.
- Researched, coordinated, and **implemented JCAHO** accreditation standards.

November 1994- March 1995
Special Procedures Supervisor
Grady Memorial Hospital, Chickasha, OK

- **100%** direct supervision of special procedures technologist and scrub technologist.
- Successful **re-organization** of patient scheduling procedures and patient teaching functions resulting in a **90%** improvement rate in patient satisfaction.
- Responsible for **100%** policy implementation and quality control regulation.

PROFESSIONAL MEMBERSHIPS AND CERTIFICATIONS

The American College of Healthcare **Executives** Member
American Registry of Radiologic Technologist (#288720)

FACILITY: Oklahoma City VA Medical Center
Training Start Date: July 1, 2004

CONTACT: **Shelley D. Haynes**
Health Systems Management Trainee (OOH)
Oklahoma City VA Medical Center
921 N.E. 13th Street
Oklahoma City, OK 73104
405-270-0501, ext. 3961
Shelley.Haynes@med.va.gov

MENTOR: Steven. J. Gentling, FACHE
Oklahoma City VA Medical Center
Director

PROJECT TITLE: **THE *POWER* OF GROUP PURCHASING**

Historically in the VHA, health care equipment purchases were independently completed at the facility level. The NAC (National Acquisition Center) was established to consolidate procurement requests through each VISN (Veterans Integrated Service Networks). Although the NAC had proven to be beneficial in the consolidation of actual purchasing there were no standardized requirements between facilities that would allow maximum market influence. In 2003, the objective changed to focusing on maximizing the VHA leverage with industry to obtain the lowest possible prices for equipment purchases (U.S. Department of Veterans Affairs, 2003). The benefits to this practice are:

- Eliminate duplicate negations with vendors
- Provide competitive pricing and technical information
- Standardized functions between the Capital Investment Process (CIP) and the NAC
- Replace the rush at the end of the fiscal year by planning and budgeting in advance
- Ensure that all vendors are given a fair opportunity to compete
- Standardizes equipment throughout an area to help create support in technology, maintenance, and service

METHOD

The market influence approach has been in practice at the Diagnostic Imaging Administration in VISN 16 since 2000. In 2004, the power of group purchasing was able to save VISN 16 Diagnostic Imaging $6 million dollars. These savings can be accomplished by gaining additional discounts and services when equipment purchases are standardized by using one vendor (bundled/group purchases).

Through my project I have researched the saving and created the steps to be applied in other VISNs and VHA facilities:

STEP	TASK	RESPONSIBILITY
1	Statement of Need	Local Facilities
2	Specification Sheet	Local Facilities
3	Review RFP	VISN Equip Advisory Group
4	Evaluate facility equipment needs	VISN EAG
5	Prioritize equipment requests and features	VISN EAG
6	Contact vendors	VISN Administrator
7	Schedule presentations	All
8	Score vendors	Local Facilities
9	Identify the benchmarked vendor	VISN Administrator
10	Select choice	Local Facilities
11	Submit choices to NAC	VISN Administrator

The statement of need should identify specific benefits of purchasing equipment and how the purchase will promote the mission of the VHA. The more detailed specification sheet or spec sheet sets the quality and performance standards of the equipment and provides the greatest scope for maximizing the value of funds. These two tasks are similar to the Request for Proposal (RFP) and completed at the facility level.

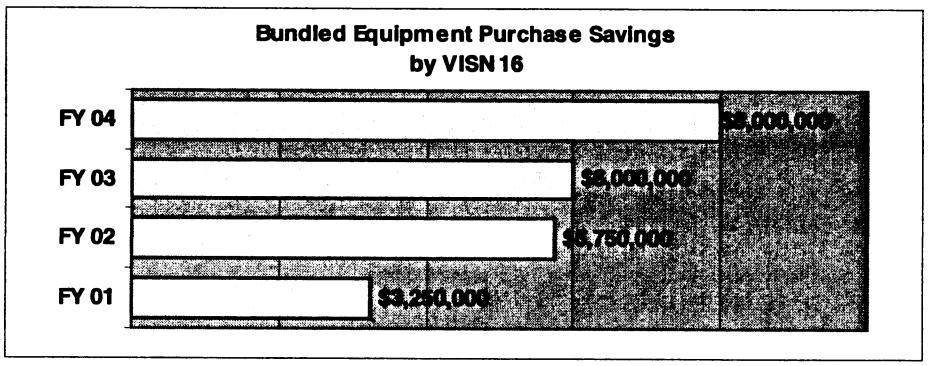
The Equipment Advisory Group (EAG) should review, evaluate and prioritize each request. The EAG members consist of VISN administration, healthcare facility Service Chiefs, IRM PAC Administrators, and Administrative Officers. The local facilities requests are then standardized further by negotiating consolidated equipment purchases to maximize equipment dollars by contacting the vendors and scheduling presentations. Following presentations the vendor are rated with weighted criteria. Scores in each category should be based on the votes of the Service Chiefs, Administrative Officers, or EAG members at each facility or VISN. The scoring is on a scale of 1-10. After the facilities score each vendor the scores are then averaged to determine individual vendor scores. The individual scores are multiplied by the criterion weight to achieve the final score. This method identifies the benchmarked vendor.

Criterion	Weight	Vendor's Avg. Individual Score			(Weight)Individual Score = Final Score		
	W	A	B	C	(W)A	(W)B	(W)C
Equip Functionality	0.22	7	9	6	1.54	1.98	1.32
Service	0.19	4	7	5	0.76	1.33	0.95
PACS Integration	0.16	6	8	2	0.96	1.28	0.32
Price	0.12	6	7	3	0.72	0.84	0.36
Value Added Svc's	0.10	7	7	6	0.70	0.70	0.60
Support Personnel	0.08	5	6	7	0.40	0.48	0.56
Financial Soundness	0.07	7	9	4	0.49	0.63	0.28
Product Selection	0.04	6	8	5	0.24	0.32	0.20
Company Culture	0.02	6	8	5	0.12	0.16	0.10
BENCHMARK		→			5.93	*7.72*	4.69

The vendor that successfully scores the highest is communicated to the local facilities. Each facility is encouraged to select equipment from the benchmarked vendor in order for the VISN to gain the additional discounts. However, the benchmarked vendor may not be the facility choice. A facility that wishes to select equipment from another vendor must write a justification of the alternate choice. The justification should detail reasons that prove the equipment benchmark is not beneficial to the facility and be approved by the facility Director.

CONCLUSION

The use of group/bundled purchases to maximize market leverage from 2000-2004 has saved VISN 16 over $19 million. This is an average savings of $4.75 million dollars a year.



Data provided by the VISN 16 Diagnostic Services Administrator

This type of saving generates a financial soundness practice for a healthcare organization (Kaufman, 2003). If the same process of maximum market leverage were successfully implemented with all equipment purchases, the VA could save millions of funds to treat more veterans. Since the establishment of veterans healthcare benefits there have been many teams that have worked to generate ideas to improve the VA healthcare system. Taskforce teams today in the VHA have developed one consensus, the veteran demographics are rapidly evolving. The veteran population is aging and consuming a tremendous amount of healthcare dollars (Department of Veterans Affairs, 2003). In 2003, the Department of Veterans Affairs spent $26 Billion dollars on healthcare, an increase of 11 percent from 2002 (http://www.cdc.gov/nchs/data/hus/hus04trend.pdf). Bundled group purchasing is a creative financially sound practice that relies on competition between vendors to maximize the market influence by stretching the government dollar to provide more care for our nations veterans.

928 Ironwood Drive Montgomery, Alabama 36117
Phone (334) 395-4450
E-mail Gregory.Ingram3@med.va.gov

Gregory E. Ingram, BS.HSMT

Education

July 2004 - present
Central Alabama Veterans Health Care System (CAVHCS)
Health Systems Manager Training Program, GHATP
1990
Adelphi University, Garden City, New York
B.S. Adaptive Physical Education

Professional Experience

2004 – Present Health Systems Manager Trainee
Central Alabama Veterans Healthcare System (CAVHCS)

- CAVHCS Estrada Web page manager and point of contact
- Local CAVHCS auditor of Fiscal Service
- Commemoration Committee chair for Medical of Honor Recipients and Tuskegee Airmen

2001 – 2004 **Supervisor Kinesiotherapy Section of Physical Medicine and Rehabilitation Service, CAVHCS, AL.**

- Supervised and set the overall goals and resources available for the assignment of the staff
  Supervised staff on consults and reach mutual agreement on deadlines, new projects, and management approaches to work
  Oversaw that the staff be relied upon to coordinate Kinesiotherapy with healthcare professionals in other clinical services

1984 - 2001 **Staff Kinesiotherapist, Section of Physical Medicine and Rehabilitation Service, Tuscaloosa, AL.**

Center, Tuscaloosa, AL. Medical Center, Dallas, TX. Audie L. Murphy Veterans Administration Medical Center, San Antonio, TX. Miami Veterans Administration Medical Center, Miami, FL. Butler Veterans Administration Medical Center, Butler, PA. Montrose Veterans Administration Medical Center, Montrose, NY.

- Administered, scored and interpreted a variety of motor skills tests
- Evaluated the assigned veteran after receiving the physician's orders for therapy and developed specific veteran care plans in accordance with the physician's orders and veteran's ability
- Administered mental and physical tests for veterans with severe or multiple diagnoses to assess treatment options

Licensure and Certification
American Kinesiotherapy Association; The Commission on Accreditation of Allied Health Education Programs (CAAHEP)

Professional Memberships
American College of Healthcare Executives (ACHE).
American Kinesiotherapy Association

Honors and Community Service
Sports Official Alabama High School Athletic Association
Sports Official Texas High School Athletic Association

Central Alabama Veterans Health Care System
Gregory E. Ingram, BS., HSMT
Health Systems Manager Trainee
215 Perry Hill Road
Montgomery, Alabama 36109
334 272-4670 Ext 2353
Training Start Date: July 13, 2004

Identifying Readiness For The Advanced Clinic Access (ACA) Initiative By Medical Service Assistants in One Veterans Health Care System

Description of the Project:

"If we can get a balance between the demand for appointments and the supply of appointments —if we can get, understand, and measure that balance—then we can eliminate waiting times." (Murray,2003)

This practicum was conducted at Primary Care Clinics of two combined campuses of a large integrated health care system in the southeastern United States. The Veterans Health Administration (VHA) has been experiencing increasing wait times for our veterans, from the moment that they have the need to seek services from a VA provider, to the time that they meet with that provider. The Initiative of Advanced Clinic Access (ACA) will lead towards getting the care that the patient needs at the time and place it is needed.

The Department of Veterans Affairs, Veterans Health Administration, a national public sector health care system in the US consisting of 162 hospitals and more than 800 outpatient clinics, developed and implemented, in partnership with the Institute for Healthcare Improvement (IHI), a change model to improve access.

This model consisted of a major system of reorganization and a model to spread Advanced Clinic Access (ACA) throughout the VA. Each element of the model has been developed and continues to be refined and reinforced. The overall goal of ACA is to provide the care that our veterans required at the time and place it is needed. Medical Support Assistants (MSA) are our front-line clerical support staff. They are most often the first person that a patient will see for care. As such, their participation in ACA improvements is essential.

Objectives:
The objective of this project was to identify knowledge and understanding of ACA principles among MSA staff. To accomplish this, the following was performed:

- Conducted a needs assessment to determine the MSA staff's understanding of ACA
- Conducted a comparative data analysis of perceived appointments scheduled per clinic compared to actual appointments recorded in data
- Conducted a poll of the percentage of MSA staff that have a clear understanding of the Priority Scheduling Process which is essential to ACA
- Assessed application of ACA principles of maintaining the team by conducting a poll of the percentage of MSA staff that close out encounters for their providers, a percentage of MSA staff that experience high call volumes at their work stations, a percentage of MSA staff that have a clear understanding of the ACA process, a job satisfaction survey of MSA staff
- Analyze recommendations for improvement as requested by the MSA staff.

Resource Requirements:
Implementation requires training of current staff on understanding of ACA. To facilitate on-going development of the initiative, for the MSA staff, the chief of the Business Office should assign the responsibilities and duties of ACA education to the administrative officer. Time to develop the governing council, policy, procedures will be required. Members of the Health Systems and Communications Customer Service Councils would assume oversight of the initiative as an ancillary duty and would require time to participate in meetings and organizing efforts.

Application Potential in Other Facilities:
According to representatives in VA Central Office, the Advance Clinic Access Initiative is groundbreaking the ACA initiative can be applied to many VA and non VA facilities that experience high wait times, high call volumes resulting in poor satisfaction surveys relating to these and other factors.

Benefits:
Morale, performance, attitude and productivity are among many benefits enjoyed by implementation of ACA by the medical support assistants. The reduction in backlog of appointment scheduling and encounter close outs, the reduction in the demand of our veterans, for services, the MSA staff's greater understanding of supply and demand and reduction in appointment types and how management can predict and anticipate patients needs base on pass performance and provide education to the MSA staff accordingly. Additional benefits include reduced employee turnover, improved quality of care, greater employee satisfaction and ultimately customer satisfaction.

Ruth C. Kirkland
10824 Stallcup Drive
Dallas, Texas 75228
H: (214) 328-2208
W: (214) 857-2111
Cell: (972) 342-1112
Ruth.Kirkland@med.va.gov

PROFESSIONAL BACKGROUND

06/04 to present: Health Systems Management Trainee/
Acting Administrative Officer for Mental Health
VA North Texas Health Care System (VANTHCS), Dallas, Texas

Projects during the HSM program have included:

- Shadowing mock surveyors
- Analyzing and graphing data from the VHA All Employee survey
- Populating an FTEE tracking database for VANTHCS
- ER Utilization study
- Administrative Investigative Board and Root Cause Analysis Team
- Handling command post communication for a city-wide disaster drill

I am also serving as the Acting Administrative Officer for Mental Health Service at VANTHCS, effective January 24, 2005.

11/96 to 6/04: Supervisory Management Assistant, Pathology & Laboratory Medicine, VA North Texas Health Care System (VANTHCS), Dallas, Texas

Supervised nine employees, reporting directly to the Chief of P&LMS, supporting both the Chief and the Administrative Officer. Duties included data analysis, troubleshooting, and process improvement recommendations/ facilitation in the areas of:

- Budget, Finance, and Coordination of contracts
- Employee training programs and recruitment
- Provided specialized data on specific test costs, workload, etc. for budget and workload forecasting

7/92 to 11/96: Medical Transcriptionist, Self-employed

EDUCATIONAL BACKGROUND

8/04 to present: University of Texas at Arlington, M.S. in Health Care Administration. Current GPA of 4.0

1986: University of Texas at Dallas, Bachelor of Science Degree in Business Administration

AWARDS/ MEMBERSHIPS

- Winner of the Leadership VA Alumni Association Exemplary Service Award, 1999 (national award)
- Member, Medical Transcription Program Advisory Board, El Centro College, Dallas, Texas
- Former Customer Service Representative for Pathology & Laboratory Medicine Service, VA North Texas Health Care System
- Awards Action Workgroup, VA North Texas Health Care System (former member)
- Pathology & Laboratory Medicine Service's Quality Assurance/Quality Improvement Workgroup (former member)
- VA Golden Age Games Volunteer, 2001
- North Texas Mensa

VA North Texas Health Care System Dallas, Texas
Ruth C. Kirkland
Health Systems Management Trainee
4500 S. Lancaster Road
Dallas, Texas 75216
214-857-2111
Training Start Date: June 27, 2004

Reducing Outpatient Phlebotomy Wait Times

Description of the Project:

Overcrowding at VA medical centers is a global problem. Some reasons are eligibility reform, unemployment and decrease in private health care benefits, and a shift in focus from inpatient to outpatient services. As a result of increased outpatient workload in VA medical centers, areas such as outpatient phlebotomy are struggling to keep up with the demand.

The outpatient phlebotomy area at the Dallas VA is a prime example of the problems faced at most VAs throughout the country. We have been experiencing increased waiting times within the phlebotomy area for some time now, at times leading to missed clinic appointments and irate patients. Some issues faced in Dallas include physical problems such as a lack of space in the current phlebotomy area to add more phlebotomy chairs (and phlebotomists), and a small waiting area shared with Pharmacy. Some problems are with clinical practices such as clinicians routinely ordering labs regardless of clinical necessity, and the practice of clinics sending most patients to lab in the mornings. One problem is fluctuations in output of phlebotomists. Finally, there are educational concerns on the part of the patients themselves that contribute to the problem. These educational issues include patients coming early due to "first come, first served" lab policy (regardless of actual lab draw appointment time), and the fact that patients needing fasting labs are sometimes told 12 hours of fasting is required, so they show up several hours before scheduled lab appointment. (Actual fasting time for lipid and glucose testing is 8 hours).

Of course, as with any other VA, space and budget are some of the constraints that must be dealt with. There have been numerous discussions involving remodeling/repurposing space in the medical center; unfortunately, all of these proposals involve funding for space, equipment, and ultimately FTE, none of which are readily available in FY05 or FY06. Therefore, we are left with the task of utilizing the space we currently have in the Dallas VA Medical Center.

With this in mind, I began an analysis of lab ordering, scheduling, and patient workflow within the phlebotomy area. I first did a comparison of outpatient phlebotomy workload for the last several years. Examining the data showed an increase in workload of almost 5% from 2003 to 2004, with historical data showing an upward trend over the last few years. Therefore I concluded workload would continue to trend upward. Next, I looked at the causes of the crowding issue through interviews with providers, Pathology & Laboratory Medicine Service staff, MAS personnel, and the phlebotomists themselves. I then analyzed VISTA reports showing the number of lab appointments by date, by hour, and by ordering clinic, as well as a VISTA report showing the number of patients actually presenting to the lab by date and by hour. This data was quite startling, and revealed several problems in lab ordering and draw patterns. For instance, although the maximum number of patients able to be drawn in the lab in one hour is around 60, (based on all nine phlebotomy chairs being fully utilized) patients were being

scheduled by the clinics at an average of 72.8 patients beginning at 6:00 AM when the lab opens, with 60% of the daily workload received between 7:00 and 10:00 AM. It was not unusual to see over 100 patients scheduled for lab draws at 7:00 AM, and another 100 at 8:00 AM. There were virtually no lab appointments scheduled after 2:00 PM, despite the fact that the lab is open from 6:00 AM to 6:00 PM.

Further analysis of this data reveals a few clinics that comprise a disproportionately large portion of the morning lab draws. For instance, on a typical Friday in January, the Hematology/ Oncology clinic alone scheduled 64 patients between 7:00 and 11:00 AM.

Another significant issue in lab scheduling is patients showing up well before their appointment time due to the lab's informal "first come, first served" policy. For example, on one day in November 2004, 46 patients were scheduled to arrive at 6:00 AM; 60 actually arrived at that time, essentially the maximum number of patients that could be drawn in one hour. By 7:00 AM, when 90 more patients were scheduled to arrive, the phlebotomy area was already overwhelmed for the day, with the overcrowding problem compounded each hour. This pattern of patients arriving earlier than their appointment time was repeated daily. With this practice, it was mathematically impossible to process patients through the lab in a timely manner, resulting in some patients being late to their clinic appointment.

Action Plan:
As mentioned above, several proposals are being discussed to remodel/repurpose the current phlebotomy area in order to provide more space. With the institution of these changes, however, it is anticipated that construction costs for new phlebotomy space can be postponed, at least temporarily. In the meantime, clinicians will be asked to review the clinical necessity of routine lab orders, and to consider post-clinic lab draws in order to allow for more even scheduling of lab appointments. Phlebotomy supervisors are closely monitoring the patient flow in order to ensure maximum utilization of labor and space. On February 14, 2005, we began utilizing the Outpatient Radiology dressing room area from 6:00 AM to 9:00 AM as an overflow phlebotomy draw area. This is helping to ease some of the crowding of the main phlebotomy area during peak draw times. On February 15, lab personnel began enforcing the "two hour" lab appointment rule which states that patients will not be seen in the lab any earlier than two hours before their clinic appointment. This change was publicized before implementation, and has received many positive comments from the patients since it began. On February 16, the lab began offering point-of-care phlebotomy draws in the Hematology/ Oncology clinic on Wednesdays and Fridays, further decreasing the crowding in the main phlebotomy area.

Application Potential to Other Facilities:
The Dallas VA may have more phlebotomy outpatients than many VAs, but these changes could certainly be implemented in other facilities, at virtually no additional cost to the facility.

Benefits:
Instituting these changes in policy enforcement, space utilization, and patient/provider education provides for better patient workflow. These few changes have led to a noticeable decrease in phlebotomy waiting room crowding and wait times, from as much as two hours (before changes) to an average of 17 minutes on February 17 (after changes). In addition, the Dallas VA is now able to provide better customer service for patients resulting in satisfied patients and staff, and ultimately, better care for the veterans.

Ericka L. Mattis
4800 Country Lane S512
Cleveland, OH 44121
(216) 896-9370
ELW1022@aol.com

Education

Xavier University, Cincinnati, OH
Master of Health Services Administration, December 2003

Xavier University, Cincinnati, OH
Bachelor of Arts in Liberal Arts, May 2001

Experience

Louis Stokes Cleveland VA Medical Center — Cleveland, OH
Health Systems Management Trainee — Jun 2004-Present

- Acting Administrative Officer, Surgical Services
- Provided key administrative support and assistance to the Chief of staff and the Medical/Surgical Business Manager
- Managed the Surgical Service Fund Control Point
- Responsible for personnel management to include recruitment, promotions, awards, training and disciplinary actions

Louis Stokes Cleveland VA Medical Center — Cleveland, OH
Health Systems Specialist — Dec 2003-Jun 2004

- Liaison between the Chief of Staff and the Medical Staff
- Conducted audits for the time and attendance for over 65 part-time physicians to ensure compliance with VHA Directive 2003-001
- Generated monthly workload reports
- Performed a cost benefit analysis to evaluate the feasibility of opening a Saturday Clinic

Louis Stokes Cleveland VA Medical Center — Cleveland, OH
Administrative Resident — Jan 2003-Dec 2003

- Exercise initiative in the development of goals, their achievement, and the interpersonal relationships to enrich the learning experience
- Actively participate in the development and facilitation of management and clinical program
- Provide necessary staff support

Cincinnati Children's Medical Center — Cincinnati, OH
Data Entry Clerk — July 2002- Jan 2003

- Updated and maintained patient records
- Retrieved and recorded legal documents

University of Missouri Kansas City — Kansas City, MO
Dental School Intern summer enrichment program — June 2001-July 2001

- Proficient with dental morphology
- Participated in and attended various classes in preparation for dental school

Activities

Member, American College of Healthcare Executives, 2003-Present
Member, National Association of Health Services Executives, 2003-Present
Board Member, Women of Wellness, 2004-Present
Member, Delta Sigma Theta Sorority, Inc., 1998-Present
VISIN 10 Strategic Planning Summit Facilitator, 2003
Controlled Substance Inspector, 2003

Skills

Strong project management skills. Proficient in Excel, Power Point and Microsoft Word.
Experience with SPSS and Microsoft Access.

Community

Adopt a Family and Soup Kitchen, August 1997-Present
Assistant Coordinator for the SACRED Steps youth dance team

References

Available upon request

Facility
Louis Stokes Cleveland Department of Veterans Affairs Medical Center

Contact
Ericka Leigh Mattis
Health Systems Management Trainee
10701 East Boulevard
Cleveland, Ohio 44106
216-791-3800 Extension 5892
elw1022@hotmail.com
Training Start Date: June 2004

Title
VERA 10: A Beneficial Management Tool

Background:
From 1985 to 1997, the Department of Veterans Affairs (DVA) has utilized three resource allocation systems; Resource Allocation Methodology (RAM) based on Diagnosis Related Groups (DRG), Resource Planning Management (RPM) and Blended Rates. All three of these systems proved to be ineffective and eventually failed because of their complexity and inefficiencies. They also perpetuated funding imbalances, and were limited in their ability to improve access to care, which ultimately lead to their failure.

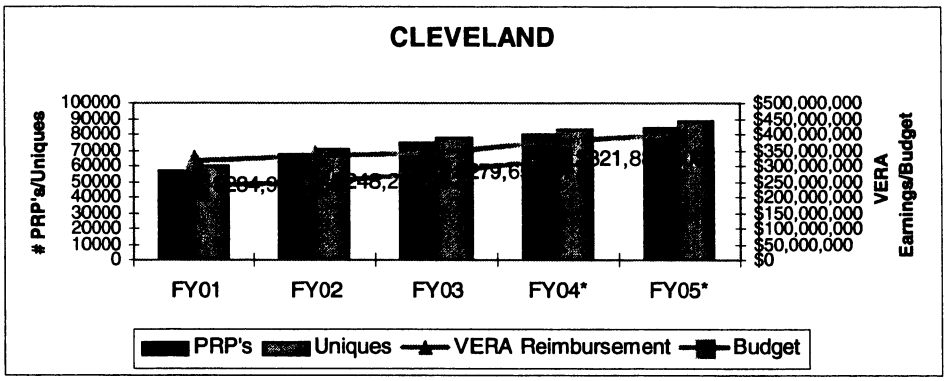
On April 1,1997 VERA was implemented as a simple means for equitably allocating resources across the Veterans Integrated Service Networks (Networks). It was implemented to improve the funding imbalances that resulted from the prior allocation systems, and to simplify the allocation process. It is an allocation system that reimburses each network based on their workload or workload indicators. After resources were allocated to the Networks, the networks were then responsible for designing a process for distributing funds to each medical facility. The objective of VERA is to support the VA's goals of; "treating the greatest number of veterans having the highest priority for healthcare, allocating funds fairly to the number of veterans having the highest priority for healthcare, recognizing the special healthcare needs of veterans, creating an understandable funding allocation system that results in having a reasonably predictable budget, aligning resource allocation policies to the best practice in healthcare, improving the accountability in expenditures for research and education support and complying with the congressional mandate" ("Why VERA" 2000). VERA achieves these goals by identifying and accounting for the fact that the healthcare needs of the patient, the cost and complexity of the VA healthcare system vary across networks.

Objectives:
The primary objective of the project is to present an educational guide that shows that VERA is beneficial to a medical facility that understands and effectively controls its costs.

Planning:
The project began by researching VERA. The immediate tasks were to give an overview of VERA, identify how to understand and control costs, and finally, show how VERA can be beneficial to a medical facility. After several weeks of research and gathering information, an interview was conducted with the Director of the Louis Stokes Cleveland VA Medical Center. It was at that moment that the realization occurred that VERA could only be beneficial to a facility that understands and manages its costs effectively. Several management tools have been created to aid a facility in accomplishing these goals; they are DSS, ARC and the Klfmenu.

Following the interview with the director, the Acting Associate Director was also interviewed. During that interview she acknowledged that although Cleveland earned $377,204,186 under VERA they were only

reimbursed $321,881,000, which is a decrease of $55,323,186. Like wise Columbus earned $75,729,609 however, were only reimbursed $55,085,000. This is due to the fact that it is up to the discretion of the network to determine how funds should be allocated to each facility. The determination was made that if funds were allocated to the facility based on VERA then it would have been a beneficial method of allocation for both facilities.



Development and Implementation:

After determining the scope of the project, three questions were identified and defined to prove that VERA is beneficial to a medical facility that understands and effectively controls its costs.

1. What is VERA?
2. How do you understand and manage cost?
3. Why is VERA beneficial?

After researching, collecting and analyzing data, and interviewing key stakeholders an educational tool was created that provided helpful information on better understanding VERA, managing and understanding costs through the use of DSS, ARC and the klfmenu, and understanding how VERA can be beneficial to a facility.

Resource Requirement:

There are no costs associated with this project. However, some facilities may experience an increase in their operational revenue if their Network office realizes the benefits in the VERA allocation process and allocates funds to their facilities based on VERA.

Application Potential in Other Facilities:

VERA is the methodology that is used to allocate resources to all of the networks within the VHA; therefore, the process of this project is applicable for any facility. However, it is imperative that all facilities understand VERA and the process for allocating funds. Once all facilities have a better understanding of the allocation system, they will then be able to more effectively assess the viability and the potential benefit of allocating funds to both the networks and the facilities based on VERA.

Benefits:

The recommendation from my assessment is that VERA should not only be used as a means for allocating funds to the networks, but funds should also be allocated to each facility based on VERA. Distributing resources to the facilities based on VERA can be beneficial to a facility because:

- Maximize reimbursements by increasing a facilities operational revenue
- Encourages a facility to Vest all patients thus improving quality of care
- Provides the incentives to rationally treat more patients.

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Nickema Moulton

Address: 8003 LakeCrest Dr. Greenbelt, MD 20770 **Phone**: (301) 441-3757 **Email**: nickema.moulton@med.va.gov

PROFESSIONAL EXPERIENCE

06/04- Present **VA Capitol Health Care Network**, Linthicum, MD

Health Systems Management Trainee

- Managed temporary staff in an insurance file clean up (enhanced project management skills)
- Collaborated with department chief to restructure Business Office
- Drafted Medical Center Policy 11-08, Scheduling of Appointments and Consultations
- Co-chaired Beneficiary Travel Committee charged with implementing change to existing system

Acting Outpatient Clinic Coordinator

- Provided program support for Advanced Clinic Access Team; collected and analyzed data to increase clinic availability
- Performed general day-to-day management functions

01/02 – 06/04 **Veterans Benefits Administration**, St. Petersburg, FL

Veteran Claims Examiner

- Processed, analyzed, developed disability claims
- Made administrative decisions and special determinations relating to service, character of discharge, domestic relationships, acknowledged deaths, and corpus of estate
- Prepared correspondences to members of Congress and special interest groups
- Composed Standard Operating Plan and provided training to Triage team members
- Possess knowledge of VA Benefits(disability, death, pension, education, vocational rehabilitation, VA health care, home loans, life insurance, and social security benefits)

06/03 – 08/03 **HCA Patient Account Services,** Nashville, TN

Patient Account Representative-Refund Specialist,

- Interpreted explanation of benefits (EOB) for appropriate refunds on health claims
- Respond to oral and written inquiries regarding refunds
- Worked with training manager to improve Refund Specialist Orientation.
- Updated monthly delinquent insurance claims.

06/00 – 08/00 **Department of Veterans Affairs**, Bay Pines, Fl

06/98 – 08/98 *Intern, Student Career Enrichment Program*

- Participated in implementation processes for Telehealth program; (wrote draft for Teledermatology Proposal)
- Provided clerical support for credentialing (reviewed physician employment packets for completeness) and scheduled pre-employment physicals
- Occupational Therapy-aide

05/99 – 08/99 **Center for Special Surgery**, St. Petersburg, Fl

Assistant, to the Business Office Manager

- Preformed patient pre-certification, registration and scheduling as it applied to day surgery
- Assisted with various tasks associated with insurance verification and billing

EDUCATION

University of Phoenix, May 2004
MBA, concentration in Healthcare Management

Tennessee State University, May 2001
BS, Healthcare Administration and Planning

SKILLS

Microsoft Certified Power User (Word, Excel, PowerPoint), Public Speaking, Veterans Benefits Software (electronic data processing (EDP), Benefits Delivery Network (BDN), CAPS, COVERS, VACOLS and CAPRI/AMIE)

Facility: VISN 5 Capital Healthcare Network

Contact: Nickema Moulton, MBA, Health Management Trainee
849 International Dr. Suite 275
Linthicum, Maryland 21090
(410) 691-7764

Project Title: *VA Revenue: A Look into Increasing Funding*

Description/Background:

The Department of Veterans faces the same challenges in the administration of its healthcare system as do other agencies on their journey to redesign and generate revenue. Both public and private sector health systems face similar challenges in trying to manage the healthcares industry's alarming changes brought on by managed care, cost control, and new care requirement. There are many obstacles that can be identified by the VA: quality mandates, possible reorganization of the entire Department of Veterans Affairs, and the increased number of veterans due to the current conflict. All of these challenges are inevitable and will continuously affect the VA. However, there are revenue generating procedures that have been establish and if implemented can help increase funding at all VA medical centers.

In 1986 Veteran Affairs took on a business process from private sector and Public Law 99-272-The Consolidated Omnibus Budget Reconciliation Act was passed (VA Manual). This law gave the Department of Veteran Affairs the authority to seek reimbursement from third party health insurers for the cost of medical care furnished to insured non service-connected veterans who are treated at the VA. In October 1995, the veterans' healthcare system began to transform itself from a confederation of individual medical centers and clinics focused primarily on inpatient care to a fully integrated system of healthcare delivery. To optimize the beneficial effects from this reform the VA needed to reform the way VHA allocated its funds. Then on April 1, 1997, VA began to allocate Medical Care funds through Veterans Equitable Resource Allocation (VERA) a capitation-based model that supports the VA's commitment to modernize VA healthcare and decentralize operational responsibilities

Objectives:

The purpose of this project is take a look at vesting the lifeline to VERA funding and discuss methods to improve the number of veterans that are vested ultimately increasing the number of dollars rewarded back to the medical center. This project also takes a look into Medical Care Cost Recovery (MCCR) and discusses processes that can be implemented or reviewed to increase billing. With the current budget constraints, it is essential that government organizations, such as the VA know and understand that there are processes that have been establish to increase facility funding independently of other facilities and the budget that has been allocated by Congress.

Planning Implementation /Development and HSMT Role:

In order to increase vesting and generate more funds via MCCR, administrative and clinical staff should have better understanding of the processes and issues that exists with

increasing revenue. As an HSM trainee, I have reviewed the entire VERA process and provided feedback and recommendation to the medical center for improvement. I am an active member of the Vesting Committee and I will chair the responsibilities with our compliance office to monitor vesting. In concurrence with tracking vesting, I have brought on three temporary Insurance Verifiers to assist in cleaning up the insurance file which currently houses over 2700 insurance companies, many of which are duplicate entries.

Vesting

- Providers need to educated on the VERA reimbursement process; providing complete a History and Physicals on ALL new patients, follow-up patients and same day/urgent patients that have not received an H&P in the last three years
- Active Reminders in CPRS alerting the clerk and provider that the PATIENT NEEDS VESTING EXAM
- Assign Vesting; each facility needs to establish a monitoring process to track the number of patients that are not being vested and why.
- A course of action needs to be in place to ensue that veterans that have not been seen at the medical center are notified that they need a H&P

	Non-Vested Patients	**Current Vera Revenue**	**Potential Vera Revenue**	**Difference**
Washington DC VAMC	3,396	$669,013	$10,598,916	$9,929,903

MCCR

- Producing clean bills.
- Decreasing insurance denials resulting from preadmission penalties, expired filing-time limits and non-covered services.
- Decreases the number of canceled bills.
- Decreases the number of rejects in preparation for the upcoming national Electronic Data Interchange (EDI) contract, and to ensure appropriate coordination of benefits (COB).
- Perform an insurance file clean-up.
- Enhances the use of auto-biller and claims tracking utilization functionality.

Anticipated Costs, Benefits and Outcomes

There are no significant costs to implement this project that will not be recouped as a result of these efforts. This project requires total support from the Business Office and key staff from MCCR. Additional temporary staffing may be required for the insurance file clean- up if your facility can not allocate in house staff for this project. The medical center has to be willing to provide the appropriate vesting staff (physicians, physician assistants, nurse practitioners, clinical nurse specialist, etc...) informative training for them to realize how important vesting is, and the benefits will be great.

Potential Applications to other Facilities:

The potential application to other facilities is evident. The VERA model and MCCR processes are nationwide. Presentation and training manuals already exist. The utilization of existing tools and monitoring devices can only help each facility increase their revenue.

Sherry N. Williams

3020 Otter Court
Augusta, Georgia
(706) 650-2498
Sherry.Williams3@med.va.gov

EDUCATION

Troy State University
Master of Science in Management
Concentration: Healthcare Management
December 2003

Norfolk State University
Bachelor of Science, Exercise Science
Graduated Cum Laude
December 1995

PROFESSIONAL EXPERIENCE

2004-Present Health System Management Trainee
VA Medical Center, Augusta, GA

- Acting Business Manager, Mental Health & Geriatrics
- Analyze and evaluate operations and procedures
- Participate in root cause analysis
- Ensure service line compliance with VHA Directives
- Provide written correspondence to congressional inquires
- Instructor, Prevention and Management of Disruptive
- Controlled Substance Inspector

2002-2004 Computer Access Instructor
VA Medical Center, Augusta, GA

- Served as Care Manager for patients
- Provided computer training for legally blind patients

1997-2000 Registered Kinesiotherapist
VA Medical Center, Augusta, GA

- Developed rehabilitation/exercise program for patients.
- Developed a unit based wellness program for Dementia and Mental Health patients.

PROFESSIONAL MEMBERSHIP

Member of Toastmasters, Club 8918 District 14
American College of Healthcare Executives
American Kinesiotherapy Association

Facility: VA Medical Center, Augusta, GA
Contact

Sherry N. Williams, MSM, Health System Management Trainee
1 Freedom Way
Augusta, GA 30904
(706)733-0188, ext. 6451
Training Start Date: 6/28/04

Project Title: Resident Assessment Instrument/Minimum Data Set: Process for Improvement

Description/Background:

The Resident Assessment Instrument is a standardized assessment tool used in long-term care facilities. The Resident Assessment Instrument (RAI) allows staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. The assessment instrument facilitates an interdisciplinary approach, involving many disciplines such as social work, dietary, nursing, occupational therapy and others. The information within the RAI/MDS should coincide with the individualized care plan, which has proved to be more of a challenge than expected by most clinicians. The assessment has a direct correlation with funding; late assessments negatively impact the facility's reimbursement. The resident assessment instrument is also useful in monitoring the quality of care provided to nursing home residents. Quality indicators are ratings which reflect the quality care received.

Objectives:

To review facility policies, procedures and training programs pertaining to the RAI/MDS for opportunities for improvement. One of the goals of the project is to improve the MDS quality indicator scores and performance measures thus mirroring the high level of quality of care received in the nursing home care units. Providing accurate and consistent documentation has proven to be a challenge in many long-term care facilities. The lack of a solid process and system in place can be detrimental to reimbursement and the overall success of a program. The goal of this project is to address the following issues: policies and procedures, late assessments, inconsistency in documentation, and improving quality indicator scores.

Recommendations:

- Designate two registered nurses from each nursing home care unit (NHCU) to assume responsibility for their assigned areas
- Designated staff will be the point of contact for the facility MDS Coordinator
- Developing a training module for staff to include nurse managers, unit clerks and others

- Editing and modifying the facility policy
- Explore the possibility of utilizing an employee on light duty status to assist the MDS Coordinator in data collection and analysis.
- Ensure compliance of 7 day observation period
- Increasing communication

Potential Application to Other Facilities:

The potential application of this concept could prove beneficial to other facilities. This project addresses the challenge from team aspect rather than individual approach. All long-term care facilities including VA and Non-VA facilities are faced with the task of completing this assessment, which is proven to be complex in nature. Establishing a best practice and having the opportunity to share it will be extremely rewarding for all involved.

Anticipated Costs, Benefits and Outcomes:

Implementation of this project would not require any additional cost. The primary commodity required is openness to change. The benefits achieved from this process change are as following: (a) prevention of late assessments (b) consistency in documentation (c) Quality indicators below the 75th percentile and (d) Improved performance measure outcomes. Employees with the responsibility of documenting in the MDS will receive specialized training aimed at improving the consistency in documentation. In addition the presence of the RAI/MDS Coordinator at the team meetings will be instrumental in facilitating the process of improvement and identifying discrepancies in the care plan and MDS data. The 7-day observation period and 14 day timeframe for completion will be monitored and adhered too. The facility policy will mirror the VISN policy eliminating any stringent standards that are not required thus increasing probability of success and improved quality indicator ratings. The assessments will be monitored closely for compliance with VHA Directive, and to avoid the potential of late assessments. Implementation of this proposal will greatly contribute to the overall quality of care received and have a positive effect financially as well.

Personal Contribution:

I am assisting the MDS Coordinator in revising the facility policy. I am also a member of the Augusta Revenue Council where I am tasked with the responsibility of monitoring the reimbursement for patients within long-term care. The highest reimbursement for critically Ill is $53,900; however, when the assessment is late the reimbursement rate drops to the Low ADL patient class which is $12,000.

LAURIN M. WORD

3429 N. Druid Hills Road Apartment O
Decatur, GA 30033 **(404) 636-6046-(H)**
email address: lmword@msn.com **(773) 469-1763-(M)**

PROFESSIONAL EXPERIENCE

June 2004-Present **Atlanta Veteran Affairs Medical Center** **Decatur, GA**

***Health Systems Management Trainee*-Assigned to Director and Executive Assistant**

- Served as Acting Administrative Officer of the Mental Health Service Line from July 2004 to December 2004
- Developed Mental Health Service Line FY05 budget
- Served in the absence of Executive Assistant to the Director
- Served on FY05 Clinical Summit Planning Committee
- Participate in executive leadership committee meetings

July 2003-June 2004 **VA Sunshine Healthcare Network,VISN 8 Office** **Bay Pines, FL**

***Health Systems Specialist Trainee-Administrative Fellow*-Assigned to Chief Operating Officer and Chief Planning Officer**

- Examined the revenue cycle of the Network observing processes at each level, made recommendations and developed action plans to implement proposed changes
- Created a VISN-wide draft policy on how to properly Credential and Privilege medical and other practitioners providing clinical Telehealth services encompassing the new 2004 JCAHO standards
- Conducted marketing and market research on the city of Orlando to determine the feasibility and cost-effectiveness of building a new medical center in the city
- Worked with Chief Planning Officer on Capital Assets Realignment for Enhanced Services (CARES) and Baldrige National Quality Initiatives
- Participated in network budget development
- Participated in executive leadership committee meetings

January 2003-June 2003 **Abbott Services** **St. Louis, MO**
(largest privately owned ambulance company)

***Administrative Intern*-Assigned to Director of Billing and Claims Administration**

- Computerized productivity measures for billing invoices, insurance claims, and collections
- Analyzed productivity volume for staffing patterns and submitted reports to department director

May 2002-August 2002 **Nebraska Methodist Hospital** **Omaha, NE**
(a 430-bed acute care hospital)

***Summer Intern*-Assigned to the Vice President of Patient Care Services**

- Cataloged and correlated physician routine order sets
- Aligned performance improvement policy with risk management policy
- Evaluated the process for coordinating family and visitors for the city-wide disaster drill

EDUCATION

August 2001-May 2003 **Saint Louis University** **St. Louis, MO**
Master of Health Administration

August 1997-May 2001 **Xavier University of Louisiana** **New Orleans, LA**
Bachelor of Science
Speech Pathology with a minor in Business Administration

SKILLS

Proficient in Microsoft Office Applications
SPSS-Statistical Package for Social Sciences

PROFESSIONAL AFFILIATIONS & AWARDS

Recipient: Saint Louis University-School of Public Health-Ignation Scholarship for Excellence
Affiliate: American College of Health Care Executives
Participant and Finalist: National Association of Health Service Executives-Student Case Competition
Member: Alpha Kappa Alpha Sorority, Incorporated

Facility Name

Atlanta VA Medical Center

Contact

Laurin M. Word, MHA
Health Systems Management Trainee
Atlanta VA Medical Center
1670 Clairmont Road
Decatur, GA 30033
(404) 321-6111 ext. 6771
Laurin.Word2@med.va.gov

Training Start Date: June 28, 2004

Project Title

Compensation & Pension Program-Department of Defense Separation Physical- "ONE EXAM"

Project Description

Introduction

In the past, separating from the United States military was not an easy task. Before a service member could separate or retire, they would have to meet Department of Veteran Affairs (VA) and the Department of Defense (DoD) requirements by completing duplicate separation examinations. The VA required the service member to complete a Compensation & Pension (C&P) examination in order to determine their degree of disability, while the military services required the service member to complete a medical assessment consisting of a questionnaire and a physical examination[1].

Since 1998, the VA and DoD have partnered to establish a single examination program that would fulfill both the requirements of the VA and DoD. To help accomplish this goal, in November 2004, the VA Deputy Secretary, Gordon Mansfield, and the DoD Under Secretary for Defense Personnel and Readiness, Dr. David S.C. Chu, signed a national Memorandum of Agreement (MOA). The MOA contains a specific implementation goal that by December 31, 2004 the VA and the military services should establish single separation examination programs at military installation sites that have Benefits Delivery of Discharge (BDD) programs. It moreover states that once a Memorandum of Understanding (MOU) is implemented at local medical centers and military sites, the MOU will continue to be honored when there are changes in leadership from either side.

Having the service member complete duplicate separation examinations within months of each other is inconvenient, delays access to VA healthcare, to the claims process and to disability compensation. This project will clarify the benefits of establishing a single separation examination program at BDD sites that would meet both the VA and military requirements.

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[1] United States Government Accountability Office. (2004). VA and DoD Health Care: *Efforts to Coordinate a Single Physical Exam Process for Servicemembers Leaving the Military.* (Publication No. GAO-05-64). Washington, DC: U.S. Government Printing Office.

Purpose

In an effort to simplify the redundancy of the separation examinations and to streamline the process for service members who are filing a VA claim, in 1994, both the VA and the military decided to initiate a pilot program that would coordinate their respective examination processes. This pilot program was called the "Separation Examination Test." The test sites included three Army installations, three Veterans Health Administration (VHA) Medical Centers, three Veterans Benefits Administration (VBA) Regional Offices, and the VA Records Management Center. As reported by the United States Government Accountability Office in their 2004 Congressional Report, the VA and Army concluded that their pilot program could consist of one physical examination designed to meet both the military services' requirements for service members leaving the military and the VA's requirements for determining disability. In addition, it was concluded that such a program would encourage a more efficient use of VA and military resources, improve the timeliness of disability claims processing, and offer convenience to service members.

Objective

The main objective of this project is to clarify the benefits of establishing a single separation examination program that would meet both the VA and military requirements.

Planning/Methodologies

The project involved historical research on the VA and the DoD requirements for separation or retirement from the military. Further research was conducted using personal interviews and an on-site visit at Fort Benning, Georgia to discuss separation procedures with the supervisor of physical exams.

Resources Required for Implementation

The most important resource required for implementation is support, commitment, and time from senior level management from the VHA, DoD and VBA.

Projected Outcomes and Benefits

The benefits of establishing a single separation examination program at BDD sites are:

- Joint VA/DoD initiative
- Service members' complete one examination for VA and DoD
- Service members' are given timely access to VA healthcare
- Service members' receive their disability compensation in less than six months
- Service members' medical records can be accessed electronically
- Cost sharing between VA and DoD

Application Potential at Other Facilities

Based on an initiative developed in the VA and DoD Joint Strategic Plan under the Joint Executive Council (JEC), a national MOA was signed by the VA Deputy Secretary and the DoD Under Secretary for Defense Personnel and Readiness in November 2004. The national MOA requires the two departments to implement a cooperative separation process/examination at all existing BDD sites and creates a framework for implementing this agreement at future BDD sites.