Excellence Through Teamwork

January 26, 2010
12:15 p.m.
Phillips Hall, Siebens 1
Excellence Through Teamwork

This celebration is an opportunity to recognize members of Mayo Clinic that inspire us. They are the dedicated people who exemplify the values and excellence for which Mayo Clinic is known.

Criteria

Teams eligible for this award meet the following criteria:

• Defined goal/aim
• Positive team dynamics
• Proven results showing significant improvement
• Beneficial impact on the organization
• Use of objective data for decision making
• Effective team leadership
• Active participation of all members on a continuous basis
• Ability to replicate results in other areas of Mayo Clinic

For more information about this award, please refer to the Mayo Excellence Through Teamwork Web site http://mayoweb.mayo.edu/recognition/excellteam.html
Mayo Clinic Excellence Through Teamwork Celebration

**Program**

Date: Tuesday, January 26, 2010
Location: Phillips Hall, Siebens 1

12:15 p.m. **Desserts and Beverages**

12:35 p.m. **Introduction of 2009 Teams**
*Leslie Fedraw & David Voller*
Members, Excellence Through Teamwork Award Selection Committee

**Guest Speaker**
*Patricia Simmons, M.D.*
Chair, Division of Pediatric and Adolescent Gynecology
Professor of Pediatrics, Mayo Clinic
Regent and Past Chair, Board of Regents, University of Minnesota

**Award Presentations**

**Closing Remarks**
*Shirley Weis*
Chief Administrative Officer
Guest Speaker Bio

Patricia Simmons is a physician and professor of Pediatrics (Mayo Medical School) in the Department of Pediatrics and Adolescent Medicine, Mayo Clinic, where she is chair of the Division of Pediatric and Adolescent Gynecology.

At the Mayo Clinic, she has served on the Executive Committee of the Board of Trustees and the Board of Governors, and as Chair of the Executive Board of Mayo Medical Ventures. She has been president of her national professional society, among other regional and national leadership roles.

Doctor Simmons, who received a bachelor’s degree from Carleton College, magna cum laude, and a medical doctorate from the University of Chicago, completed her residency and fellowship at the Mayo Graduate School of Medicine.

She is actively involved in her community, a frequent author, and lecturer in her field, and recipient of awards for excellence in teaching.

Doctor Simmons has served as chair of the Board of Regents of the University of Minnesota, to which she was elected by the Minnesota State Legislature in 2003 and 2009.

Her work in healthcare policy includes participation in Mayo Clinic’s National Relations Steering Group and State Public Affairs Committee. At the request of the President of the University of Minnesota, she chairs an initiative on the future of academic medicine.
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Goal/Aim
The primary goal of the Accelerating Clinical Trial Integration project is to reduce the time from concept to study activation by at least 20% for protocols entering the system beginning on December 31, 2009 without sacrificing quality, safety or compliance with regulatory and institutional requirements.

Process
The project was enterprise-wide with leadership, support and collaboration from MCA, MCF and MCR. Processes addressed through this project included protocol development, budget and contract negotiations, research study cards, pharmacy set-up and training.

Impact/Results
The project accomplished an improved clinical trial system that is efficient, predictable, consistent and compliant with institutional and federal regulations. It is in alignment with the Mayo Clinic Research priorities of satisfying our patients, increasing external revenue sources and accelerating the process of translating discovery to patient care. This resulted in:
• Quicker patient access to novel treatments
• Improved satisfaction from investigators, staff, sponsors and patients
• Improved reputation within the industry
• Increased contracts/funding

Members:
Linda L. Berge
Robin J. De Pagter
Brenda Jech
Randall S. Jones
Stacey T. Jones (MCA)
Nicole K. Knutson
Shaun D. Maloney
Sumithra J. Mandrekar, Ph.D.
Teresa A. Mc Joynt
Brandon C. Messmer
Tom J. Partridge
Kelly D. Paulson
Jason H. Pitzen
John G. Smith
Susan V. Sumrall (MCF)
Russell J. Vanderboom
Susan M. Wescott
Goal/Aim
The goal was to provide a resource for safe management of behavioral emergency situations in non-psychiatric specialties.

Process
Due to concerns for patient and staff safety, this multidisciplinary team was initiated to develop a behavioral emergency response team utilizing staff experienced in managing challenging behaviors. The team identified and educated response team members and staff calling this resource.

Impact/Results
The Behavior Emergency Response Team (BERT) was identified as an integral resource by the Mayo Clinic Hospital Practice Committee in meeting a long-standing need for safe management of co-morbid psychiatric/behavioral issues in patients hospitalized for primary medical reasons and reduced the need for a special unit representing a large financial savings. Data from the BERT indicates a high level of staff satisfaction with the team’s initial response with 86/89 (3 calls no info) rated as effective and 85/89 (4 calls no info) still rated as effective at a four-hour follow-up interval.

Members:
Erwin E. Borgen, Jr.
Debra L. Cox
Denise Hatteberg
Lori A. Larson
Elizabeth L. Pestka
Amy M. Zwygart
Goal/Aim
Despite available and effective treatments, most patients do not receive treatment for tobacco dependence: the leading cause of preventable death in the United States. The goal of this project was to address this by creating an accessible clinical entry point for the Nicotine Dependence Center (NDC) in a high-traffic area on route to the Division of Pulmonary and Critical Care Medicine (PCCM).

Process
Research by the SPARC Innovation Program determined that the facility should communicate non-judgmental and relevant messages that would encourage patients, and others to seek services. Team members worked with SPARC and the NDC to actualize suggested concepts which was conceived, designed and constructed “in-house.”

Impact/Results
The Center for Tobacco-Free Living now provides illustrations, interactive touch screens, video, and easy clinical access with a non-judgmental and encouraging spirit. In the first months after opening there were more than 1000 visitors and patient referrals from PCCM doubled.

Members:
William J. Barry
Patricia M. Boyd
Michael V. Burke
Steven P. Campbell
Rachel F. Carroll
Jon M. Curry
David S. Eide
Lonnie J. Fynskov
Richard D. Hurt, M.D.
Christine Janae Leoniak
Joanna R. King
Susan Y. Kline
Michael J. Krowka, M.D.
Brian D. Mathison
Peter M. McConahey
Shawn M. Pastika
Jason H. Pitzen
Jonalle M. Sauer
Paul A. Sims
David T. Smyrk
Sheila K. Stevens
Anju Thapa KC
Lani J. Wolff
Clinical Information Systems
Transformation Strategy Team

Goal/Aim
The vision of the Mayo Health System (MHS) Electronic Medical Record (EMR) is to make health care information available anywhere for every patient, every day, all the time; to provide the same high quality care at any entry point.

Process
The “best care” for patients includes timely access to patient records; identifying best practice; evidence based practice (standardized, ability to monitor quality and measure outcomes); and a consistent level of quality if the door says “Mayo.” These standards of care can best be achieved by: the record/data existing in one place; standard nomenclature; immediate, electronic access; agreed-upon practices of care; monitoring quality across the system; measuring outcomes across the system; common, EMR-enabled plans of care; and evidence integrated within the care process. MHS is committed to the development and implementation of a system-wide EMR.

Impact/Results
To date three sites are in production
Approximately 500 providers
8200+ total users
Supporting at peak, 3,400 concurrent end users
Approximately 1.3 million daily transactions
In 10 hospitals, in 33 communities
With 280 foreign system interfaces
Planning and project redesign being completed for next phases

Members:
Rhonda A. Abbott
Nicole M. Anderson
Donnelle M. Barker
Laurie L. Bauer
Janet L. Befort
Mary B. Berger
Ann R. Bills (MHS)
Jennifer A. Briske
Kari S. Bunkers, M.D. (MHS)
Brian P. Burgess
James S. Busenius
Mark C. Carey
Barbara J. Clark
Renee Dubreville
Jackie L. Evans
Richard A. Fricker
Sally A. Gilbertson
Jason R. Gross
Carolyn L. Hanson (MHS)
Cheryl Haycraft
Lois C. Hines (MHS)
Lucy M. Holroyd

– Continued on the next page.
Members:

Regina L. Howlett  Mario E. Medrano  Vickie L. Sather
Bharti Jain  Lopez (MHS)  Tanya W. Sio
Cindy R. Johnson  Beth A. Melson  Cathy M. Sorenson
(MHS)
Cynthia J. Kelley  Timothy A. Miksch  Melissa A. Sperber
Jennifer L. Khan  Elizabeth  Steven W. Steele
Stacy E. Kirwin  Montgomery  Cynthia J. Strauss
Renae M. Kost  Patricia K. Olevson  Robert A. Swanson,
Philip Krautkremer  Douglas W. Pappin  Jr. (MHS)
Judy K. Lundy  Carol I. Parent  Laura M. Unverzagt
Jason A. Lutter  Shanmugasunda  William Unverzagt
Eileen M. Mallory  Ramalingam  Angela M. Vail
(MHS)  Sherry L. Rush
Susan L. Mc Dermott  Neal T. Sanger  Paula A. Wire
Department of Laboratory Medicine & Pathology Inventory Expense Team

Goal/Aim
The Department of Laboratory Medicine and Pathology (DLMP) Inventory Expense Team’s (DIET) goal was to improve awareness of supply expense at a Posting Accounting Unit (PAU) level and to facilitate problem investigation and reporting when unusual spending was recognized.

Process
In order to accomplish the goal, the team chose to develop a supply expense review process facilitated by a database tool which summarized key information from multiple sources and allowed the logging of exceptions when an unusual supply expense situation occurred. Special consideration was given to develop a user friendly tool to assist supervisors and provide suitable education on the process during the implementation phase.

Impact/Results
Through the use of the DIET process and tool, the awareness of PAU level supply expense has significantly increased within DLMP. This has resulted in substantial savings to the department by finding errors in receipts, incomplete standing orders, inaccurate charges, charges to wrong PAU, duplicate charges, identification of volumes being credited to wrong PAU. A reduction in outdated supplies has also been achieved by placing orders on a need basis versus a bulk order. This initiative has improved access to supply expenses which enables work areas to make appropriate business decisions and to identify expense reduction opportunities.

Members:
Carla D. Brunsvold
Jerrad M. Dietenberger
Joseph M. Doppler
Susan K. Dunemann
Lynda A. Fleming
Mary F. Jones
Timothy B. Plummer
Melissa M. Ward
Department of Laboratory Medicine & Pathology New Employee Education Facilitators

Goal/Aim
The team’s mission is to provide essential, departmental education to new employees entering the Department Laboratory Medicine & Pathology (DLMP), ultimately preparing them for and allowing them to be successful as they transition into their work unit roles.

Process
Due to deficiencies, this team took an initial design and developed a successful program that continues to effectively prepare new employees for the challenging work that occurs within DLMP.

Impact/Results
Preparedness of new employees in the role of quality, safety, and, ultimately, mission and values to our patients, etc., has increased due to the content shared within the departmental program. In addition, the standardized approach to material ensures a consistency of foundational learning for each new employee to DLMP, ultimately preparing them for their continued growth at the work unit level.

Members:
Jeffry M. Harden
Thomas P. Huntley
Vicky M. Soppa
Melanie L. Yrjo
Depression Improvement Across Minnesota, Offering A New Direction Depression Team

Goal/Aim
The goal was to implement a sustainable, evidence-based model of care management for depression at two Mayo clinic sites and compare results with multiple other clinics using the same model across the state.

Process
The team developed the new role of depression care manager and hired staff into this role. A registry was designed to measure change and to integrate with the Mayo EMR. A measurement tool (the PHQ9) was approved, introduced into the workflow, and monitored. To increase utilization of that form, a scanable form was implemented. Primary care providers were educated about the new model and care managers went through training at Institute for Clinical Systems Improvement. A new role for psychiatry was developed with appropriate backup, and regular feedback of outcomes was provided to the team and providers involved. Many decisions were guided by the team review of data.

Impact/Results
The team was successful in implementing the Care Manager model at two clinics and results of the two Mayo clinics lead the state in process and outcome measures. Results were so good that Mayo was able to negotiate a doubling of the fee charged insurance companies for the service, and Employee Community Health is actively looking to spread the model to Baldwin and Kasson clinics. Lessons learned have helped to inform measurement of outcomes in Psychiatry, and have informed the development of care management models for diabetes and asthma. Implementation of this collaborative care model has allowed the expertise of multiple health care disciplines to be integrated into a new care delivery system for quality patient care.

Members:
Kurt B. Angstman, M.D.   Isaac O. Johnson
Robert O. Bender   Patricia V. Kisley
Marcie L. Billings, M.D.   Paul S. Klugherz
Jeannie M. Boness   Heather M. Marker
Steven M. Bruce, M.D.   Gabrielle J. Melin, M.D.
Ramona S. DeJesus, M.D.   Jay D. Mitchell, M.D.
Lisa M. Dutton   Pamela J. Nelson
Barbara J. Graham   Svetlana Simovic, M.D.
Doris G. Greene   John M. Wilkinson, M.D.
Donna M. Hinch   Mark D. Williams, M.D.
Diabetes Medication Instructions for Fasting Tests/Procedures Team

Goal/Aim
The team’s goal was to develop clear, concise, and consistent instructions and supporting resources for patient with diabetes who are scheduled for a fasting tests, procedures or surgery at Mayo Clinic, and decrease the number of Sentinel Events associated with incorrect medication/fasting instructions.

Process
In response to several Sentinel Events (n=8 for 2008), the Clinical Practice Committee charged a multi-disciplinary team with broad representation across different areas to standardize the information for diabetes medication instructions, create new resources and processes to support the instructions, and increase awareness about this patient safety issue.

Impact/Results
Since the implementation of the standardized diabetes instructions, there have been no reported Sentinel Events resulting from patients with diabetes who are fasting and changes to their medications. There has been an average of three calls per day to the new diabetes medication instruction line, and all questions have been resolved over the phone with staff. Approximately 40% of the callers have been connected with an NP/PA for further clarification about their specific diabetes medications, and all have reported high confidence in their ability to understand and follow their instructions.

Members:
Debra K. Bohlen  
Casey W. Crane  
Margaret P. Dougherty  
Barbara K. Hanna  
Rebecca L. Hinchley  
Yvonne A. Krulish  
Todd B. Nippoldt, M.D.

Stephanie L. Onsgard  
Kristine R. Schmitz  
Monica R. Sieg  
Rebecca A. Smith  
Carol L. Willett  
James A. Yolch
Goal/Aim
The team’s goal was to create a high-quality print magazine to support Mayo Clinic’s research discoveries that can be translated into new therapies to help patients.

Process
The team was assembled by Research Communications/Public Affairs and Illustration and Design/Media Support Services to represent the level of talent and skills needed to meet the concept and vision. The process included: concept development, editorial selection and scope, rigorous, multilayer editing, simultaneous design and art development – including coordinated photography – and final review and continuity checks.

Impact/Results
Mayo Clinic now has its first recurring print research magazine. Copies have been distributed at all three campuses, to department and research chairs and to patient and staff areas. Return cards are coming in on a weekly basis for subscriptions and roughly 20 percent also ask for more information on supporting one or more areas of research. This information is forwarded to Development. Copies have also been sent to major media and scientific press outlets and at least two news articles have resulted. Several reporters have asked for regular subscriptions ranging from freelance science writers to correspondents from the New York Times.

Members:
Karen E. Barrie
Jeffrey P. Bell
Peggy L. Chihak
Sharon L. Erdman
Yvonne Hubmayr (contracted)
Joseph M. Kane
John E. Laven
Michael P. Legrand (MCF)

Cheryl J. McCready
Matthew C. Meyer
Robert J. Nellis
Tsvetelina Parvanova
Stephen J. Russell, M.D., Ph.D.
Jeffrey A. Satre
Ronald O. Stucki
Renee E. Ziemer
Electronic Time Keeping Replacement Project Team

Goal/Aim
The sole goal of the Electric Time Keeping (ETK) Replacement Project was to replace the core functionality of the electronic timekeeping system to reduce risks associated with the inevitable failure of the system.

Process
A diverse, high-performing team was tasked with replacing the ETK system. In partnership with Kronos, they followed the vendor’s best practice methodology to develop and execute a comprehensive project plan. Winning teams have members who make things happen. The collective talents and teamwork this team displayed made implementing this project happen.

Impact/Results
By all accounts, the ETK Replacement Project Team was successful. The implementation of Kronos Workforce Timekeeper was completed on schedule and within budget. The change impact on users was minimized and feedback received has been very positive. This project leveraged the lessons learned from MAGIC and leaves a legacy of lessons learned and best practices on project management to share with projects that will follow.

Members:
Skylar W. Ackland                Jeffrey A. Green
Kenneth E. Alderman             Barbara L. Gregoire
Lacey M. Amundson               Donna L. Hawkinson
Eric A. Ayen                    Laura V. Haynes
Scott R. Becker                 Alan J. Heimer
Janice M. Bigalk                Brent A. Helgren
Brian W. Decker                 Jason B. Herman
Lori A. Denison                 DeeAnn E. Himli
Christian J. Dvorak             Donna S. Kieffer
William F. Ebben                Youn H. Kim
Marcia C. Edwards (MCA)          Barbara K. Kriesel
Nicolle L. Espinosa             Justin L. Lanners
Clare A. Fisk                   Kim L. Loppnow
Deanna K. Gander                Cynthia L. Lund
Chris N. Gawarecki              Charles Malayter
Michelle L. Gishkowsky

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Members:

Margery A. McIntire
Nancy E. Meyer
Martin A. Nelson
R. Scott Olson
Katie L. Paulson
Teri L. Perez
Wendy J. Perez
Charlotte Podein
Kindra A. Ramaker
Donald G. Riggan (MCF)
Glen C. Rogers
Lisa L. Rogich
Nathan A. Rolland
Joanne Marie J. Rosener
Kristine M. Rossman
William F. Sears, Jr.
Meagan G. Soukup
Charles B. Springer
Theresa M. Steele
Mark L. Strelow
Jody L. Strike
D. Ingrid Van Loon (MCA)
Amanda C. Verdick
Amanda K. Vermilya
James P. Warren
Kathleen A. Wellen
Leland G. Weinmann
Pamela K. Wheelock
Cara M. Wilson
Jeff T. Zahnle
Employee Community Health Influenza Immunization Clinics Team

Goal/Aim
Improve the delivery of 18,000 doses of seasonal flu vaccine to the Employee and Community Health (ECH) patients in an efficient, coordinated and timely manner.

Process
Establish centralized flu immunization clinics for all ECH patients. The team developed a standard process for delivery of scheduled flu and catch up immunization appointments, supply chain and recruitment of appropriately trained nursing staff.

Impact/Results
The Employee and Community Health Influenza Immunization Clinics group was able to plan and provide patient centered seasonal flu and other needed immunizations in an efficient and timely manner. Through a cooperative and collaborative effort, in a five week period, they provided approximately 20,000 immunizations.

Members:
Robert O. Bender
Irene E. Berg
Joleen L. Bernau
Richard R. Bessette
Barbara J. Brambrink (MHS)
Ann L. Carter (MHS)
Susan M. Holland
Patricia V. Kisley
Dusty J. Klesner
Joy S. Larson
Eric W. Lindskog
Kari J. Mongeon Wahlen
Kay L. Nelson (MHS)
Kimberly J. Reed
Tracy L. Roraff
Lisa L. Ruehmann (MHS)
Tammy L. Schmit
Denise A. Whalen
Stephanie G. Witwer
Enterprise Electronic Voting Team

Goal/Aim
The goal was to coordinate a process and integrate a “One Mayo Clinic Electronic Voting Process” for Mayo Clinic Arizona, Mayo Clinic Florida and Mayo Clinic Rochester.

Process
An “Enterprise Electronic Voting Team” was formed to develop and coordinate an electronic voting process, for the first “One Mayo Clinic” Annual Staff Meeting. Processes were developed for individual sites as well as “One Mayo” candidates, i.e., Board of Governors, endorsement of site CEO’s, etc. A 41 page manual was developed which includes information for communications, the setup process for Opinio (the program used for the voting), reports and forms, the post-voting process, etc.

Impact/Results
The “Enterprise Electronic Voting Team Manual” will be used for future elections. The team was challenged in the midst of the voting process, to “regroup” to prepare for a special election to endorse the CEO for MCF. The procedures provided the information that was needed. Processes are now in place to prepare for the annual election, special elections as well as procedures for a “tie vote” or a situation where a candidate is not affirmed or endorsed. Strong working relationships were developed with staff members from all three sites. Everyone worked well together and had fun!

Members:
Frank B. Allen (MCF)  James M. Kruse
Kathleen N. Barbour (MCF)  John J. Mentel, M.D. (MCF)
Carol K. Benson (MCA)  Daniel A. O’Neil
John P. Cranmer (MCA)  Vicki A. Ruff
Barbara A. Cummings (MCF)  Darrell L. Sandeen
Linda M. Donlin  Carol E. Semeit (MCA)
Joyce A. Even  Susanne L. Skree
Maria A. Fallon (MCF)  Brenda G. Stowe
Jane M. Haeflinger  Liza L. Torborg (contracted)
Carol A. Jaquith  Karen T. Trewin
Becky M. Kessler  Amy Z. Vrabel (MCA)
Enterprise Learning System Team

Goal/Aim
The Enterprise Learning System (ELS) team’s mission is to ensure that every patient benefits from the collective knowledge and expertise of the entire Mayo staff. The Enterprise Learning System provides streamlined access to Mayo-vetted knowledge and expertise at the point of care and documents physician competencies for continuous professional development.

Process
A team was formed to develop a prototype to demonstrate the value of the concept. Based on the success of this early work, a larger team was assembled, and a formal project charter and business plan were put into place. The team took the time to decide how they would work together – they developed and documented processes for software development and content creation. They invested time in getting formal and informal training to ensure that they had the tools they needed to succeed, and pulled together to deliver a successful product.

Impact/Results
Preliminary data indicates that providers are able to get answers to clinical questions more quickly and accurately using the ELS than other on-line resources. In addition, there have been cases of the ELS notifying caregivers of potentially life-threatening conditions that might otherwise have been missed.

Members:

Kristin K. Bailey
Janet K. Bartz
Mindy K. Bearden
Jeanette M. Christiansen
Ragnavendra Donepudi (contracted)
Rebecca L. Emde (contracted)
Michelle L. Felten
Carol J. Fitzgerald
Patrick Geszvain (contracted)
Kristi Hager (contracted)
Amy S. House
Thomas L. Kratky
Anne M. Larsen (contracted)
Farrell J. Lloyd, M.D.
Joseph K. Manthi (contracted)
Robert McIlree (contracted)

Ravi K. Nadimpally (contracted)
Rick A. Nishimura, M.D.
Steve R. Ommen, M.D.
Sreeviswa Peesapati (contracted)
Subhaschandra B. Pinnamaraju (contracted)
Mary J. Poterucha
Anand R. Rao (contracted)
John T. Scheuermann
John A. Schultz
Jane L. Shellum
Sam D. Smelter
Kristi J. Sorensen
LeRoy Spratling, Jr.
Richard L. Sutton (contracted)
Deanna R. Thompson
Dale R. Zwart
From Zero to a Hundred – Compliance with JACHO, Hospital Based Inpatient Psychiatric Services Team

Goal/Aim
Improve performance of the Hospital Based Inpatient Psychiatric Services (HBIPS) core measure performance at Mayo Psychiatry and Psychology Treatment Center for discharge measures from baseline rate of 5%.

Process
Early in the project a multidisciplinary retreat was organized to review the current process for HBIPS, the new Joint Commission Requirements, and current compliance scores. Team brainstormed solutions to correct the gap between current process results and goal results. Collection of concurrent data on compliance was gathered and distributed in a transparent process to all units and disciplines. This immediately generated feedback on what was needed to comply with the core measure criteria, as well as enthusiasm for change of low compliance rates and a healthy competition to be the best unit/team. The multidisciplinary members of each practice team on the units collaborated to generate improved results and test and implement solutions.

Impact/Results
The compliance for HBIPS discharge criteria being met improved from 5% in October, 08 to 86% in April, 09. HBIPS reported results are shared with the practice on a quarterly basis and are continuing to drive ongoing improvement activities in the practice.

Members:
Jason E. Barclay
Christine W. Galardy, M.D., Ph.D.
Anantha Kollengode, Ph.D.
Simon Kung, M.D.
Timothy W. Lineberry, M.D.
Kathryn M. Schak, M.D. (MHS)
Christopher L. Sola, D.O.
Mary K. Tri
Christopher A. Wall, M.D.
Hand Hygiene Sub-Committee

Goal/Aim
The goal of the team was to operationalize hand hygiene improvement activities among all healthcare workers across inpatient and outpatient settings, as measured by 90% sustained hand hygiene compliance at Mayo Clinic Rochester by the end of 2008.

Process
The Hand Hygiene Sub-Committee was formed to address barriers to success with hand hygiene compliance. The team utilized the literature to build a foundation from which to develop and move initiatives forward. A strong relationship was maintained with direct care providers at every step. The team developed and provided education through multiple venues, worked through barriers brought forward by both staff and leaders, and provided encouragement and support to care providers across the institution.

Impact/Results
Although the team did not see sustained 90% compliance across Mayo by the end of 2008, they did jump-start the momentum for teams across Mayo to reach this goal. By July 2009, tremendous improvement was seen across Mayo, with most units reaching 70% or greater compliance. The Hand Hygiene Sub-committee was able to take people, units, and teams by the hand and point them in the right direction.

Members:
Maren R. Johnson
Beverly A. Kaehler
Barbara A. Lecy
Marybeth L. O Neil
Martha J. Siska
Hospital Admission Process Improvement Team

Goal/Aim
The Hospital Admission Process Improvement (HAPI) team’s goal was to reduce uncompensated inpatient days by 15,500 by December 31, 2009. Baseline data was from 2007. This is a shared goal with two other projects that are part of the Hospital Census Management Improvement project. Those teams include Inpatient Discharge Planning and the Mayo Post Acute Care (MPAC) program.

Process
To reach the shared goal, the HAPI team’s charge was to design and implement a centralized hospital admissions office, and develop standard admission processes for Mayo Clinic Rochester to assure patients receive timely admission and care by the most appropriate service provider. Additionally, the team was to collaborate with Inpatient Discharge planning and MPAC to assure dismissals are timely and to the appropriate care setting.

Impact/Results
A centralized admissions office was established in February of 2009 (Admissions Coordination Office). The team has implemented three of the four identified admission processes, with work continuing to complete the last one. The number of uncompensated inpatient days has been reduced by 24,446* as of the end of August, 2009 (158% of goal!).

*Reflects a decline from 134,614 uncompensated days in 2007 (baseline) to 110,168 uncompensated days as of August, 2009).

Shared outcome process measures include:

• Average number days patients are on a delay list have reduced to 3.4 (from 13.5 in January 2009).
• 522 social admissions have been averted from the Emergency Department

Members:
Lori A. Ehlenfeldt
E. Stuart Eickelberg
Barbara L. Frederick
Harold D. Kossman
David L. Mapes
Christa A. Miller
Sally J. Morse
Sandra L. Prince
Tony W. Spaulding
Michael P. Thieke
Nathan A. Van Brunt
Amy W. Williams, M.D.
Jacqueline C. Wright
Improving Turnaround Time Priority Electrolyte Panel Potassium Team

Goal/Aim
The team’s goal was to reduce the electrolyte panel turnaround time from 180 minutes to 60 to 120 minutes as advertised on the Mayo Clinic Rochester Institutional Procedure Guide website and on the Hospital Medical Service Request form for priority orders. This project was identified through review of the division quality indicator metrics that track turn around times.

Process
The division Lean team attended Quality Academy TEAMs training to enhance its skills and learn new tools to improve process quality. The five phases of Six Sigma improvements, Define-Measure-Analyze-Improve-Control (DMAIC) were used as the problem solving methodology.

Impact/Results
Overall turnaround time improvement is between 60 and 100 minutes. Responding to a patient for a blood collection order showed the greatest improvement (80%). These outcomes demonstrate the elimination of waste in the end-to-end processes resulting in faster treatment for patients.

Members:

| Jodi L. Boysen       | Twyla M. Rickard |
| Tara L. Calvert      | Julienne K. Rieken |
| Susan M. Hoehne      | Krista L. Schubert |
| Olivia S. Klavetter  | Molly M. Smith    |
| Mohammed Mustapha    | Judith A. Spelhaug |
| Lavonne I. Nelson    | Samantha A. Thomas |
| April M. Oelkers     | Sharon R. Wiesner |
Inpatient Warfarin Safety Management Team

**Goal/Aim**
The charge for the multidisciplinary team was to reduce the risk of excessive supratherapeutic anticoagulation due to warfarin therapy for inpatients by implementing a standardized process through the use of an order set with embedded pharmacy rule.

**Process**
The team attended the Quality Academy and utilized the Define, Measure, Analysis, Improve, Control (DMAIC) framework to help accomplish the goals. The right team mix of knowledge, skills, and abilities was crucial. Proven data was an effective buy-in technique during implementation.

**Impact/Results**
Overall, there was a 55 percent reduction in the number of patients who experienced an excessive therapeutic level of anticoagulation with the use of the standard process. Preliminary financial analysis indicated that International Normalized Ratio (INR) defect rates were significantly lower, direct patient costs had remained the same, and length of stay had remained the same.

**Members:**
- Jacqueline M. Attlesey-Pries
- Ruth M. Boland
- Timothy J. Brennan
- Julie L. Cunningham
- Paul R. Daniels, M.D.
- Magali P. Disdier Moulder
- Mark J. Enzler, M.D.
- Laura K. Grazier (contracted)
- Theresa M. Joyce
- John C. Kuth
- Christa Y. Leung
- Dennis M. Manning, M.D.
- David L. Mapes
- Robert D. McBane, M.D.
- Penny K. Messner
- James P. Moriarty
- Laura J. Myhre
- John G. O Meara
- Narith N. Ou
- Joyce A. Overman Dube
- Russell D. Schoessler
- Peter W. Svendsen
Integrated Prenatal Care Team

Goal/Aim
The primary goal of this project was to reduce and standardize the number of prenatal visits while optimizing resources by utilizing a team-based approach that also served to improve access and satisfaction.

Process
After review of precedent and the Quality Academy process, a multidisciplinary team utilizing physician and certified nurse midwife (CNM) staff was developed. It was subsequently piloted, refined, and then implemented following considerable effort, negotiation, and perseverance.

Impact/Results
Results to date show that patients who received care under the ‘Team’ model were seen a mean of 10 times with 56% of those visits with a CNM and 44% with a M.D. compared to the baseline which was 13 visits, 100% of which were with a physician. PRC patient satisfaction data on ‘Overall Teamwork’ has improved incrementally from 42% (3Q07) to 67% (4Q08) excellent, ‘Access to Appointments’ has improved from 46% (3Q07) to 55% (4Q08) excellent, “Overall Efficiency” has improved from 42% (3Q07) to 68% (4Q08) excellent, and ‘Did You Feel There was a Mayo Clinic Doctor in Charge of Your Care’ has improved from 74% (3Q07) to 86% (4Q08) ‘Yes’. Additionally, standardized visit structure, visit elements, documentation, and care of certain clinical conditions were developed, refined, and implemented which have served to further improve process and outcomes.

Members:

Lenae M. Barkey
Christine P. Domask
Abimbola O. Famuyide
Rachael L. Hamilton
Keith L. Johansen, M.D.
Bruce W. Johnston, M.D.
Karren M. Karlen
Margaret E. Long, M.D.

Mary L. Marnach, M.D.
Mary M. Murry
Candi L. Nelson
Travis C. Paul
Susan M. Skinner
Susan M. Sobolewski
Elizabeth Westby, M.D.
Goal/Aim
To complete the Internal Control Evaluation (ICE) project aimed at ensuring the integrity of Mayo Clinic’s financial reporting and allowing management to certify on the effectiveness of internal control over financial reporting in accordance with the provisions of Section 404 of the Sarbanes-Oxley Act.

Process
The ICE Project included the completion of process and control documentation for several business processes and related technologies, evaluation and testing of the effectiveness of internal controls, support of remediation activities for control weaknesses, management certification on the effectiveness of internal control over financial reporting, and real-time evaluation of project timeline and deliverables by the external auditors.

Impact/Results
Management was able to certify that Mayo Clinic did not have any significant deficiencies or material weaknesses over its financial reporting internal controls in accordance with the provision of Section 404 of the Sarbanes-Oxley Act. Certification occurred within the timelines designated by the Audit and Compliance Committee.

Members:
Kelli J. Bartels          Sarah R. Jopp
Jacob S. Beckel         Brett J. Karst
Joan M. Dugstad          Linda S. Mc Gee
Becky Fritcher          Danielle M. Richardson
Carrie L. Graunke        Scott P. Peloquin
Chad A. Haugen          Jane C. Theros
Douglas J. Hildebrandt   Rochelle N. Timmer
Kristina M. Iverson      Sarah A. Tyson
Denise K. Jans
Joint Commission Requirement for Improvement Team to Develop a Medical Record Index

Goal/Aim
To respond to a Joint Commission Requirement for Improvement issued during the unannounced survey of Saint Marys Hospital in the summer of 2008. They noted that some healthcare providers had difficulty finding electronic medical record (EMR) data that were peripheral to their daily workflow. Meeting a 19-day deadline, the team developed an index to patient-specific information in the EMR.

Process
The team quickly decided to deploy this as a web page that could be accessed from within applications in the EMR and from reference web pages, such as the Nursing and MICS home pages. Half of the team worked on developing the website, while the nurses and physicians developed content for the web pages.

Impact/Results
The Joint Commission surveyed Mayo Clinic and Rochester Methodist Hospital several months later and stated that the “Surveyors noted significant progress with medical record navigation since the June MPPTC/SMH surveys” and that it was “Obvious that much work has been done.”

Members:
Nancy K. Archer
William J. Barry
Erin N. Dickerhoof
Marcelline R. Harris, Ph.D.
Jeffery J. Huhn, M.D.
Jennifer J. Larsen
Timothy S. Larson, M.D.

Jacqueline L. Moen
John D. Pederson
Michelle A. Plahmer
James A. Rosemark
Theresa L. Severson
Debbie L. Storlie
Mayo Clinic Access Identification Card
Project Team

Goal/Aim
Mayo Clinic Access Identification Card (MCAIC) is the Mayo Clinic approved form of employee identification replacing the black name tag and will be used to identify themselves to patients, visitors, and to each other. The team was charged with creating the card design, setting up policies/procedures, naming standards, credentials and ensuring operationally the cards are printed and distributed to over 44,000 employees, contractors, and volunteers.

Process
Team worked off a set of guiding principles focusing on identification rather than recognition of a degree.

Impact/Results
The black name tag was replaced with an approved form of identification for over 44,000 employees, contractors and volunteers. Allowed 1,000 additional staff to have credentialing listed that is needed for their positions. Other entities at Mayo are looking at implementing the new identification. I.e. Gold Cross, MCA, MCF. Patient safety and service is enhanced by having the MCAIC as a name badge.

Members:
Jason R. Berg
Christopher J. Douglas
Jane M. Haeflinger
Warren T. Harmon
Rachel L. Kessel
Kent D. Krienke
John Lemanski
Michelle K. McDermott
James E. McNeil, Jr.

Mary Ann Morris
Jennifer A. Ott
Kaye S. Peng
Stephen M. Robb
Ann M. Schauer
Shalon D. Schneider
Tyson L. Stackhouse
Timothy P. Stafford
Goal/Aim
The goal was to successfully enroll Mayo Clinic in the Minnesota Vaccine for Children Program, which provides free vaccine for the patients eligible for state provided vaccine and to save Mayo Clinic Employee Community Health $1 million annually.

Process
Due to the opportunity to reduce the expense of child vaccines for Mayo Clinic by participating in the Minnesota Vaccine for Children’s program, a team was formed to identify how to meet the State requirements.

Impact/Results
The team implemented:

• Mayo Clinic was approved for the State of Minnesota Vaccine Program.
• The impact to Mayo through June 2009 is $600,000 with a projected year-end 2009 savings to be more than $1 million.
• A new Minnesota Vaccine for Children eligibility Mayo Clinic form was developed.
• A report in MICS was developed to reconcile Minnesota State ordered vaccine stock vs. actual utilization.
• Developed a system for par levels for vaccine which improved the ordering processes for both the Minnesota vaccine and the Mayo provided vaccine which resulted in less vaccine at the clinic sites. This resulted in less waste due to discard of expired vaccines.
• Five additional sites have now been approved by the State of Minnesota after replication efforts in record time because of this team’s new processes and an educational program to the additional sites.

Members:
Richard R. Bessette
Kevin R. Dillon
Juliane J. Hass
Denese E. Lecy
Eric W. Lindskog
Deborah A. Nelson
Tammy L. Schmit
Jerry J. Sobolik
Karen L. Ytterberg, M.D.
Goal/Aim
The main goal is to increase adult inpatient care unit or emergency department staff RN knowledge related to sepsis recognition and early intervention. MCR institutional mortality review data indicated that we have possibly preventable deaths related to unrecognized or untreated sepsis.

Process
A nursing sepsis workgroup was formed to address this perceived knowledge deficit by requiring over 3000 RNs to attend a 1 ½ hour education session about sepsis recognition and early intervention. The workgroup developed and taught classroom power point presentations, developed an order set, pocket cards, Web site and guidelines related to sepsis recognition and intervention. Content for the presentation came from a learning needs assessment completed by nearly 1700 RNs.

Impact/Results
A 90 day post-education session knowledge survey indicates that RNs in the adult inpatient care unit and emergency department have demonstrated an increase in knowledge related to sepsis recognition and early intervention.

Members:
Bekele Afessa, M.D.   Lori A. Larson
Eric J. Cleveland     Ann R. Loth
Lisa L. Downer         Lisa M. Mundy
Jennifer L. Elmer      Barbara C. Ness
Joanna L. Enerson      Jennifer L. Pittman
Laura K. Evenson       Beth A. Sievers
Pamela L. Grubbs       Jeanne M. Voll
LeAnn M. Johnson
Goal/Aim
The goal was to develop and implement an on-call directory where information is viewable and accessible to Mayo Clinic Rochester healthcare providers, scheduling personnel, and telephone operations. At the end of the implementation every on-call schedule will be maintained through a standardized format on a web based On-Call Directory which will reduce the occurrence of sentinel or near-sentinel events.

Process
Due to sentinel events, the On-Call Directory Task Force was formed to investigate methods to improve the On-Call system and practice. The team determined the individual departments should review and then enter and maintain their own on-call information in the web-based On-Call Directory. The team would then implement the new system to all 56 departments which includes 350 on-call lists and 550 service areas. The new system also makes on-call information standardized and viewable to all Mayo employees.

Impact/Results
There have been no sentinel events for departments that have gone-live maintaining their information in the on-call directory and there has been a reduction in the number of provider calls misdirected by the telephone office.

Members:
Thomas Aronhalt
Deborah J. Bires
Brian A. Crum, M.D.
Michelle K. McDermott
Mary Ann Morris
Kathleen M. Shaw
Amy M. Van Gundy
Goal/Aim
The Pediatric Orthopedic Workgroup was formed and was charged with improving teamwork and communication between healthcare providers for pediatric orthopedic patients. In addition, the workgroup was focused on enhancing the care provided to pediatric orthopedic patients so that patient outcomes could be improved.

Process
The interdisciplinary members of the workgroup were willing to meet regularly and use open communication to discuss the current issues for communication, teamwork, and patient care outcomes. The members developed initiatives that could best enhance these three areas. The members were each committed to following through on their contributions towards the initiatives and goals.

Impact/Results
The workgroup achieved their goal of enhancing teamwork, communication, and patient care outcomes because there has been enhanced satisfaction for healthcare providers in the care of pediatric orthopedic patients.

Members:
Kathleen A. Augustine
Diana L. Barr
Kari L. Cambern
Amy J. Chihak
Patricia M. Conlon
Mark B. Dekutoski, M.D.
Jeannie E. Dybdal
Philip R. Fischer, M.D.
Jason J. Fratzke
Bonnie J. Goff
Holly L. Hanson
Elisa M. Johnson
Julia A. Jurgensen
Mary Knutson
Amy L. McIntosh, M.D.
Wendy S. Moon
Tami K. Omdahl
Sarah E. Orchard
Jodi L. Rindflesch
William J. Shaughnessy, M.D.
Linda D. Sorensen
Anthony A. Stans, M.D.
Wendy N. Timm
Sara J. Warmka
Tracy A. Watson
Goal/Aim
The Pediatric Practice Improvement Committee members are responsible for collecting and reviewing quality data on a monthly basis for the Pediatric Unit. The members are then charged with creating action plans and disseminating quality information to peers and to obtain greater than or equal to 90% compliance with documentation.

Process
Due to quarterly quality data supporting that recurring areas needed improvements, the committee members developed a system to assess data on a monthly basis to provide ongoing, timely feedback and education to peers for improvements.

Impact/Results
The committee members have created an environment that promotes a positive learning environment for peers and promotes quality documentation. These results have been confirmed by feedback from the Department of Nursing Quality Program and from the data collected each month by the committee members. Due to the commitment of the committee members to this project the Pediatric Unit has improved practice, quality and documentation.

Members:
Kari L. Cambern
Patricia M. Conlon
Jeannie E. Dybdal
Sara M. Gasper
Maggie M. Gibbs
Holly L. Hanson
Deborah L. Horn

Bethany A. Longtin
Denise McCarney
Dawn M. Sanderman
Sarah M. Thu
Lynette Traxel
Tracy A. Watson
Redesign & Standardization of Operational Processes Supporting the Institutional Review Boards Team

Goal/Aim
The team’s goals were to ensure the Institutional Review Boards (IRB) reviews meet Federal regulatory standards, specifically in the areas of documentation of minutes and communication of outcomes; and that these reviews are reliably completed within 30 calendar days.

Process
A systematic approach was taken to first establish the standards required to meet regulations, followed by gap analysis of the existing process vis-à-vis the requirements. Once consensus was reached, the team set out to redesign the future state using process flowchart and Value Stream Mapping methods. The team then pilot tested the new process with two of the five Full Committees. When there was agreement that the process had worked as planned, the team proceeded to finalize the procedures and checklists used to support the new operational model. The staff members were trained on the new process before full implementation.

Impact/Results
A quality self-assessment, conducted six months after implementation, validated that the redesigned process met federal regulatory requirements. Turnaround metrics, tracked monthly since the start of implementation, show that Greater than Minimal Risks applications submitted to the IRB are now reliably completed within 30 calendar days. This level of predictable performance has significant positive impact on the entire research enterprise.

Members:
Jamie L. Angst
Michelle K. Daiss
Roberta L. Drury
Tamyra L. Dull
Maria T. Greilinger
Mary H. Hopper
Pamela K. Jones
Melissa M. Kuntz
Teresa M. Laitinen-Tipton
Elizabeth J. Leisen
Carol Siegel
John G. Smith
George Then
Cailla M. Tri
Goal/Aim
To support the community and the arts, Mayo Clinic created a goose as part of the Rochester Arts Council’s fundraising efforts. Mayo joined 17 other area organizations in sponsoring geese statues.

Process
In usual Mayo fashion, a team approach was used to artistically embellish the goose. The concept — creating a piece of art that is as precious and dignified as Mayo Clinic — required the use of materials from buildings throughout Mayo Clinic, including: Stone found in campus buildings, leftover stained glass pieces from campus meditation rooms and copper “feathers” cut by our own engineering department.

Impact/Results
The result of the Mayo Goose – Reflections of Mayo – sitting in Annenberg Plaza on display is an ongoing visual attraction for our employees, patients and visitors. It is inspiring, a morale booster and beautiful.

Members:
Mary A. Ayshford  Kenneth L. Hollermann
Rosemary L. Cashman  Steven R. Jurrens
Tom B. Christenson  Joseph M. Kane
Lisa M. Clarke  Steven D. Orwoll
Richard A. Conrad (contracted)  Patrick A. Rian
Francesca B. Dickson  Ann M. Schauer
Amy L. Gigler  Craig A. Smoldt
Robert A. Hight

Reflections of Mayo – Goose Project Team
Goal/Aim
The team’s goal was to reduce the time it took for practitioners to receive results on kidney biopsy patients.

Process
Lean Process improvements teams were formed in Renal Biopsy and Electron Microscopy Core labs to drive improvements. The Renal Biopsy lab adjusted processes and purchase automation for staff to be more efficient. A number of processes were improved to reduce the time it took to fix and process patient materials to be ready for pathologist interpretation.

Impact/Results
Over a three year period, the time between accession and results reported, dropped from 13 business days to seven. The time it took for tissue to be processed and grids prepared by the Renal Biopsy lab dropped from six days to two, without the addition of staff and with similar levels of supply costs.

Members:
Jon E. Charlesworth
Mary E. Fidler, M.D.
Wade D. Fiedler
Donna Lager, M.D.
Denis A. Rollmann
Sudden Cardiac Arrest Quality Improvement Workgroup

Goal/Aim
The team’s goal is to identify patients at risk for sudden cardiac arrest (SCA) and provide these patients with consultation discussing risk stratification and treatment options.

Process
Use our existing Electronic Medical Records (EMR) to identify patients with left ventricular ejection fraction (LVEF) measurements of less than or equal to 35%, cross reference this to the internal cardiac defibrillator (ICD) data system to see if patient has existing ICD, and then cross reference these patients to the EMR flow sheet to identify patients who have received the SCA discussion in the past and are not interested in internal cardiac defibrillator therapy. These screening elements are triggered when LVEF measurements are sent to the EMR.

Impact/Results
For a one month period, the SCA screening tool reviewed 1,923,637 items coming into the EMR. The LVEF function reviewed 4,579 unique data elements of which alerted the SCA screening inbox with 222 patient alerts which would equate to 2664 appropriate patients per year. These alerts are sent to the inbox real-time in order to reach out to patients while they are still actively being cared for within the Mayo Rochester campus.

Members:
Nancy G. Acker
Debra L. Andreen
Douglas S. Beinborn
Robert R. Bleimeyer
Pedro J. Caraballo, M.D.
Samanthie I. Epps
Tammy A. Kester
Mark R. McConnell
James A. Peterson
Robert F. Rea, M.D.
Tracy L. Webster
**Goal/Aim**
To improve the appropriate use of venous thromboembolism prophylaxis (VTE-P) to over 95% and to implement a rapid spread project of best practices across an entire hospital.

**Process**
The team focused on using lessons learned from prior pilots to implement spread of a VTE-P tollgate across all admission and post-operative order sets. The team identified ways to adapt the established VTE-P tollgate to individual practices in order to accommodate special needs, and then deployed the tollgates via the EMR and CPOE systems. A BLAZE rule was developed using the individualized practice inputs that will be sensitive and specific in reminding clinicians to re-start VTE-P in patients who become without VTE-P, thus attempting for VTE-P rates exceeding 95%.

**Impact/Results**
Appropriate VTE-P rates improved from 79.2 to 94.6% without an increase in bleeding complications. The BLAZE rule should result in extension and sustainability of gains.

**Members:**
Carl F. Berardinelli  
Robert R. Cima, M.D.  
Leslie A. Fedraw  
Deborah J. Hinrichs  
Jenna K. Lovely  
Timothy I. Morgenthaler, M.D.  
Timothy J. Wallerich
Excellence Through Teamwork
Award Selection Committee

Members:
Ronald Alston
Pamela Barrs
Leslie Fedraw – Co-Chair
Diane Foss
Steven Kruisselbrink – Chair
Denese Lecy
LaDonna McGohan
Pamela Mickelson
Heidi Shedenhelm
David Voller
Brenda Wanous
Anita Wickersham