TL 3: Describe and demonstrate the strategic planning structure(s) and process(es) used by nursing to improve the healthcare system’s effectiveness and efficiency.

The strategic planning process is an integral function of Nursing and Patient Care Services under the leadership of the Senior Vice President for Patient Care and Chief Nurse (CNO), Jeanette Ives Erickson. In her 1991 Nursing Management article, “Articulating Values and Assumptions for Strategic Planning”, she writes of the importance of aligning strategic planning with an organization’s core values: “Even though some events cannot be predicted or controlled, an organization can take a proactive stance toward change, both in initiating events and preparing responses to contingent events. To manage change, an organization must have a well-defined values statement and a mission statement which is understood by everyone. Awareness of an organization’s values and the assumptions an organization makes about the internal and external environment are elements of an overall strategic plan.” Consequently, under her leadership, Nursing and Patient Care Services (PCS) has developed a strategic and operating plan every year since she assumed the helm in 1996.

Aligning the over 4200-strong leadership and staff comprising PCS around a common purpose and direction is accomplished through the PCS strategic planning process (see Figure below). Strategic goals are driven from the foundation of the Hospital’s mission and PCS’ vision, values and guiding principles. These governing ideas and statements guide the organization’s daily work.

![Diagram of Strategic Planning Process]

**Patient Care Services Strategic Plan**

**Hospital Mission**

**Vision**

**Strategic Goals**

**Organizational Priorities**
Areas of emphasis stemming from the long-term goals on which we will focus efforts and resources in the year 2012.

**Improvement Teams**
Design and implement an improvement plan: Committees or short-term groups empowered to design or improve systems

**Key Initiatives**
Identify an opportunity: Programs and projects across multiple disciplines, departments, and committees that are intended to effect organization-wide performance improvement or offer a new service to meet patient and employee needs

**Performance Measures**
Measure performance, set goals for improvement, and monitor for sustained performance: Qualitative & quantitative methods to assess the overall effectiveness of key initiatives

**Plan**
**Check**
**Act**
**Do**
The PCS strategic planning process is a dynamic one and is informed by a multitude of information sources including: patient and staff feedback through formal and informal channels; care delivery models; external and internal trends and regulation; professional standards; the environment of care; credentialing and privileging requirements; and financial, quality and safety indicators. PCS’s strategic goals are continually assessed and reassessed as new information from these sources becomes available. In addition, the strategic goals, initiatives and tactics are continually evaluated through the Plan-Do-Check-Act (PDCA) process of performance improvement. Likened to the steps in the nursing process, the steps in the PDCA process guide refinement. Careful attention is given by the PCS Executive Committee to ensure that the PCS strategic plan is aligned with the Hospital’s plan.

The process of developing strategic goals for PCS, and their execution through associated tactics, has significant effects on the six areas for quality care improvement laid out by the Institute of Medicine in their seminal 2001 book, Crossing the Quality Chasm, including the efficiency and effectiveness of care. While developing strategies, the goal of improved, patient-centered care is never far from the minds of the PCS leadership team, as seen by the patient-centeredness is a focal point of the PCS vision (TL 1), Professional Practice Model (OOD 11) and strategic plans (OOD 3.h, p. 5) and (OOD 3.i., p. 6). The six IOM aims are also an integral component of PCS’s emerging Patient Care Delivery Model (OOD 11). In fact, these goals are so central to the work of Patient Care Services that they are embedded in the job descriptions of staff at all levels, from the staff nurse to the Chief Nurse. The following excerpts from position descriptions of nurses at all levels elucidate these connections to the six aims for improvement:

**Staff Nurse:** “Staff nurses ensure that care is safe, efficient, effective, timely and meets the cultural, spiritual, and ethnic needs of each patient and family.” (Attachment TL 2.e)

**Nurse Practitioner:** “Promotes a collaborative relationship and effort between the medical staff and professional nurses toward continuity of patient care and efficient use of resources.” (Attachment TL 2.d)

**Clinical Nurse Specialist:** “Initiates, or participates in quality assurance and performance improvement activities for evaluation of structure, process and outcome criteria as it relates to clinical practice.” (Attachment TL 2.c)

**Nursing Director:** “The Nursing Director is accountable for the delivery of consistent, high quality patient care, promoting the development and satisfaction of nursing and support staff, providing operating efficiencies and insuring compliance with hospital and regulatory policies and standards of practice.” (Attachment TL 2.b)

**Associate Chief Nurse:** “…the Associate Chief Nurse participates in the efficient and effective management of the department of nursing, and the development of its strategic plan.” (Attachment TL 2.a)

**Chief Nurse:** “Creates a bold agenda for ensuring that patient care is patient-centered, timely, efficient, effective, equitable, and safe.” (OOD 2.a)

In this source of evidence, we will present information about the process of strategic planning in Patient Care Services through the lens of two strategic planning cycles: 2010-11 and 2012-13.
The PCS strategic goal development process begins with the hospital’s mission and strategic goals (TL 1). The MGH President’s overarching strategic goal for the year 2011 was to “Effect Measurable Improvements in the Quality and Safety of MGH Care.” With this overarching goal as a touch point, in the fall of 2010, the Executive team of PCS conducted a two-day strategic planning retreat (Attachment TL 3.a). This retreat was used to formulate the strategic goals for 2011. Although the goals are developed and decided at this retreat, they were reviewed and revised throughout the year as new information became available.

On the first day of the retreat, a number of topics were discussed in small interdisciplinary breakout groups, such as the quality of direct care, the collaborative governance structure, the education, diversity and satisfaction of the workforce, and the changing needs of our patients, among other topics. The breakout groups of leaders reviewed data for the different discussion topics, such as staff satisfaction survey results, and reported out to the larger group about the key themes and strategic considerations they identified. These smaller breakout groups presented their recommendations for change to the entire retreat attendance, and then the larger group discussed how these potential changes fit with the hospital’s strategic goals. At the end of the day, these findings were synthesized into overall areas of priority and focus.

The second day of the retreat began by reviewing the overall findings from the prior day’s discussions. These themes, combined with the hospital’s mission and strategy, and the PCS vision and values, were used by the leadership team to collaboratively develop the strategic goals for 2010-2011. Within each of these goals were also developed a number of tactics to help achieve the goals. Each tactic was assigned ultimate ownership by a single PCS leader, although each would require interdisciplinary collaboration to achieve. A copy of the retreat proceedings is in Attachment TL 3.b. Each tactic owner must then develop a charter for their tactic, an example of which is seen below:

<table>
<thead>
<tr>
<th>Tactic 5: Improve hospital cleanliness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Next Step Owner: G. Reardon</td>
</tr>
</tbody>
</table>

**Aim/Linkage to Strategic Goal:** Exceed 2011 HCAHPS P4P patient satisfaction target (TBD).

**Problem Statement:** Improve patient satisfaction with the cleanliness of the patient room environment as measured by HCAHPS. Achieving 2011 target will require increased focus by all members of the care team.

**Target/Benefit:** Improve patient satisfaction through staff empowerment, improved processes, patient outreach, education and training, and quality oversight. Standardize work to promote efficiency and quality. Ensure MGH realizes 2011 P4P payment.

**In Scope:** Inpatient patient room cleanliness. While the P4P HCAHPS results focus on 27 Adult inpatient units the scope of this tactic includes all inpatient rooms.

**Out of Scope:** This tactic targets inpatient patient room cleanliness. Broader MGH cleanliness improvement opportunities are out of scope.

**System Capabilities/Deliverables:**
1. Continue improvement and oversight efforts underway.
2. Broaden involvement of all roles and disciplines in improving cleanliness and patient satisfaction
3. Explore new cleaning techniques, tools, and processes to enhance quality and efficiency

**Resources Required/Team:** Primarily Clinical Support Services and Knight Center. It takes a village = leadership from all PCS disciplines.

**Metrics/Measurements:**
- HCAHPS results (Baseline 2010 = 71.4%, P4P Target = 71.7%)

**Milestones:**
- Date: 10/25/10
- Monthly TBD

**Description:**
- On target YTD to meet 2010 HCAHPS P4P goal
- HCAHPS trend reporting
- Implementation of new processes, education and outreach
The three strategic goals for Patient Care Services in 2011 were as follows:

**Goal #1:** Meet or Exceed Expectations of Patients and Families
**Goal #2:** Enhance Care Delivery by Improving the Efficiency and Effectiveness of Systems
**Goal #3:** Ensure Staff have a Strong Voice in the Design of Care and Service

Each one of these goals is directly related to making care at MGH more efficient and effective. For example, within the first goal to “Meet or Exceed Expectations of Patients and Families”, were tactics to enhance staff responsiveness, implement hourly safety rounds, “and reduce hospital-acquired infections, all of which aim to improve patient care.” The goal to “Enhance Care Delivery by Improving the Efficiency and Effectiveness of System” specifically targets both efficiency and effectiveness. And the last strategic goal, “Ensure Staff have a Strong Voice in the Design of Care and Service”, included the tactic of increasing the efficiency and effectiveness of educational offerings across PCS departments.” By always keeping the effectiveness of patient care in mind, the PCS leadership team ensures that its goals will always be of utmost importance. More information on all of the goals and related tactics, and their impact on the efficiency and effectiveness of care, can be found in source of evidence TL3 EO.

After reaching consensus on the three strategic goals for 2010-2011, the leadership team developed specific tactics to achieve each of these goals. These strategies and tactics were shared in numerous forums including the weekly Nursing Director meetings, Staff Nurse Advisory Committee and unit-based staff meetings. The progress towards achievement of these goals is discussed and updated on a regular basis with the PCS Executive Team at its biweekly PCS Executive Committee meetings (Attachment TL 3.c). These strategic goals are also communicated to the MGH Community by the CNO in her column in Caring Headlines (Attachment TL 3.d).

**2012-13 Patient Care Services Strategic Planning Process**

Patient Care Services repeated this process again for the 2012-2013 strategic plan. The PCS leadership team held two one-day retreats in the fall of 2011. Agendas for each day can be found in Attachment TL 3.e and Attachment TL 3.f). Starting with the framework of the renewed hospital's overarching goal to “Make MGH Care Better and More Affordable”, and the results of the prior year's strategic goals, the leadership team developed the following initial strategic goals for 2012:

**Goal #1:** Develop an efficient and effective patient- and family-centered model of care delivery advancing relationship-based care philosophy
**Goal #2:** Design and Implement new programs to improve Patient and Family Satisfaction
**Goal #3:** Lead Patient Affordability Direct Care initiatives
**Goal #4:** Support and participate in Care Redesign team efforts
**Goal #5:** Advance the culture of Excellence Every Day
**Goal #6:** Design and implement clinical and business information systems that support patient care, education, and research

A summary of the process and the 2012 strategic goals and tactics can be found in OOD 3.i. These goals, and the tactics within each of them, then became an ongoing topic for discussion for PCS management and staff. The goals, once further developed and ratified, were communicated more broadly to the institution in the CNO's Caring Headlines' column (Attachment TL 3.g). The progress towards each of these goals is carefully monitored and regularly updated, as seen in minutes
from a recent PCSEC meeting (Attachment TL 3.h) and the updated PCS 2012 Strategic Goals and Tactics grid (Attachment TL 3.i).

Individual departments within the PCS organization then use these strategic goals to develop their own aligned departmental goals. For example, the Institute for Patient Care held a retreat in December of 2011 (Attachment TL 3.j) in which they reviewed the PCS strategic goals, the state of the hospital and the industry, and crafted their own goals for the year to come. These departmental processes help the entire PCS organization achieve its strategic goals and ultimately improve the care effectiveness of the entire institution.

Patient Care Services, through its rigorous and thoughtful strategic planning process, ensures that it is achieving its and the hospital’s mutual goals of making care at MGH more effective, efficient, and patient-centered.
Day One

The Colony Hotel

7:30 - Porch Dining Room – Complimentary Breakfast Buffet.
For those staying at the Colony, give the hostel your room number.
For those staying at the Breakwater Inn, give the hostess your name.

8:30 a.m.  (Please note that continental breakfast will be available in meeting room at 8:00 a.m.)

8:30 a.m.  The Carriage House

Introduction and Context
I will open the meeting by providing some background and context for our work together. Discussion of Who has the D. How can we make decisions and carry out the plan in a timely and efficient manner.

9:30 a.m.  What is Keeping us up at Night?
On an index card, please list the one thing that is worrying you. I will collect the cards and randomly redistribute them by separating substance from source.

9:30 a.m.  Large Group Discussion
It is critical that we not only assess and reflect, but also dialogue about 2010 strategies and tactics and if activities are still relevant. If so, how will we implement before new work begins?

10:00 a.m.  Break

10:20 a.m.  Small Groups Discussion
Based on the prior discussions and work leading up to the retreat:
1) What might we do differently, as a team, to make progress on the issues at hand?
2) What could stop us or hinder our progress?
3) What would help propel/enable our progress?
4) Who might do what next to ensure progress on the issues at hand?

11:30 a.m.  Large Group Discussion and Action Plan
Each group will present its best ideas from the prior session.

Noon  Lunch – Porch Dining Room

1:00 p.m.  Large Group Discussion
1) P4 P targets, Partners Strategy, ACD, B3C, etc, JCAHO readiness, SPPE
2) 5-10% budget Cuts
3) Patient Care Delivery
4) Unfinished 2010 business???

3:30 p.m.  Go out and have fun

6:15 p.m.  Stripers Waterside Restaurant @ the Breakwater Inn
127 Ocean Avenue
Kennebunkport, ME
207-967-5333
Day Two

7:30 - Porch Dining Room – Complimentary Breakfast Buffet
For those staying at the Colony, give the hostel your room number.
For those staying at the Breakwater Inn, give the hostess your name.

8:00 a.m. (Please note that continental breakfast will be available in meeting room at 7:30 a.m.)

8:00 a.m. The Carriage House
Framing the Day

8:20 a.m. Five to Ten Percent Budget Cuts while keeping patients safe

9:30 a.m. 2010 PCS Strategies and Tactics

10:00 a.m. Small Groups Discussion
1) Based on the morning, what would you change?
2) How would you measure our outcomes?
3) Will our staff resonate with this work?
4) Will you feel connected personally and as a team?

10:45 a.m. Group Reports

11:30 a.m. Large Group Discussion
1) What might we do differently, as a team, to make progress on the issues at hand?
2) What could stop us or hinder our progress?
3) What would help propel/enable our progress?
4) What will we delegate to Collaborative Governance Committees?
5) Who might do what next to ensure progress on the issues at hand?

12:30 Working Lunch

1:30 p.m. Outstanding issues to discuss before we adjourn
I. Overview:

Day 1 – September 29, 2010
J. Ives Erickson kicked off the annual retreat with a recap of the 2009 and 2010 strategic plans, and new and continuing tactics for the 2011 strategic plan. There was a discussion on the article Who Has the D? by Paul Rogers and Marcia Blenko. J. Ives Erickson finished off the day with an update on Partners Strategy Teams.

Day 2 – October 1, 2010
Day 2 was largely discussion centered, and the group decided on several items as they relate to PCSEC and the 2011 Strategic Plan.

1. All current PCSEC projects were reviewed by the group and an initial draft of the 2011 Strategic Plan was created (see II below).
2. 2011 Strategic Plan sponsors will utilize a project charter (see III below).
3. 12 current projects/initiatives were reviewed and determined as ongoing initiatives that were not part of the 2011 Strategic Plan. These projects are always on the radar; some require immediate action (see IV below).
4. PCSEC will have a new agenda, and the meeting will be more discussion focused and less formal. K. McCullough will be organizing the agenda for these meetings.
5. PCSEC will monitor initiative/project progress via a unit based dashboard. D. Colton, M. Ditomassi, K. McCullough and L. Lebrun will refine the initial draft.
6. News You Can Use will be modified by G. Peirce and the Communication Council; it will act as a key communication vehicle regarding strategic initiatives throughout PCSEC.
II. 2011 PCS Strategic Plan:

The following goals and tactics were identified as part of the 2011 PCS Strategic Plan. Tactics requiring a charter are shaded in grey.

### Strategic Goal #1: Improve Quality

<table>
<thead>
<tr>
<th>Tactic #</th>
<th>Tactic</th>
<th>Immediate Action (I) Milestone(M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>P4P: Cleanliness</td>
<td>(I) Project Charter (I) Determine target</td>
</tr>
<tr>
<td>2</td>
<td>P4P: Staff Responsiveness</td>
<td>(I) Project Charter (I) Determine target and partner with Volunteer Services</td>
</tr>
<tr>
<td>3</td>
<td>Implement Safety Rounds</td>
<td>(I) Project Charter</td>
</tr>
<tr>
<td>4</td>
<td>Reduce Hospital Acquired Pressure Ulcers</td>
<td>(I) Project Charter (I) Pressure Ulcer Team charged with rental bed contract (work with G. Reardon; see tactic 24)</td>
</tr>
</tbody>
</table>

### Strategic Goal #2: Redesign direct and indirect patient care – J. Ives Erickson and M. Cramer

<table>
<thead>
<tr>
<th>Tactic #</th>
<th>Tactic</th>
<th>Immediate Action (I) Milestone(M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Acute Care Documentation</td>
<td>(I) Project Charter</td>
</tr>
<tr>
<td>6</td>
<td>Medical Interpreter/Technology Utilization</td>
<td>(I) Project Charter</td>
</tr>
<tr>
<td>7</td>
<td>Collaborative Governance Redesign</td>
<td>(I) Project Charter (M) Implement new model by 1/2011</td>
</tr>
<tr>
<td>8</td>
<td>Readmit Pilot</td>
<td>(I) Project Charter</td>
</tr>
<tr>
<td>9</td>
<td>Practice review of expensive items</td>
<td>e.g. nitrous oxide</td>
</tr>
<tr>
<td>10</td>
<td>Review of clinical roles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient Observers/Sitters</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Specialist Direct Care Contribution</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychiatric CNS</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Follow-up phone calls</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Go Green</td>
<td>e.g. paper, linen, recycle, brochures</td>
</tr>
<tr>
<td>13</td>
<td>Continuity of Care for high-risk patients</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Program Redesign: PATA</td>
<td>D. Tenney</td>
</tr>
<tr>
<td>15</td>
<td>Program Redesign: Foxboro</td>
<td>J. Ives Erickson/M. Sullivan</td>
</tr>
<tr>
<td>16</td>
<td>Lunder Move</td>
<td>(I) Project Charter</td>
</tr>
</tbody>
</table>

### Direct Patient Care

- Follow-up phone calls
- Go Green (e.g. paper, linen, recycle, brochures)
- Continuity of Care for high-risk patients
- Program Redesign: PATA
- Program Redesign: Foxboro
- Lunder Move (I) Project Charter

Sponsor(s):
- G. Reardon
- R. Corder/G. Banister/P. Bartush
- K. Perleberg
- J. Somerville/G. Banister
- S. Millar
- P. Bartush
- G. Banister
- T. Gallivan/J. Somerville
- G. Reardon/R. Kacmarek
- D. Burke/T. Gallivan/J. Somerville/D. Tenney
- D. Tenney
- J. Ives Erickson/M. Sullivan
- D. Tenney/T. Gallivan/G.
<table>
<thead>
<tr>
<th>Tactic #</th>
<th>Tactic</th>
<th>Immediate Action (I) Milestone(M)</th>
<th>Sponsor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Backfill Plan</td>
<td>(I) Project Charter</td>
<td>J. Ives Erickson</td>
</tr>
<tr>
<td>18</td>
<td>TCAB</td>
<td>(I) Project Charter, (M) Roll-out TCAB to all units by 1/2011</td>
<td>G. Reardon</td>
</tr>
</tbody>
</table>

### Indirect Patient Care

<table>
<thead>
<tr>
<th>Tactic #</th>
<th>Tactic</th>
<th>Immediate Action (I) Milestone(M)</th>
<th>Sponsor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Aggregate two Blum Centers and HOPES Program</td>
<td></td>
<td>A. Daniels/G. Banister</td>
</tr>
<tr>
<td>20</td>
<td>Knight and Simulation</td>
<td></td>
<td>G. Banister</td>
</tr>
<tr>
<td>21</td>
<td>Patient and Family Lodging</td>
<td></td>
<td>A. Daniels</td>
</tr>
<tr>
<td>22</td>
<td>Payroll Process</td>
<td>(I) Project Charter</td>
<td>T. Elliott</td>
</tr>
<tr>
<td>23</td>
<td>Scheduling Process</td>
<td>(I) Project Charter</td>
<td>S. Millar</td>
</tr>
</tbody>
</table>
| 24       | Reduce Non-Salary Expense                  | (I) Project Charter; one all inclusive charter created by G. Reardon (e.g. non-salary tiger teams)

**Critically Review:**
- (I) Subscriptions and Dues – All
- (I) TL Contract - G. Peirce
- (I) Explore Shawmut Printing - M. Ditomassi/S. Sabia/G. Peirce
- (I) Contracts: Health Stream, Qualtrics Labs, SPSS Inc. - G. Reardon
- (I) Pacific Interpreters Contract - P. Bartush
- (I) Sports Medicine Admin. Fee – J. Ives Erickson/M. Sullivan

G. Reardon
Strategic Goal #3: Embrace Diversity

<table>
<thead>
<tr>
<th>Tactic #</th>
<th>Tactic</th>
<th>Immediate Action (I)</th>
<th>Sponsor(s)</th>
</tr>
</thead>
</table>

III. Project Charters
The group decided that for each strategic plan tactic there would be a project charter. Key aspects of the project charter include:
- Project Aim/Linkage to Strategic Goal
- Problem Statement
- In Scope
- Out of Scope
- Deliverables
- Resources Required/Team
- Metrics/Measurements
- Milestones

Please see the attached charter template, and an example provided by J. Somerville and G. Banister for Tactic 4: Reduce Hospital Acquired Pressure Ulcers. Tactics/initiatives requiring charters are indicated in section II, and sponsors should submit their charter(s) to L. Lebrun by Friday, October 15, 2010.

Charter Template:    Example Charter:

IV. Ongoing/Everyday Work – on radar, but not part of strategic plan

<table>
<thead>
<tr>
<th>Project/Initiative #</th>
<th>Project/Initiative Description</th>
<th>Immediate Action (I) Routine Action (R) Milestone(M)</th>
<th>Sponsor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reduce patient falls</td>
<td>(R) Monitor falls on unit based dashboard</td>
<td>K. Perleberg</td>
</tr>
<tr>
<td>2</td>
<td>Increase vaccination</td>
<td>(I) Everyone vaccinated receives a yellow sticker; both clinicians and non-clinicians – S. Taranto (I) October 21, 2010 – Article on the importance of vaccination – S. Sabia</td>
<td>S. Taranto</td>
</tr>
<tr>
<td>3</td>
<td>Promote safety lift use</td>
<td>(R) Continue to monitor</td>
<td>M. Sullivan</td>
</tr>
<tr>
<td>4</td>
<td>Fundraising plan for Nursing and PCS Center for Excellence</td>
<td>(M) Raise $10,000 by March 2010 (I) Work with development/HR for PCS/B3C fundraiser</td>
<td>M. Ditomassi</td>
</tr>
<tr>
<td>5</td>
<td>Utilize event reports</td>
<td>(R) Produce quarterly dashboard</td>
<td>K. Perleberg</td>
</tr>
<tr>
<td>6</td>
<td>Utilize process</td>
<td>(R)</td>
<td>M. Cramer</td>
</tr>
<tr>
<td></td>
<td>Improvement to streamline systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Laptop Encryption</td>
<td>(I) List of people out of laptop encryption compliance; Directors reach out to these individuals</td>
<td>PCSEC</td>
</tr>
<tr>
<td>8</td>
<td>Compass</td>
<td>(I) Teams being formed</td>
<td>TBD</td>
</tr>
<tr>
<td>9</td>
<td>Joint Commission Readiness</td>
<td>(I) Begin to communicate time frame in which JC will visit: 2/2011 – 4/2012</td>
<td>K. Perleberg</td>
</tr>
<tr>
<td>10</td>
<td>Magnet Redesignation</td>
<td>(I) Work with core team to design and carry out Magnet Redesignation Plan; Establish education and certification goals with Nursing Executive Operations Team</td>
<td>M. Ditomassi</td>
</tr>
<tr>
<td>11</td>
<td>Lunder Education Plan</td>
<td>(I) Hire individual dedicated to this initiative</td>
<td>TBD</td>
</tr>
<tr>
<td>12</td>
<td>Physiologic Monitors</td>
<td>(M) Complete roll-out; Connect with Safety Event Reports</td>
<td>T. Gallivan</td>
</tr>
</tbody>
</table>
I. General Updates:  
(F) Associate Chief Nurse Search: J. Ives Erickson shared an update with the group regarding the two candidate finalists. Although both appeared to be closely matched in the rankings from the PCSEC evaluations, their strengths differ and they both will need support developing their respective areas of limitation, whether it be learning the MGH culture/values or improving their skills in public speaking. There were also common themes expressed. The individual who takes on the position of associate chief nurse will need significant time devoted to learning the new role, getting to know a new peer group, and setting up new relationships. A number of key projects will be assigned including the move of the Neuro Units into the new Lunder building. According to a main stipulation of the backfill plan, the Burns Intensive Care Unit, including inpatient and outpatient, will need to move to better space. Transplant will also move to a new unit. An additional 4-5 new teams have been formed for the Care Redesign Team, which will also likely involve this associate chief nurse. The learning curve for this position will be steep. Given the number of responsibilities that fall under this role, particularly involving the Lunder building move, Debbie Burke has been reallocated oversight of the Cancer Center.

Discussion ensued about the benefits/drawbacks of two value-driven candidates: one with significant internal experience, and the other a highly qualified external candidate, with no MGH experience. PCSEC members agreed that they would interview each candidate again, and each candidate will present a presentation based upon a Harvard Business School case study. It was also suggested by J. Ives Erickson that the candidates meet with the chiefs at an upcoming meeting.
II. Strategic Tactics

(F) Review all Strategic Tactics

Strategic Tactic #1: Enhance Staff Responsiveness to Patients and Families

• G. Banister reported that her group is on target with 78.8, (actual 79.8) for RN communication; 80.9, (actual 81.6) for MD communication; 71.7 (actual 72.3) for room cleanliness; and 61.4 (actual 65) for staff responsiveness.

Strategic Tactic #2: Implement Hourly Safety Rounds

• K. Perleberg shared that all units and the ED are pleased with the results of hourly safety rounds. Standardization is helpful and all are observing the “7 Ps” during rounding.
• Data from falls and pressure ulcers from January – March, 2011 is still being compiled. In 2010, falls with injury rate from July-September, and October-December, were lower than the national benchmark.

Strategic Tactic #3a: Ensure Equitable Care for Patients – Create a Proactive Advocacy Program

• K. Perleberg reported that the metrics focus is on the Patient Family Advisory Council. This group is currently drafting a mission.

Strategic Tactic #3b: Ensure Equitable Care for Patients – Implement the Disabilities Program Plan

• K. Perleberg indicated that Zari Amirhosseini will be giving 20 presentations in 2011. Sessions are well attended.

Strategic Tactic #3c: Ensure Equitable Care for Patients – Improve Communication with Efficient Use of Resources and Technology

• P. Bartush shared that 51% of the V-POPs available are in use; 68% were used in the past month. There has been strong nursing support.
• To date, over 80 separate educational sessions have been offered on V-POP.

Strategic Tactic # 4: Reduce Hospital Acquired Pressure Ulcers

• G. Banister indicated that data is trending in a positive direction. Patient and family education is being offered. Hospital is not on target yet; more time is still needed.

Strategic Tactic # 5: Improve Hospital Cleanliness

• No update reported.
Strategic Tactic # 6: Increase Documentation Efficiency and Quality – ACD UAT Design Integration and Testing

• S. Millar indicated that the group is on track with Acute Care Documentation. Piloting of ACD will be in February of 2012. Work continues on how to create training models. Some work between the MGH and the Brigham will be helpful in this regard.

Strategic Tactic # 7: Revise Payroll System so that Non-Exempt Employees are Paid Accordingly to HR Policies. Begin Revising Scheduling Policies and Practices to More Precisely to Meet Workload Demand

• S. Millar spoke about moving the nonexempt payroll into Kronos. MGH is the last hospital to do this. Approximately 1,100 staff will be involved. There will be a number of various administrative issues connected to the new system. For example, if a nonexempt staff member was taking a 30-minute meal break and was interrupted to do work for 15 minutes, the employee would need to be paid for that 15 minutes.

Strategic Tactic # 8: Increase Direct Care Time – Supplies at the Bedside

• J. Ives Erickson reported that this tactic is on target.

Strategic Tactic # 9: Prevent Unnecessary Readmissions

• No update reported.

Strategic Tactic # 10: Execute Successful Move into the Lunder Building

• J. Ives Erickson indicated that this project is moving ahead on track.

Strategic Tactic # 11: Reduce Non-Salary Expenses

• No update reported.

Strategic Tactic # 12 – Enhance Staff Input in Decision-Making that Influences Care Delivery – Implement Re-designed Collaborative Governance Model

• G. Banister announced that the new Collaborative Governance model was launched in April, 2011, on schedule.

Strategic Tactic # 13 – Create and Implement a Diversity Fellowship

• D. Washington updated the group regarding the Hausman Fellowship. Photographs were sent on to Mrs. Hausman and she approved. Mrs. Hausman will also attend the graduation.
• The goal is to have at least two fellows in the first year. For the first year only, applicants will be selected from Patient Care Services to pilot the program. The focus will be on
three aspects of diversity in recruiting for the fellowship: race/ethnicity, persons with disabilities, and sexual orientation.

• The committee has until the end of April, 2011, to find a recipient.

III. (I) Announcements:

• K. Perleberg shared that the pocket guide for readiness, in anticipation of the upcoming visits from the Joint Commission, Magnet, and Department of Public Health, is ready for publication. The range of potential visit dates include: Joint Commission, from February 28-August 31, 2012; Department of Public Health in 2011; and, Magnet by October of 2012.

• G. Banister mentioned that the submission date for awards and recognition has been moved up to May 5, 2011. The goal is to receive 200 nominations in line with the 200th anniversary of the MGH.

• M. Sullivan spoke about how far Occupational Therapy has come since the 1960s. Nancy Watts was a visionary and thought leader who was responsible for elevating the practice to the level it has reached today.

• N. Sullivan shared that Peter Slavin, MD, participated on a healthcare panel on Channel 5’s “Chronicle” with healthcare leaders from across Massachusetts.

• J. Ives Erickson mentioned that there could be an upcoming strike from nurses at Tufts.

Action Items and Next Steps

• J. Ives Erickson mentioned that a topic for a retreat later this year would be to start grooming internal nursing directors as associate chief nurse candidates, so that when an associate chief position opens, a qualified candidate will be ready to move into the slot.

• J. Ives Erickson announced that the “five-minute updates” on the strategic tactics will take place every two months from now on. The exception to this rule will be if a tactic goes from green to red; in that case, the tactic will immediately be put on the agenda so that help will be forthcoming.
Jeanette Ives Erickson

2011 PCS Strategic Goals
Planning for success

Strategic planning is an important, dynamic, ongoing process in every successful organization—the larger the organization, the more important the strategic plan. I can assure you that the 2011 PCS strategic goals are the result of a thoughtful, comprehensive process based on the observations, ideas, and suggestions of staff and leaders from every discipline within Patient Care Services. Not only did they bring their considerable knowledge and creativity to the table as we had these discussions, they brought their understanding of patient-care needs, hospital systems, and appropriate allocation of resources.

Over a period of several months and numerous meetings and retreats, taking into account Partners corporate strategies, MGH strategic goals, and the fiscal and political climate surrounding healthcare reform, the PCS Executive Team arrived at what we consider the highest priorities for the coming year (see PCS Strategic Goals on opposite page).

We’ve seen the ambitious blueprint of the Partners-wide plan that focuses on care re-design, affordability, and revitalizing Partners’ reputation as a world-class healthcare organization. At the heart of that plan is the need to cut costs while continuing to improve care. This is the challenge faced by all hospitals and care providers as we transition into the era of national healthcare reform amid lingering economic unrest. As the largest service at MGH, it’s vital that Patient Care Services’ goals align with those of the hospital and with Partners’ strategic plan, as well.

A strategic plan is only as effective as the people who execute it. That means we need the engagement and participation of every person in Patient Care Services. As I said, strategic planning is an on-going process. Your thoughts and suggestions are welcome. Your insight and experience provide valuable guidance. Front-line staff are in a position to know what changes are necessary in order to improve systems.

Working together will be key as we try to identify opportunities to consolidate, improve, and/or standardize systems in an effort to eliminate waste. Working together will be key as we try to synthesize information faster, learn from our mistakes faster, and arrive at viable solutions faster. And what about data? Is there too much data? Are we using it effectively? We need to ensure that our data-collection, presentation, and distribution are meaningful, relevant, and user-friendly. As we move forward, we’ll be seeking your input on which data you think is necessary and which isn’t.

At a recent retreat, I asked attendees (PCS Executive Team and leadership from all PCS disciplines) to brainstorm ideas about how to improve throughput,

continued on next page

“It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change.”
—Charles Darwin
I can assure you that the 2011 PCS strategic goals are the result of a thoughtful, comprehensive process based on the observations, concerns, ideas, and suggestions of leaders from every discipline within Patient Care Services. I believe our 2011 strategic goals we need to focus on in the coming year and complement the goals identified by MGH and Partners. I look forward to working with you as we execute the tactics described below. For more information, or if you have any questions, please consult your directors or supervisors.

### 2011 Patient Care Services Strategic Goals

#### Meet or exceed expectations of patients and families
- Enhance staff responsiveness to patients and families
- Implement hourly safety rounds
- Ensure equitable care for patients
- Create a proactive Advocacy Program
- Implement the Disabilities Program plan
- Improve communication with efficient use of resources and technology (e.g., V-POP, communication boards, vision and hearing enhancers, etc.)
- Reduce hospital-acquired pressure ulcers
- Improve hospital cleanliness

#### Enhance care-delivery by improving the efficiency and effectiveness of systems
- Increase quality and efficiency of documentation
- ACD UAT design and integration testing
- Continue process improvement
- Revise the payroll system so non-exempt employees are paid according to HR policy
- Revise scheduling policies and practices to more precisely meet workload demands
- Increase direct-care time
- Move supplies closer to the bedside
- Prevent unnecessary re-admissions
- Execute a successful move into the Lunder Building
- Reduce non-salary expenses

#### Ensure staff have a strong voice in the design of care and services
- Enhance staff input in decision-making that influences care-delivery
- Implement re-designed collaborative governance model
- Create and implement a diversity leadership fellowship
- Increase efficiency and effectiveness of educational offerings across PCS departments
Massachusetts General Hospital  
Patient Care Services Retreat  
October 17, 2011  

8:00am to 5:00pm  
Liberty Hotel: West Cedar Room  

Agenda

7:00 AM  A light breakfast will be available
7:30 AM  Welcome and overview
7:45 AM  Update on Care Redesign and Patient Affordability
8:15 AM  Questions
8:30 AM  Strategic Risks: open discussion
10:00   Break
10:30   Break-out groups
   A) Innovation 1
   B) Innovation 2
   C) Throughput: Role of PCS to ensure more efficient and timely care delivery
12:00   Lunch
1:15 PM  Report out from break out groups
1:45 pm  Break-out groups: defined from morning discussions
2:45 PM  Break
3:00 PM  Report out
3:30 PM  Educational requirements to advance change
4:00 PM  Communicating change
4:30 PM  Open discussion and next steps
5:00 PM  Adjourn
Patient Care Services Retreat
8:00 a.m. 5:00 p.m.
Liberty Hotel, West Cedar Room
November 17, 2012

Agenda

1. Mission, Vision, Values and Credo
2. 2011 Strategic Plan and Outcomes
3. Patient Affordability
   - Background
4. Patient Affordability Goals and Metrics
5. Length of Stay
6. Staffing Standards
7. Care Redesign Goals and Metrics
8. PCS Retreat Summary
9. Draft 2012 Strategic Work Plan
10. Next Steps
Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse

Our mission:
To provide the highest quality care to the individuals and communities we serve, near and far; to advance care through excellence in biomedical research; and to educate future academic and practice leaders in the healthcare professions.

If there’s one thing we’ve learned from years of working and planning together, it’s that the more challenging the times, the more ambitious our strategic plan needs to be. With the country’s volatile political and economic climate combined with the critical need to make health care more efficient and affordable, the leaders of Patient Care Services have crafted a strategic plan that is, indeed, ambitious. After months of thoughtful deliberation, we have identified the following strategic goals for 2012–2013:

1) Develop an efficient and effective patient- and family-centered model of care that advances our relationship-based philosophy
2) Lead patient-affordability and care re-design initiatives
3) Design and implement new programs to improve patient- and family-satisfaction
4) Advance the culture of Excellence Every Day
5) Design and implement clinical and business information systems that support patient care, education, and research

I’d like to share just some of the tactics, programs, and initiatives we’re employing to achieve these goals. Perhaps our efforts related to Goal #1 (developing a patient- and family-centered model of care that advances our relationship-based philosophy) are most visible with the recent launch of our 12 innovation units. These special units have introduced a number of interventions, such as the new attending nurse role; use of the SBAR tool (Situation-Background-Assessment-Recommendations) to improve hand-off communication; a new Patient-Family Notebook; inter-disciplinary team rounds, and other care-delivery enhancements to test their impact on clinical outcomes, unit costs, length of stay, and patient- and staff-satisfaction.

It’s only been four months since we launched the innovation units, but already both anecdotal and HCAHPS feedback has been overwhelmingly positive. We’ve realized significant gains in most key indicators (nurse and physician communication, cleanliness, night-time quiet, pain-management, and others). And the aggregate length of stay for innovation units (excluding the NICU and ICUs) has come down 3.3%, an improvement that many attribute to the attending nurses’ involvement in coordinating care and discharges.

It appears that interventions on innovation units are making a difference, but we’re employing a robust system of evaluation and analysis to ensure the real data supports the feedback we’re receiving. We’re planning a retreat for the fall to share best practices and explore ways to roll out (appropriate) interventions on a larger scale.

continued on next page
Goal #5 (designing and implementing information systems that support patient care, education, and research) is crucial to the success of all our other goals. Seamless electronic documentation, safety reporting, and clinical and payroll systems are the underpinnings of our ability to provide high-quality care. Enhancing our information systems and educating the workforce on their use and applications are the mainstays of our strategic plan.

I said it was ambitious. We know that health care is in dire need of decisive, demonstrable change, so to deliver anything less would be short-sighted. I’m confident that with our collective wisdom and creativity, we will effect the solutions necessary to continue to provide excellent care to every patient and family every day.

Updates

I’m pleased to announce the following appointments:

- Jan Filteau as nurse manager in Case Management
- Erika Rosato, RN, as nursing director for the Yawkey 8 Infusion Unit and the Yawkey 7 Henri & Belinda Termeer Center for Targeted Therapies
- Vanessa Gormley, RN, as clinical nurse specialist for the Lunder 7 Neuroscience Unit
- Melissa Donovan, RN, as clinical nurse specialist for the White 8 General Medical Unit
- Meghan McDonald, RN, as clinical nurse specialist in the Emergency Department
- Stephanie Ball, RN, as clinical nurse specialist for the Blake 12 ICU

Our tactics for achieving Goal #2 (leading patient-affordability and care re-design) are closely aligned with MGH strategic goals and the Partners Patient Affordability Direct Care initiative. We’re focusing primarily on reducing non-salary expenses and ensuring appropriate utilization of resources. Much of this work overlaps Goal #1: looking for ways to reduce length of stay, exploring new processes for safe and efficient transitions of care, and participating on care-re-design teams to translate ideas into practice.

Goal #3 (designing and implementing new programs to improve patient- and family-satisfaction) will require the active participation of every member of the Patient Care Services team. We’ve conducted a thorough review of the HCAHPS data to identify the most pressing opportunities for improvement. Our efforts will center around noise-reduction, cleanliness, increased communication and support for patients and families, and the development of a cultural competence education program.

I can’t think of Goal #4 (advancing the culture of Excellence Every Day) without thinking of our dear friend, Keith Perleberg. He would want us to carry on this important work, and that’s exactly what we’re going to do. Our Excellence Every Day portal has already become an indispensable resource for staff, and we’ll continue to enhance it with information related to Magnet evidence-preparation, Joint Commission readiness, collaborative governance, innovation-unit updates, and other key issues. We’re working closely with the PCS Office of Quality & Safety to develop systems to monitor and evaluate patient-centered outcomes, and this information will be broadly shared throughout Patient Care Services.

Goal #5 (designing and implementing information systems that support patient care, education, and research) is crucial to the success of all our other goals. Seamless electronic documentation, safety reporting, and clinical and payroll systems are the underpinnings of our ability to provide high-quality care. Enhancing our information systems and educating the workforce on their use and applications are the mainstays of our strategic plan.

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Patient Care Services Executive Committee  
August 8, 2012  
2:30 to 4:00 p.m.  
Massachusetts General Hospital  
Trustees Room

MINUTES

Presiding: J. Ives Erickson, RN, DNP  
Present: G. Banister, RN, PhD, L. Carbunari, RN, M. Cramer,  
M. Ditomassi, RN, DNP, R. Kacmarek, PhD, R. Lipkis-Orlando, RN,  
S. Millar, RN, W. Newell, A. Nunes, J. Polk, G. Reardon,  
M. Sullivan, DPT, N. Sullivan, S. Taranto, D. Tenney, RN,  
D. Washington, RN, PhDc

Guests: Saira Chaudary, Administrative Fellow, Patient Care Services  
Dr. Dungan Yang, Director of Party Committee, Office and Organizational Division, Peking Union Medical College Hospital, Beijing, China

Staff Support: M. Greenberg

1. **MGH Recognition – J. Ives Erickson, RN, DNP**  
   - J. Ives Erickson, RN, DNP, congratulated the group on the U.S. News recognition of MGH as the #1 Hospital. In addition, she thanked the team for their contributions in making the July 23-27, 2012, Joint Commission accreditation visit successful.

2. **Introductions – G. Banister, RN, PhD, and Marianne Ditomassi, RN, DNP**  
   - G. Banister, RN, PhD, introduced Dr. Dungan Yang, Director of Party Committee, Office and Organizational Division, Peking Union Medical College Hospital, Beijing, China, who is a visiting Administrative Fellow.  
   - G. Banister, RN, PhD, introduced Saira Chaudary, Administrative Fellow, in Patient Care Services.  
   - M. Ditomassi, RN, DNP, introduced Rev. John Polk, newly-appointed Director of MGH Chaplaincy. He joins the team from St. Luke’s Hospital in Kansas City.

3. **Joint Commission – J. Ives Erickson, RN, DNP**  
   - J. Ives Erickson, RN, DNP, reviewed the Joint Commission’s list of Preliminary Direct and Indirect Impact RFIs. In addition, she reviewed a list of suggestions for improvement identified during the Joint Commission process.

4. **PCS Staff Advisory Committee – M. Sullivan, DPT**  
   - M. Sullivan, DPT, reviewed the proposal for the PCS Staff Advisory Committee. The first targeted meeting is November 14, 2012. Key to the next meeting is for PCSEC members to share this opportunity with their staff and promote applications (using Collaborative Governance application form). It was also noted that we need to identify a project manager to support this new group.
5. PCS Strategic Plan and Tactics – J. Ives Erickson, RN, DNP

- J. Ives Erickson, RN, DNP, led the group through the 2012-2013 strategic goals and tactics, and identified tactics which were completed and those in process, that will be discussed further at the September 18, 2012, PCSEC Strategic Planning Retreat. M. Ditomassi, RN, DNP, will revise goal/tactic worksheet to reflect discussions.

6. Announcements – All

- S. Millar, RN, identified that additional security questions will be required in the future to ensure security of information systems.
- S. Taranto announced that there will be an RN market adjustment in early September, 2012. Details will be forthcoming.
### PCSEC 2012 Strategic Goals & Tactics
#### PCSEC Member Lead – Worksheet (As of 8.8.12)

**Goal # 1: Develop an efficient and effective patient and family centered model of care delivery advancing a relationship-based care philosophy.**

<table>
<thead>
<tr>
<th>Tactic</th>
<th>Status</th>
<th>Next Steps</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish 12 innovation units to test the elements of the care delivery model across the care continuum.</td>
<td>Done</td>
<td>- Create sustainability plan.</td>
<td>Associate Chiefs and Health Professions Directors</td>
</tr>
<tr>
<td>Capture and integrate best practices and spread to other units.</td>
<td>Ongoing:</td>
<td>- Evaluation</td>
<td>G. Banister with Munn Center</td>
</tr>
<tr>
<td>Seize opportunities to obtain input into/feedback about innovation unit interventions from patients and families, e.g. PFACs, focus groups, rounds, etc.</td>
<td>Ongoing:</td>
<td>- Evaluation</td>
<td>G. Banister with Munn Center; Support from Rick Evans and Robin Lipkis-Orlando</td>
</tr>
<tr>
<td>Ensure robust measurement systems to capture outcomes of innovation units.</td>
<td>- Dashboard complete</td>
<td>- Update monthly</td>
<td>M. Ditomassi</td>
</tr>
<tr>
<td>Focus on patient and staff satisfaction.</td>
<td>- HCAHPs data</td>
<td>- Associate Chief Nurses and Health Professions Directors communicate findings to staff and develop performance improvement plans</td>
<td>Associate Chiefs and Health Professions Directors</td>
</tr>
<tr>
<td>Address inequities in quality and access to care: conduct unit-level culture rounds.</td>
<td>- Culture Rounds</td>
<td>- Develop plan</td>
<td>D. Washington with support from Anabela Nunes and John Polk</td>
</tr>
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</table>

**Goal # 2: Lead Patient Affordability and Care Redesign initiatives.**

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Reduce supply expenses (inpatient, ED, and OR).</td>
<td>- MGH Committee to be established.</td>
<td>- Share update at future PCSEC meeting</td>
<td>PCSEC G. Reardon/B. Kacmarek (co-leads)</td>
</tr>
<tr>
<td>Develop inpatient, ED, and</td>
<td>- Inpatient done</td>
<td>- Continue</td>
<td>OB – D. Burke</td>
</tr>
</tbody>
</table>
| OR staffing standards. | - OB in development  
- ED - hold  
- OR - hold | development of OB, ED and OR staffing standards. | ED – T. Gallivan  
OR – D. Tenney |
|---|---|---|---|
| Ensure appropriate utilization of ED resources; reduce ED LOS for both admitted and discharged ED patients. | - ED volume has increased 7% without increasing LOS  
- Metrics for monitoring by Partners ED leaders group established  
- Planning for additional Short Stay unit to assist in decompressing ED | - Ongoing monitoring of metrics and development of response plans  
- New unit to open on July 30 | T. Gallivan |
| Utilize best practice strategies to contribute to a hospital-wide initiative to reduce LOS. Create new process for safe and effective transitions of care including those to outpatient practices and with Partners Continuing Care (PCC). | - Innovation Units | - Need Plan | J. Ives Erickson  
T. Gallivan |
| Participate in Care Redesign team efforts and integrate ideas generated from these teams into practice. | - There is PCS representation on all Care Redesign teams, as appropriate. | - Continue to participate in Care Redesign teams and provide updates to PCSEC team. | PCSEC |
| Ensure care is equitable across the continuum. | | | |

**Goal # 3: Design and implement new programs to improve Patient and Family Satisfaction.**

<table>
<thead>
<tr>
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</tr>
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</table>
| Design and develop new tactics to improve cleanliness, noise reduction and staff communication. | - Initiatives have been designed to: promote cleanliness, implement quiet hours, and promote staff communication with patients through hourly safety rounds | - Continue to work with staff on cleanliness, noise and communication initiatives.  
- Keen focus on hourly rounding. | - Clean – G. Reardon  
- Noise – R. Evans  
- Staff Communication – Associate Chiefs and Health Profession Directors |
| Engage interpreters more in patient and family dialogue and in quality related activities. | - Medical interpreters participate in quality rounds.  
- Interpreters available in person, by | - Continue to identify opportunities to engage interpreters | A. Nunes |
<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Increase volunteer presence at information desks to proactively support patients, families and visitors.</td>
<td>- Volunteers at front desk have been oriented to playing a more proactive role in welcoming and escorting patients/families.</td>
<td>- Continue to promote volunteer greeter and escort role.</td>
<td>W. Newell</td>
</tr>
<tr>
<td>Increase presence of Patient Advocates to patients, families and clinicians; engage volunteers in this work.</td>
<td>- Patient Advocates rounding on Innovation Units.</td>
<td>- Identify opportunities to expand Advocate rounding to additional units; Explore role that volunteers can play to support this work.</td>
<td>R. Lipkis-Orlando W. Newell</td>
</tr>
<tr>
<td>Develop and implement Cultural Competence education program.</td>
<td>PCSEC Discussion</td>
<td>Develop curriculum</td>
<td>J. Ives Erickson (short-term; D. Washington (long-term plan)</td>
</tr>
<tr>
<td>Utilize Service Excellence program to create a greater “presence” with patients and families.</td>
<td>Implementation of MGH service strategy elements is underway: - Extensive staff and leader education about key patient experience measures - increased and refined reporting of key metrics to support unit level service improvement plans - efforts to strengthen hourly rounding - implementation of best practices including quiet times and discharge phone calls</td>
<td>- Expand implementation of quiet times to other units - Implement discharge calling on all Innovation Units and launch automated calling system - work with Associate Chiefs to strengthen hourly rounding - further refinement and standardization of key metrics reports</td>
<td>R. Evans</td>
</tr>
</tbody>
</table>

**Goal #4: Advance the Culture of Excellence Every Day (EED)**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Develop structures for collecting and submitting Patient-Centered outcome measures.</td>
<td>- HCAHPs - Quality indicators - Staff Perceptions Survey - RN survey (NDNQI)</td>
<td>- Continue to collect and disseminate outcome data; develop unit-specific performance improvement plans.</td>
<td>Associate Chiefs and Directors</td>
</tr>
</tbody>
</table>
Further develop Excellence Every Day portal as a practice resource for staff.

- Robust resource.
- New portal pages added each month.
- Innovation Unit component added to site.
- Continue to develop new pages based on practice priorities and keep previous pages updated.

M. Ditomassi/G. Banister/K. Whitney

Inform, educate and engage others in advancing the PCS strategic goals.

- PCSEC members shared plan with respective team
- Align respective areas of accountability plans with PCS plan
- Interdisciplinary advisory committee
- Caring Headlines updates
- Continue to promote communication about PCS strategic plan

PCSEC

Develop a strategic communication plan to promote Excellence Every Day culture.

- Revision of EED Resource Guide
- EED portal page
- Unit tracers
- Sustainability plan

K. Whitney with PCS Quality & Safety team

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**Goal # 5: Design and implement clinical and business information systems that support patient care and research**

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Participate in design and implementation of new documentation and safety enhancement systems.</td>
<td>- Partners Committees established</td>
<td>- Need Education Plan for leadership and staff</td>
<td>J. Ives Erickson</td>
</tr>
<tr>
<td>Implement new Timekeeping systems.</td>
<td>- Develop plan, education and policies to implement Kronos system.</td>
<td>- Implement 8/5/12</td>
<td>S. Taranto</td>
</tr>
</tbody>
</table>
| Participate in Enterprise Clinical System Development. | - Partners Committees established           | - Focus year one will be at Sr. Executive level
  • Develop education plan | J. Ives Erickson |
| Educate the workforce regarding utilization and compliance of new electronic applications, e.g., electronic white-boards, Voalte phones. | - Wave 1 rollout done | - Need roll-out plan | G. Reardon/G. Banister |
The Institute for Patient Care 3rd Annual Retreat

Agenda

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Date: December 8, 2011
Time: 7:30am – 4:00pm—Program begins at 8:00 am
Dress: Casual
Location: Charles Navy Yard - Bldg 75-1103
Next to the garage in Navy Yard. If taking the shuttle, get off at Bldg. 149 and go across the street.

I. Welcome/Overview/Mutual Expectations, Norms, and Commitments

II. Community-Building
   
   A. Appreciation/Recognition/Key 2011 Accomplishments
   B. Announcement

III. Context/Landscape: Challenges & Opportunities
   
   A. What's happening at Partners that will influence The Institute for Patient Care?
   B. Patient Care Services Strategic Plan & Innovation Units
   C. The Institute for Patient: Visioning for the Future and Strategic Opportunities
   D. Group Discussion—Breakout sessions

IV. Operational Excellence: Collaboration, Competencies, Challenges
   
   A. Case Study: RN Residency (via a Panel) --What we attempted, what we did, impact thus far, synergies, process and outcome victories, lessons learned, next adaptations.
   B. Other challenges or cases
   C. Group discussion

V. Innovation Units, Acute Care Documentation and Other Opportunities for Collaboration/Synergy
   
   A. Creating structures and processes
   B. How should we best monitor and reinforce our actions

VI. Next Steps/Concrete Action Planning

VII. Closing Commitments/Remarks