

Healthcare Quality and Patient Safety

Facility: Naval Hospital Camp Pendleton

Title of Project: Cervical Cancer Screening Optimization

Summary: For 2017 the American Cancer Society estimates that 12820 new cases of invasive cervical cancer will be diagnosed resulting in approximately 4210 female deaths. Early detection is vital for successful treatment. During the months of June July and August 2016 the San Onofre Branch Medical Clinic 52 Area Branch Medical Clinic part of Naval Hospital Camp Pendleton NHCP averaged a 58.67% screen rate among the patient population pool. This translates to a Healthcare Effectiveness Data and Information Set HEDIS ranking at the 10th Percentile indicating that the needs of over 41% of the population pool 314 patients were not being met. This process improvement project involved the San Onofre clinic with the objective to increase the Cervical Cancer Screening HEDIS Performance Measure from the 10th to the 75th Percentile by 1 Jan 2017. In addition the clinic sought to increase its ranking among the thirteen NHCP clinics from 13/13 to 6/13 ultimately becoming the top performing clinic. By 1 Jan 2017 the San Onofre clinic reached the 75th percentile and shortly thereafter surpassed the 90th percentile due to the new improvements. The incredible success of this project resulted in process replication to additional HEDIS screening measures within the 52 Area clinic as well as other separate NHCP clinics.

Facility: 99th Medical Group – Nellis Air Force Base

Title of Project: Enhanced Recovery Program

Summary: In 2009 our hospital enrolled in the American College of Surgeons ACS National Surgical Quality Improvement Program NSQIP a nationally validated program to measure and improve surgical care. For 18 months all-case surgical data indicated our facility was an outlier for surgical site infections SSIs and rated in the 10th decile bottom 10% of all NSQIP enrolled hospitals for this metric. Our objective was to reduce SSIs and improve surgical outcomes. The NSQIP Surgical Clinical Reviewer SCR and NSQIP Surgeon Champion SC conducted an in-depth review of our NSQIP data and devised a pilot test using modified Duke University protocols for colorectal surgical cases. SSI rates showed initial improvement and our facility stratification improved from the 10th to the 6th decile. The SCR and SC coordinated an expanded effort and constructed a hybrid plan for improvement. The plan utilized parts of the ACS Enhanced Recovery After Surgery ERAS practices and components from the Duke University Protocol for colorectal surgeries. A multi-disciplinary team was assembled that included leadership engagement to implement new standardized surgical processes. Progress was measured using data extracted from patient interviews electronic health records and NSQIP reports. Our MTF is now rated as an exemplary performer and is in the top 10% or 1st decile for SSIs for all NSQIP enrolled sites. All-case surgical morbidity return to OR cases and patient readmissions metrics also improved. In conclusion this surgical quality improvement project demonstrates how data can be used to identify trends and goal-focused champions can lead team initiatives that improve care preserve key resources and foster AFMS Trusted Care goals of zero harm and patient centered care.

Facility: Walter Reed National Military Medical Center

Title of Project: High Value Cost Conscious Care: Optimizing the Electronic Medical Record to Reduce

Summary: Health care expenditures in the United States are the highest in the world comprising 17.8% of the gross domestic product. Laboratory test overutilization is a major contributor to wasted costs with 16 to 40%

of lab orders estimated to be clinically unnecessary or redundant. This issue negatively impacts patient care and health care spending within our institution and the MHS as a whole. The overall goal of this initiative was to sustainably improve delivery of high-value health care to our patient population and promote a culture of cost-consciousness amongst providers. Specifically we designed a novel multi-intervention systems-based approach utilizing the electronic medical record EMR to reduce ordering of clinically unnecessary laboratory studies that add little value to patient outcomes. Between 2014 and 2017 three sequential modifications to the ordering interface in the EMR Essentris were implemented. Data on number of common laboratory studies on the inpatient internal medicine service at our institution were collected over a two-month period following each intervention. Inpatient bed day IPBD data were used to adjust for variations in hospital census. The primary outcome was number of labs/IPBD in a two-month period compared to prior years with secondary outcome of associated cost reductions. Between 2014 and 2017 the number of labs/IPBD in a two-month study period decreased from 4.99 to 3.26 IRR 0.65 95% CI 0.64 to 0.67 p 0.001 due to cumulative effects of the three serial Essentris interventions. This overall reduction of 34.6% corresponds to estimated cost savings of up to \$1.25 million. Our sequential interventions resulted in major and sustainable reduction in unnecessary laboratory studies. Modification of the EMR to limit automaticity and promote clinically appropriate laboratory ordering is a no-cost strategy that can be easily implemented throughout the MHS leading to significant cost savings and improved value of care.

Facility: Fort Belvoir Community Hospital

Title of Project: Improve Sterile Instrument and Process Handling

Summary: Exposure to a patient with unsterile or defective instrumentation unit is a huge concern to any Military Treatment Facility MTF. Despite its state of the art equipment the MTF has been operating at 8% defective unit rate since the hospital became operational in 2011. In order to provide the best care for the facility's patients the Sterile Processing Department SPD Process Improvement initiative was launched. Basically the goal of the project is to improve sterile instrument process and handling in order to reduce defects within the process. With an initial team of seven the mandated was to improve the Sigma Quality Level SQL of the current process from 2.9 to 3.4. The inefficiencies of the current process included ineffective quality assurance QA practice irregular decontamination practices lack of defect monitoring non-value-added process step lack of regular in-service training and quarterly training reviews. To achieve our objectives the previous QA scorecard was modified to reflect existing challenges and needs. A QA subject matter expert SME was identified and set about to retrain all personnel and ensure standardization of the process throughout the various shifts within SPD. The same approach was used to effectuate the decontamination aspect of the process. In addition to these steps wrapped instrumentation units were placed on transport trays prior to sterilization as opposed to after sterilization to reduce wrapper tears and contamination of units. All these factors helped to achieve an improved sigma quality level of 3.35 which represents 98.5% of the process goal. Since this is the first green belt process improvement project within the SPD department this success rate establishes a solid foundation for quality surgical care for both the current and future patient population. Although there was some financial commitment the project only focused on operational benefits since much of the spending was planned prior to initiation of this project. The positive results of this project imply that improving sterile instrument process and handling requires commitment from staff and leadership to ensure continuous high quality.

Facility: David Grant Medical Center

Title of Project: Implementation of an Enhanced Recovery after Surgery Program to Reduce Surgical Complications

Summary: Our facility has been using NSQIP data for 7 years now and while we have been able to make specific improvements in limited areas such as UTI rates we have been troubled by persistently high rates of readmissions OR 1.22 10th decile and readmissions OR 1.77 10th decile high outlier. To address this we designed a multi-phase multi-disciplinary program to directly address both by means of a robust Enhanced Recovery After Surgery Program. We custom-tailored this program to the highest-volume surgeries performed at our institution using current evidence-based best practices. We also noticed that many cases which were listed as reoperations were in fact planned multistage surgeries and that many readmissions were for less than 24 hours. We addressed both by educational programs on proper documentation and admission status orders. The result based on on-demand report for 2017 shows reoperation rate of 2.07% CI 1.4-2.8% OR 0.89 and readmission rate of 5.19% CI 4.06-6.46 OR 1.09. Our site was also one of only two in the DoD to receive the Meritorious Outcomes ACS NSQIP Hospital Award given to the top 10% of NSQIP participating sites nationwide and we are primed to repeat this performance if current trends hold.

Facility: Brian Allgood Army Community Hospital

Title of Project: Increase HEDIS Low Back Pain Imaging Compliance at MEDDAC-K

Summary: Brian Allgood Army Community Hospital BAACH in June 2016 was 80.1% in the Healthcare Effectiveness and Data Information Set for low back pain imaging with 12 month rolling average of 77.35%. The NCQA CY2016 90th%tile benchmark is 83.2% and 75th%tile is 80.2%. This poor performance has a negative impact on exposing patients to unnecessary harms radiation exposure and increases healthcare costs. A team consisting of the Population Health Nurse physician champion and radiology worked together using the A3 8 Step Practical Problem Solving Method to measure determine root causes develop solutions and implement solutions. Solutions that were incorporated by BAACH to achieve 85.43% by March 2017 a total change of 8.45% included mistake proofing the process by involving radiology in ensuring the providers documented in accordance with Low Back Pain Clinical Practice Guideline in the radiology order a provider compliance scorecard and patient and provider education.

Facility: USAMEDDAC Ft. Stewart/Hunter Army Airfield

Title of Project: Winn Army Community Hospital Clinical Improvement of Low Back Pain

Summary: In 2013 the Low Back Pain LBP Clinical Practice Guideline CPG was chosen for implementation based on its impact on Soldier readiness and the associated costs. A Team was formed to assess the VA/DoD LBP CPG against current practice using focused review. The Military Health System Population Health Portal MHSPHP was used as the primary data source. The MHSPHP provides reliable and continuous monitoring of the use of LBP imaging which reflects appropriate treatment. At that time the organization's HEDIS performance for No Low Back Pain Imaging was below the 10th percentile. The Team identified gaps in provider knowledge regarding treatment of LBP and inappropriate use of imaging. In early 2014 Radiology and Physical Therapy PT provided numerous educational sessions to Army Medical Home AMH staff to address the knowledge deficit. Based on the literature review the Team concluded that early PT supports positive outcomes with decreased utilization of unnecessary services. In September 2014 a PT was embedded in one Soldier Centered Medical Home SCMH as a pilot to address acute musculoskeletal injuries provide early therapy and decrease unwarranted imaging. The SCMH's baseline performance was in the 10th percentile and

steadily increased to the 90th percentile by July 2015. In November 2015 the Chief of Radiology created a Standard Operating Procedure SOP for LBP Imaging by which requests were cancelled that did not meet criteria. In addition visible Command support further assured success of the project. Based on the success of this initiative PT was embedded within two other satellite clinics with the following results: Child DMIS A of which the pilot SCMH belonged 90th percentile by May 2016 Child DMIS B 90th percentile by October 2016 Child DMIS C 75th percentile by March 2017 Child DMIS D & 90th percentile during 2017

Facility: Health Net Federal Services LLC

Title of Project: Improving Colorectal Cancer Screening by Mailing Fecal Immunochemical Testing (FIT) Home Screening Kits to Beneficiaries

Summary: In 2014 the Military Health System Population Health Portal MHSPHP indicated over 30% of civilian TRICARE PRIME adults in the North Region were not current for colorectal cancer CRC screening despite active beneficiary and provider outreach since 2011. Objective. To impact the overall CRC screening rate in the civilian PRIME TRICARE-North population by sending established evidence-based fecal immunochemical testing FIT kits to beneficiaries due for screening which could be mailed directly to a lab for processing. Working with a lab vendor's pre-set program we provided over 20000 beneficiaries with InSure FIT kits between January and March in each of three consecutive years 2015-2017. Appropriate exclusions were applied to accurately identify the population due for screening. Beneficiaries and providers were notified of the upcoming programs via newsletters and articles on the website. We collaborated with our claims vendor partner to ensure smooth claims processing and reporting. Participation was tracked throughout and reminders were sent to beneficiaries during the three programs. All participants were mailed their test results and those with positive results were also called to encourage the need for follow-up care/evaluation. Positive lab results were shared with the beneficiaries PCMs. Participation was robust in all three years: 5222 20% 4973 20% and 5481 24% which compare favorably to the vendor's database average of 10-15%. Detected rates % of participants screening positive were 8.5% 7.0% and 12.2% which is comparable to the vendor's database average of 7.2%. The North Region's civilian PRIME CRC screening rate based on the MHSPHP increased +5.15 percentage points after FIT I +0.67 percentage points after FIT II and N/A after FIT III. We successfully delivered three iterations of an evidence-based prevention intervention to a large TRICARE population which resulted in robust participation levels and noteworthy improvements in CRC screening rates.

Facility: Naval Hospital Pensacola

Title of Project: Improve HEDIS Antidepressant Medication Management

Summary: The National Committee for Quality Assurance established a benchmark for the quality of antidepressant medication adherence for adult patients newly diagnosed with depression using Healthcare Effectiveness Data and Information Set HEDIS methodology. In 2014 the performance by the Military Treatment Facility MTF had decreased to the 50th HEDIS percentile for acute phase 84 days and to below the 25th HEDIS percentile for continuation phase 180 days. To increase the quality of antidepressant medication management AMM a proactive standardized process was initiated and implemented over nine months with a goal to achieve the 90th HEDIS percentile for both phases of AMM. To allow earlier identification of patients newly diagnosed with depression started on medication a database was created by the informatics department. A designated clinic champion reviewed each case for appropriate diagnosis of depression provided clinician feedback at time of prescribing and contacted patients by phone to ensure medication

adherence effectiveness and tolerability. This process was initially implemented in a large medical homeport clinic that included over 50% of the health system's patients falling within this measure. Over 16 months this standardized process increased medication adherence from 50th to 90th HEDIS percentile in acute phase and from 25th to 90th HEDIS percentile in continuation phase of treatment. The improvement was sustained over the following nine months once the goal was achieved. This initiative was reproduced in all other medical homeport clinics within the health system and has demonstrated progressive increases in patient adherence. A similar proactive process would be beneficial and easily implemented in other primary care settings for effective treatment of depression.

Improved Access

Facility: 15th Medical Group – Hickam Air Force Base

Title of Project: Partners in Care Program

Summary: Partners in Care is a program designed to educate beneficiaries on common medical ailments and ultimately promote self-care or home health care. By providing valuable education as well as tools and resources to beneficiaries develop health self-awareness are empowered to prevent illness and become active partners with their health care team. Graduates of the class receive privileges to obtain free over the counter OTC medications from the clinics pharmacy for both themselves and their family members. This practice successfully avoids many unnecessary clinical appointments. On average the program saves 45 clinical appointments monthly. In 2016 Partners in Care taught 471 enrollees decreased demand for acute appointments by 539 and saved the facility \$148080.00 in health care costs See Attachment 1. The program increases patient and provider satisfaction and decreases work and school days lost. Through simple education Partners in Care empowers the enrollee: Participants feel more confident self-treating minor illnesses and injuries and successfully managing their own health care.

Facility: Colorado Springs eMSM

Title of Project: Access to Care

Summary: The Colorado Springs Military Health System CSMHS also known as the Colorado Springs Enhanced Multi-Service Market eMSM consists of three parent Military Treatment Facilities including Peterson Air Force Base Medical Clinic Primary Care and limited Specialty Care United States Air Force Academy Clinic Ambulatory Surgical Center and Evans Army Community Hospital EACH; Community Hospital. Additionally the CSMHS has seven other child clinics to include but not limited to two Community Based Medical Homes Solider Centered Medical Homes a Cadet Clinic Schriever Air Force Base Clinic and various other smaller outposts. The CSMHS has initiated numerous Market-wide initiatives to support the effective delivery of quality safe healthcare to the Colorado Springs region. In an effort to optimize access to care for its 123000 Prime enrolled beneficiaries and 170000 total eligible beneficiaries the CSMSH implemented three major programs including utilization of float providers to cover Primary Care Manager PCM gaps implementation of an Extended Hours Clinic in the Northeast sector of Colorado Springs as well as leveraging various contracted Specialty Care Providers in order to help satiate patient demand for highly sought-after clinical specialties. These three strategies laid the foundation to ensure CSMHS beneficiaries receive timely access to primary care and specialty care within the direct care/military healthcare system. Moreover the ability to create access to meet the cascading demand of the patient population improved our providers clinical currency by ensuring primary care channels remained open to feed patients into our specialty care product lines reduced private sector costs and generated a feeling of trust in our healthcare system for our patients. The CSMHS leadership continuously measures the success of these Market initiatives through weekly product line reviews in which leadership is presented data demonstrating the resulting increase in direct care productivity/workload decrease in purchased care/network leakage and showing the cost benefit analysis/return on investment for implementing these access strategies. Since implementing these Access to Care Initiatives we have seen a 3.3% increase in primary care patient satisfaction and a 9.8% surge in inpatient satisfaction and have avoided over \$2.7M in purchased care costs.

Facility: Walter Reed National Military Medical Center

Title of Project: Dispensing Pharmacists Prescribing Naloxone for Patients at Risk of Opioid Overdose

Summary: Opioid overdose is the leading cause of injury-related death nationwide. Since 2000 over half a million people have died from an opioid-related overdose including 33091 people in 2015 alone 12.

This number has been steadily rising over the past decade and has tripled since the year 2000. More people now die from an opioid overdose than from motor vehicle accidents annually 2. To combat this epidemic the Centers for Disease Control CDC Veterans Administration/Department of Defense VA/DOD Substance Abuse and Mental Health Services Administration SAMHSA and the American Medical Association AMA all support providing naloxone as a reversal agent to patients at risk of opioid overdose 3456. As evidence of its effectiveness naloxone administration by non-medical persons has saved the lives of over 26000 people since 1996 2. The Naloxone Project was initiated through collaboration between the Anesthesia department and the Pharmacy department in October of 2016. The goal of this project was to improve patient safety by providing naloxone to individuals that had a higher risk for opioid overdose based on their morphine equivalent daily dose MEDD. The process to achieve this goal was three-fold. First we educated pharmacists regarding naloxone prescribing. Second pharmacists were given the authority to prescribe naloxone. Third Pain Management/Anesthesia clinical pharmacists prescribed naloxone for those patients that were missed. In order to make the naloxone prescribing successful it was necessary to adjust our processes to overcome patient resistance and support the pharmacists workflow. Before initiation of the Naloxone Project eleven naloxone prescriptions had been written. Seven months after initiation of the project 246 prescriptions had been prescribed for patients at risk. This demonstrates that naloxone prescribing by dispensing pharmacists has a significant impact on the number of patients who receive the medication.

Facility: Madigan Army Medical Center

Title of Project: Decrease Preoperative Appointment Duration at MAMC

Summary: Since January 2016 the Madigan Army Medical Center Surgical Services Center preoperative appointment duration average is 102.3 minutes and the scheduled appointment duration is 90 minutes. Exceeding the allotted appointment duration leads to increased patient wait times decreased patient and staff satisfaction decreased patient capacity and increased clinic/hospital cost. The goal of the project was to decrease the average appointment duration from 102.3 minutes to 90 minutes or less. Solutions included mobile blood draws in each exam room utilization of Vocera for increased communication modification of appointments schedule visual controls for each exam room teleconference appointments for healthy patients streamlined patient packets for referring clinics with education for clinic staff and reducing non-value added steps overprocessing. Solutions led to a 40% decrease in average appointment duration from 102.3 minutes to 61 minutes and a 6-year projected cost avoidance of \$445K.

Facility: US Naval Hospital Okinawa

Title of Project: Liaison Naval Officer Program

Summary: Mental health affects readiness and often requires specialty services. USMC medical officers MO face unique challenges in assessing medical readiness due to geographically disparate units that maintain high operational tempo with high turnover rates. Limited communication between MOs and Mental Health MH providers impinges upon ability to monitor patient safety of patients who are unfit for duty. The objective was to develop a method to improve communication between services and increase early interventions to reduce suicides among USMC services members stationed in forward-deployed units across Okinawa Japan. The new Liaison Naval Office Program was developed to fill the identified gaps. Resulting increases in communication education and same day appointment availability have decreased associated Emergency Department visits by 56% inpatient psychiatric hospitalizations by 21% and no reported suicides in tracked patients.

Facility: 87th Medical Group – McGuire Air Force Base

Title of Project: Access to Care Improvement

Summary: In 2015 this Medical Group MDG became the sole single-service operated medical clinic supporting 17000 enrolled Tri-Service patients and 68000 eligible TRICARE beneficiaries at the only Tri-Service

Joint Base in DoD. As appointment availability grew to greater than 1.5 days for 24-hour appointments and greater than 8 days for future appointments the Medical Group embarked on an Access to Care improvement initiative and fully embraced the Patient-Centered Medical Home PCMH model of care delivery. To enable the transformation and guide tactical and operational goals MDG leadership re-energized a multi-disciplinary Access to Care Working Group ATCWG. Their first objective was to improve access and continuity of care. The group analyzed one year of historical call volume data to calculate appointment demand by day and type. They then implemented aggressive template management practices and concurrently eliminated cross-booking at the appointment line level to incentivize providers to proactively manage their patients. The goals of this objective were measured through the Third Next Available Appointment TNA and PCM Continuity metrics available from the Military Health System MHS Dashboard. Their second objective was to optimize the available resources to effectively meet population needs. For this objective the group leveraged the skills of all assigned personnel. This resulted in the augmentation from four specialist services to our primary care teams. As a result the Medical Group reached new ATC heights of less than .6 days to a 24-hr and less than 4 days to a future appointment and maintained those access standards throughout the year with the exception of the summer transition months of July August and September. These rates were consistently #1 in Air Mobility Command and scored as high as #1 in the Air Force and #3 among all DoD facilities. These results support our conclusion that the overall initiative was a resounding success.

Facility: 14th Medical Group – Columbus Air Force Base

Title of Project: Importance of Continuous Process Improvement

Summary: In FY16 the executive staff's strategic plan focused on optimizing access to care. The Medical Group was successful in improving access while increasing patient satisfaction. Our team focused on four main objectives: embedding specialty provider positions like behavioral health optimization program manager BHOP and Health Promotions in the patient care areas implementing support staff protocols SSP for walk-in care decreasing patient wait times through the walk-in return to fly clinic RAC and improving social media outreach. A few months after implementation access to care statistics began to improve. Appointment availability Primary Care Manager PCM continuity and direct care walk in services all increased while the third next available appointment rate and emergency room and urgent care utilization rates began a positive downward trend. Following the basic principles of Continuous Process Improvement CPI and a High Reliability Organization HRO the executive staff's FY17 strategic plan shifted to not only maintaining the aforementioned improvements but continuously reviewing and improving those processes. This year the Access Management Working Group focused on fine-tuning workflows and identifying additional areas for improvement within last year's focus areas. The focus this year included optimizing specialty provider utilization expanding standard staff protocols SSP for walk in care increasing RAC efficiency and decreasing the need for clinic visits with an increased use of technology and outreach. Working groups were formed and training days were used to develop specific measurable attainable and timely goals and processes through Lean Daily Management LDM.

Facility: 9th Medical Group – Beale Air Force Base

Title of Project: An Integrated Solution

Summary: The Intelligence Reconnaissance and Surveillance ISR mission drives unique medical needs for patients. From increased requirements for mental health care to the need for primary care during off-duty hours personnel working shifts have restricted time to receive medical care and can often not be seen in the standard 0730-1530 timeframe. An increase in complaints regarding access to care and growing pressure from AFMS generated this access to care initiative. The objective was to allow patients a greater variety of options for how and when to receive care while not increasing the already overwhelming workload for medics. The goal was to ensure the right patient was seen at the right time. Due to limited resources and lack of funding for additional manpower positions it was imperative the quality of care was not impacted. This required critical thinking to ensure proper implementation. Three main changes evolved in the MTF. First daily clinic-wide huddles created an open medium to discuss patient safety events issues requiring immediate attention and broadcasted workloads for PCMH teams ultimately identifying underutilized personnel. The second

initiative was extending operating hours offering patients evening appointments. Lastly enhanced provider access created opportunities for patients to receive medical care without being seen by their traditional provider. Results indicate access to care increased to 56 hours per week and Urgent Care usage decreased by 24%. The monthly referral rate decreased from 331 in August 2016 to 225 in June 2017. Third next available FTR decreased from 7.57 in August 2016 to 3.74 in March 2017. During the initial implementation of initiatives primary care leakage decreased from 27.1% in August 2016 to 19.3% in October 2016. A critical look at the type and time of services provided to patients identified areas for improvement. Targeting communication operating hours and services provided created a successful access to care venture.

Patient Engagement

Facility: San Antonio Military Medical Center

Title of Project: The Supervision Stoplight: A Visual Aid to Patients Recognition of GME Supervision Hierarchy

Summary: Background: Although the hierarchy of supervision is implicit to health care workers multiple studies have shown that patients have a surprisingly poor understanding of the graduate medical education GME chain of command. Objective: The aim of this performance improvement project was to determine if a color color-coded badge scheme along with an informational pamphlet could enhance patient understanding of the roles of physicians in training and the hierarchy of supervision. Methods: This was a performance improvement project involving patients and family members who were either seen in the outpatient clinic or admitted to an inpatient service. Pre-implementation data was collected to get a baseline understanding of patients knowledge of the supervision hierarchy structure. All medical students interns residents fellows and attending physicians were required to wear color-coded badges correlated with their training status. Patients and family members received a pamphlet detailing the roles of these providers and the supervision hierarchy. Post-implementation data was collected to measure improvement in patients understanding. Results: Comparing post-implementation and pre-implementation groups 95 of 113 84% versus 104 of 136 76.5% correctly identified the attending physician as the leader of the GME team which was not significant. However within the post-implementation group only 67% of patients correctly identified the attending physician as the GME team leader if they did not receive and written or verbal communication explaining the supervision structure compared to 84% when written or verbal communication was provided and 94% when written and verbal communication was provided. Conclusion: A color-coded badge scheme along with written and verbal explanation significantly improved patients understanding of the roles of physicians in training in their care and the hierarchy of supervision.

Facility: Naval Medical Center San Diego

Title of Project: POSTPARTUM WARNING – A Nursing Partnership to Standardize and Improve Postpartum Discharge Education

Summary: Background: Despite advances in medical technology maternal morbidity and mortality continues to rise. A majority of the more than 600 annual maternal deaths in the U.S. take place during the postpartum period. Additionally some complications may solely develop or present in the postpartum period. Established standardized protocols ensure postpartum patients with risk factors for postpartum complications receive appropriate discharge teaching regarding their increased risk and guidance on where to get help. Often postpartum patients without risk factors receive inconsistent or minimal instructions regarding warning signs and when to seek medical care. Objective: We sought to develop standardized patient teaching regarding postpartum maternal warning signs to provide consistent information for ALL postpartum women regardless of previously identified risk factors. Methods: A literature review was conducted to identify recommendations on postpartum discharge instructions and education materials designed to increase knowledge of postpartum maternal warning signs. We developed a multidisciplinary working group and created a one-page patient education handout for all postpartum women discharged from our institution. The handout included information regarding potential warning signs indications for seeking additional care and direct contact numbers for additional information or questions. Nurses working on maternal-infant units received additional training in order to provide optimal discharge teaching utilizing the handout. Results: Implementation of the improved postpartum discharge education project has resulted in consistent standardized patient education to assist women in early recognition of the signs and symptoms of childbirth complications that can occur after hospital discharge. Continued process improvement efforts include translation of the postpartum education handout into other languages to meet patient needs. Conclusions: Standardized postpartum discharge education including postpartum complications should be taught to

all postpartum patients regardless of risk factors. Engaging nursing staff and ensuring consistent postpartum discharge education is critical to empowering women to seek additional care for postpartum complications.

Facility: 47th Medical Group – Laughlin Air Force Base

Title of Project: Text-Me-Now Initiative

Summary: Reason; During the third quarter of CY15 the facility Patient Advocate PA and Quality Services Director SGHQ identified a pervasive customer service issue. Overall Patient Satisfaction was 71.3% 13.7% below the 85% AFMOA goal. During monthly Service Delivery Assessment SDA reviews the facility had between 1-4 patients who reported being extremely unhappy with services. Due to our small patient population size this small number had a significant adverse effect on our customer services metric. We identified two problem areas identifying what specifically was displeasing our patients and identifying who these patients were without overtaxing our limited resources. A change to our SDA questions and a point of service survey led us to understand that promptness of our responses to complaints went a long way towards assuaging negative perceptions of care received. Description: The MDG purchased a cell phone. It was assigned to the Group Patient Advocate to answer any texts. The Text-Me-Now program was advertised throughout the facility. Signs were placed in all patient care rooms and in patient waiting areas. Data from the Text-Me-Now are briefed to the Exec staff and Patient Satisfaction numbers were monitored via the Service Delivery Assessment SDA tool. Summary: Final SDA data showed an increase of 14.2% in those that strongly agree that they are able to see their provider when they want. A 14.6% increase in those who would recommend the MTF to others and completely satisfied up from 95.8% to 98.3%. The new processes have driven the % of 5s completely satisfied up to over 81%. Conclusion: As a Text Me Now program first adopter the MDG increased its overall Patient Satisfaction to 81.1% within several months. The MDG socialized this success to the MAJCOM which adopted the process as a Best Practice across the Air Force Medical Service AFMS.

Facility: 97th Medical Group – Altus Air Force Base

Title of Project: "I Don't Understand" – Removing the Silence for those with Limited Health Literacy

Summary: Health Literacy is a prominent area in which the lack of understanding could cause harm and is at the core of Trusted Care and patient safety. Previously the Military Treatment Facility MTF had no method of determining if patients in need of assistance were able to understand and process basic health information to make appropriate health decisions. Determining the health literacy of the patient population enabled the MTF to tailor education efforts for each individual patient. Within each clinic limited health literacy screening and health information understanding for 100% of the patient population was targeted by this initiative. Analyzing patient understanding of basic health information was separated into three phases of focus and each targeted for improvement. First the MTF implemented a standardized questionnaire for each patient to complete upon the initial visit to the clinic. Second the MTF provided tools for each patient to assist in their understanding while stressing the importance and possible repercussions of improper interpretation of provider instructions and information. Third any patient identified as a possible limited health literacy skill risk via the questionnaire was offered the opportunity for a referral with individual tailored education from the Healthcare Integrator HCI or the Disease Manager DM within the clinic. Questionnaire compliance was monitored weekly by random samples of patient encounters coupled with tracking of identified at risk patients through the disease management section. The MTF considered a single capture of an at risk individual as a successful project. During the duration of the project thirteen individuals were identified and referred for assistance. Longevity evolution and sustainability of the program due to ever changing

patient population are paramount. The MTF commitment to ensuring Health Literacy is at the forefront of patient care for the future.

Facility: 17th Medical Group – Goodfellow Air Force Base

Title of Project: Improving Relationships through Patient Engagement

Summary: Maj General Allen issued an invitation to Military Treatment Facilities MTFs to join the Patient and Family Engagement Coordinator PFEC demonstration. This was a perfect catalyst highlighting importance of Patient Engagement as a key pillar of Trusted Care. Our facility immediately began transitioning our strong Patient Advocate and Marketing programs to a more proactive Patient Experience team. The objective was to establish a successful Patient and Family Advisory Council PFAC growing membership by 2 members each month targeting 12 active participants and addressing three patient concerns each quarter. Once the internal team was established the PFAC Charter was created. Next staff members advertised the PFAC within the clinic to patients and leadership marketed meetings throughout the Wing. The Council meets monthly and consists of all demographics: Active Duty family members retirees and their family members and clinic staff. During the meetings we explain the previous months customer service scores and feedback and inquire with our patients on ways to improve. We show last months open items and progress and how those initiatives have impacted our customer service metrics. Lastly we allow time for an open question and answer session as well. In summary Patient Engagement is very important to us and has become a part of our culture of safety. As the PFAC has grown we now have 16 volunteers with 12 active members on the Council. Thus far we have implemented 13 of the 14 suggestions. In conclusion creating a PFAC has been a great learning opportunity and fun part of our jobs getting to know patients and what is important to them. This has now transitioned from a project into a thriving Patient Experience program for our staff and patients. We look forward to continuing to partner with patients in our journey to Zero Harm and Trusted Care.