TL 4 EO: One CNO-influenced organization-wide change.

“As everyone at MGH well knows, there’s no such thing as “the status quo” in health care. Change is the order of the day, every day. Technology changes. The economy changes. Patients change. And we change. I am reminded of the quote by German poet/playwright, Bertolt Brecht, ‘Because things are the way they are, things will not stay the way they are.’ We can attest to the truth of that statement.”

The above quote from the Chief Nurse’s (CNO) editorial column in the September 1, 2011 issue of the Patient Care Services’ (PCS) newsletter, Caring Headlines, aptly sets the stage for this source of evidence. Under the leadership of the CNO, today’s dynamic healthcare environment is viewed as an exciting time in the evolution of care delivery. It is also viewed as a great time to be a nurse influencing the future of the nurse-patient relationship. As the healthcare system undergoes massive change, it’s is an opportune time to creatively design and trial new care delivery models that hardwire patient safety across the trajectory of care and better integrates patients and their families into decision-making. On March 19, 2012, twelve inpatient units at Massachusetts General Hospital (MGH) were asked to implement a core set of interventions with the shared objective of making care delivery more effective and efficient for patients, families and staff.

1. Describe the purpose and the background:

As mentioned in TL 4, the CNO has been an instrumental leader in Partners HealthCare Systems’ “Direct Patient Care” component of the Patient Affordability and Care Redesign initiative. This initiative not only addresses the changing healthcare landscape at the system-wide level of Partners HealthCare but specifically at each entity within Partners. This work has been conducted recognizing that the best way to be responsive to change is being creative, innovative, and always remaining open to new ideas. This work was launched at a time when national health care reform and a troubling economic climate were on the forefront of health care delivery, nationally. The planning process that emerged rendered two main areas of focus (Attachment TL 1.c):

1. **Care redesign** efforts were realized by convening a multidisciplinary team to identify new approaches to care while focusing on conditions and episodes rather than traditional procedures, visits, and admissions. Examples of the medical conditions selected include colon cancer, coronary disease, stroke, diabetes, and primary care.

2. **Patient affordability** focused on comprehensive efforts to reduce direct patient care costs, improve patient flow, enhance managing human resources, and reduce overhead expenses.

Under the heading of patient affordability, the initial efforts focused on opportunities to reduce costs within inpatient settings, the emergency room and the perioperative setting. During the initial review of existing practices, the Partners System saw standardization emerge as a common theme essential to achieving potential cost savings. This involved standardization and consistency of supplies used and new products accessed across the Partners System along with the articulation of shared rules for adopting new technology.

As it relates to direct patient care, this discussion ultimately led to the exploration of a new care delivery model. The CNO, Jeanette Ives Erickson, co-chairperson of this effort at the Partners and MGH levels, believed that designing a new patient care delivery model especially focused on the delivery of care to patients with specific health problems would allow the organization to be more
cost-effective and ultimately develop more efficient practices with the real goal of improving patient care. The CNO noted that “Redesigning care will require transformational change that cannot occur at the risk of our patients.”

The belief that change can be “designed, tested, evaluated, and replicated” on Innovation Units led to an organization-wide opportunity for all clinicians to step forward with ideas to enhance quality and safety. Just as the name implies, Innovation Units were specifically created to test, change and measure outcomes. The framework was to design, implement, re-calculate, re-group, adapt or abandon the ideas altogether. The interventions on Innovation Units would be geared toward improving clinical outcomes, enhancing patient- and staff-satisfaction, and reducing costs and lengths of stay.

The Chief Nurse used the wisdom of Dr. Richard Bohmer and Dr. Thomas Lee in their New England Journal of Medicine article, The Shifting Mission of Health Care Delivery Organizations to design her approach to launching Innovation Units. They state, “The knowledge of how to configure structures and processes to attain the best possible clinical outcomes will become health care organizations’ most important asset. In outcome-oriented organizations, production knowledge regarding how to go about improving patients’ outcomes is as much an organizational property as an individual one. Hence, organizational learning is critical and requires deliberate action. Evaluating experience and using it to inform ways of improving clinical outcomes is the new mindset.”

Care Delivery Models

Of note, Partners HealthCare System’s pursuit of an effective care delivery model began in 1996 when the corporation engaged Health Workforce Solutions (HWS), a human resources consulting firm, in the development of a long-term recruitment and retention strategy to meet future patient care demand. In fact, the MGH CNO led this effort in conjunction with the Partners Chief Nurse Council members. Integral to the long-term workforce question was an underlying research query asking the following questions: 1) What new innovative care delivery models are being tested across the United States that have the potential to change or reinvent care delivery? 2) What promise do these models hold? 3) What roles do nurses play within the new care delivery models? 4) How do these new models impact quality of care? 5) Are the models cost-effective? 6) Can the new model be replicated or adapted to different regions or markets?

These six key questions posed by Partners Health Care System Administrators and Chief Nurses formed the basis for HWS’s initial research into care delivery models. Their research led to the identification of five common elements to be included in new care delivery models, as follows:

<table>
<thead>
<tr>
<th>Five Common Elements for Inclusion in New Delivery Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>An elevated nursing role from traditional care delivery to serving as a coordinator of care for patients and families.</td>
</tr>
<tr>
<td>Sharpened focus on the patient and family and strategies to promote greater patient and family involvement.</td>
</tr>
<tr>
<td>Smoothing of patient transitions and handoffs through the use of specialized tools for assessment, teaching, communication and measurement.</td>
</tr>
<tr>
<td>Leveraging of technology to enable care model redesign. Examples include electronic medical records, cell phones, bar-coding systems for inventory and medication, to name just a few.</td>
</tr>
<tr>
<td>Recognizing the importance of producing measurable results.</td>
</tr>
</tbody>
</table>
The common elements pointed toward the value of patient-centered care, which can be realized or enhanced within the context of a new and innovative patient care model. The focus on the patient and family to improve communication with renewed attention to safety and resource use that are not only cost effective and of high quality but also can enhance overall patient, family and staff satisfaction with care during hospitalization was the goal.

2. Discuss how the work was done (methods or approach); and, 3) Discuss who was involved and what units participated.

The elements from the HWS study served as the underpinnings of MGH’s current Innovation Units. The core principles behind these Innovation Units are:

<table>
<thead>
<tr>
<th>Core Principles for Innovation Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care is patient- and family-focused, evidence-based, accountable, autonomous, coordinated, and continuous.</td>
</tr>
<tr>
<td>Clinicians are intentionally present and know their patient.</td>
</tr>
<tr>
<td>Care is provided by designated nurses and physicians who assume accountability to ensure continuity.</td>
</tr>
<tr>
<td>Continuity of team care delivery is a basic precept.</td>
</tr>
<tr>
<td>Each patient has the opportunity to participate in the planning of his/her care.</td>
</tr>
<tr>
<td>Technological advancements create opportunities for improved communication and efficiency.</td>
</tr>
</tbody>
</table>

The launching of the Innovation Units was initiated by the CNO, Jeanette Ives Erickson, of MGH. It began with a call for applications in August 2011 to become an Innovations Unit (Attachment TL 4EO.a) Interested units submitted proposals based on a template (Attachment TL 4EO.b), articulating areas for improvement and specifically speaking to strategies that they believed would enhance continuity of care, promote interdisciplinary rounds, embrace patient and family relationship-based care, and develop tactics to enhance efficiency. Twelve Innovation Units were selected to participate in this inaugural work and spanned the practice areas of Pediatrics (Ellison 17 & 18), General Medicine (Ellison 16), General Surgery (White 7), Vascular Surgery (Bigelow 14), Orthopaedics (White 6), Oncology (Lunder 9), Newborn/Family (Blake 13), Psychiatry (Blake 11) and three intensive care units (Blake 4 Neonatal, Ellison 9 Cardiac, and Blake 12 Surgery). Attachment TL 4EO.c and Attachment TL 4EO.d are examples of proposal submissions from Lunder 9 Oncology and Ellison 16 Medicine.

Interdisciplinary leadership and staff working on the selected Innovation Units began the work of redesign on the Innovation Units by attending a series of three retreats (See Attachment TL 4EO.e for copies of retreat agendas). Attachment TL 4EO.f displays the 165-person list of retreat participants. In addition to the Innovation Unit leadership and Attending Nurses, 40% of the participants were representatives from departments and disciplines across the Hospital (highlighted in yellow.) Changing the care delivery model requires the involvement of the Hospital community. Attachment TL 4EO.g is an example of feedback from the Associate Chief of Pharmacy for being included in the strategic initiative.

At the retreats, a framework was presented to participants in an effort to help align the units around enhancing the patient’s journey. A continuum of care diagram was used to illustrate the process of care before, during, and after hospitalization. The schematic highlights the “gaps” found along the continuum of care to be closed with care delivery redesign.
To address these gaps, over the series of the retreats, the twelve MGH Innovation Units identified interventions that they believed were central to the new work of care redesign. Attachment TL 4EO.h is the recap of the 12.12.11 retreat at the beginning of the 12.19.11 retreat. Attachment TL 4EO.i is the closing presentation at the 1.23.12 retreat which ends with a slide identifying the kick-off date for Innovation Units – March 19, 2012.

Over the course of the retreats, the following interventions were identified:

**Relationship-Based Care**

Relationship-based care is more than an intervention; it’s a philosophy, a way of thinking about care delivery. Koloroutis and colleagues describe three tenets of relationship-based care: a) the caregiver’s relationship with the patient and family; b) the caregiver’s relationship with his or her colleagues; and, c) the caregiver’s relationship with himself/herself, known as self-awareness. In an organization that provides relationship-based care, every member of the team knows the patient as a person and has access to information across the continuum. The team participates in coordination of care, knows who’s responsible, and reviews the plan daily with the patient, family, and team. In addition, the team builds the plan of care around the patient’s goals and expectations and coordinates patient care and teaching with essential information needed and provides time to evaluate learning. The team also aligns support around patient populations rather than transactions.

**The Attending Nurse Role**

At the heart of the Innovation Unit model is the introduction of an innovative nursing role, the Attending Nurse. Within the context of the MGH model, the Attending Nurse functions as a clinical leader and coordinator managing care of patients on a single unit from admission to discharge. The Attending Nurse interfaces with the interdisciplinary team, the patient, and the family.
to foster continuity and responsiveness to issues that can promote effectiveness, safety, quality, and efficiency. Components of the Attending Nurse role are outlined in a position description (Attachment TL4EO.j) The Attending Nurse role is budget neutral. No additional direct care staffing resources were allocated to the Innovation Units.

**Enhancing Handover Communication**

Time constraints require nurses to share essential information quickly, but nurses self-report that the information they provide and receive during patient handover situations is highly variable from nurse to nurse. Research has shown that up to two-thirds of sentinel adverse events in hospitals are related to communication problems. Towards that end, this intervention responds to the need to relay patient information from caregiver to caregiver, from caregiver to patients and families, and from the hospital to other organizations or to the patient’s home quickly, accurately, and timely. The process relies heavily on the SBAR (Situation, Background, Assessment and Recommendations) communication tool that “prompts” caregivers to provide complete information during handovers. This intervention should be thought of not as the introduction of a new tool, but as an implementation of a new standard of practice. Effective communication handoffs promote safety, efficiency, and effective outcomes.

**Welcome Packets**

When patients have input into clinical communications, organizations see a reduced risk of fragmentation of care, miscommunication-related adverse events and a greater likelihood of continuity of care. Innovation Unit welcome packets contain two key components: a patient and family notebook and a discharge envelope. This intervention was developed to introduce patients and families to the Innovation Unit; assist the patient and family in becoming actively involved in the patient’s care; identify patient education needs; and help plan for discharge. These goals are accomplished by staff through encouraging patients and families to use the notebook each day to take notes and write down questions about their care. Patients and families also have the opportunity to write down questions and concerns to discuss with the nurse and team members prior to patient discharge.
Staff also reviews the discharge checklist throughout the hospital stay so that patients are better prepared for discharge. The discharge checklist is designed as an envelope and ensures that one place exists to store important patient education information, include the patient notebook, and discharge instructions and is available for patients and families to take home.

Enhancing Pre-Admission Data Collection

One goal of the Innovation Units is for nurses to better understand the patients and related health problems they face before and while they are being cared for. To ensure continuity and accurate information-gathering for all patient populations, a new Admitting Face Sheet was developed. This sheet includes the patient’s anticipated discharge date and projected discharge disposition to better inform interdisciplinary care planning. This data contains information about the patient that reinforces the focus on discharge planning and begins upon the patient’s admission to the hospital.

Domains of Practice and Care Contributions

With implementation of interdisciplinary rounds it becomes essential for all professional providers to have an increased understanding of all the disciplinary domains of practice involved with the health care team. Towards that end, each discipline was charged with reviewing and updating their domains of practice. This information was shared in various forums to heighten awareness and understanding of each discipline’s scope of practice. Identifying domains of practice is designed to optimize resources and contributions from all members of the health care team and utilize professional knowledge within the boundaries of licensure, certification, and scope of work. Attachment TL 4EO.k contains an example of a domain of practice statement by the Nutrition and Dietetics Department.

Interdisciplinary Team Rounds

Prior to launching the Innovation Units, no consistent formal mechanism existed for daily communication between and among all members of the care team. Interdisciplinary rounds is an effective strategy that brings all members of the team together on a daily basis to identify obstacles to the progression of care, create a more holistic approach to care delivery, and ensure that issues are shared and addressed in a timely manner.

Early feedback on this intervention suggests that a majority of clinicians agreed with the interdisciplinary rounding intervention and reported an improvement in daily work and efficiency. One staff member noted,

“Interdisciplinary rounds keep everyone on the same page. We identify the target discharge date and discuss the post-hospital plan. Having everyone together at the same time, we all hear the same information and can align our schedules accordingly in a way that's best for the patient. It has definitely improved communication.”

Supporting Technology

Efficient, well-coordinated care depends on the staff’s ability to communicate effectively. Having the right tools makes communication faster and easier. Technological advances facilitate staff communication in fast-paced clinical settings. The staff members working on the Innovation Units are equipped with specially programmed phones and portable, wireless laptops to make access
to, and dissemination of, information more efficient. And in-room whiteboards and electronic whiteboards at nurses’ stations enhance the ability to know the patients and coordinate their care.

**Discharge Planning and Readiness**

An array of tools is contained in a Discharge Planning toolkit designed to proactively facilitate planning for patients’ discharge. The expectation is that from the moment a patient is admitted, staff begin to work with patients, family, and team members to identify potential barriers and/or risks that might delay the discharge process. More specifically, each patient is known to the nurse and interdisciplinary team, and responses to the care experience are carefully documented throughout the patient’s hospitalization. In addition, measures, tools, and checklists have also been implemented to ensure that each patient has a plan of care and a proposed length of stay that matches their medical necessity and is enhanced by effective communication, documentation, and optimal system functioning.

Also, screening tools support the identification of patients who are at high risk for readmission. The implementation and assessment of these evaluation measures have been the result of collaborative efforts with representative caregivers from across the care continuum. Nurses from acute, non-acute, and home care settings have all had an active voice in defining the concept of discharge readiness and to recognize when it is not present and actions needed to ensure timely discharge.

**Discharge Follow-Up Phone Call Program**

In an effort to reduce hospital readmissions, manage care effectively outside of the acute care setting, and ensure patients understanding of discharge instructions, a discharge follow-up phone call program was implemented on all Innovations Units. This intervention provides a way to ensure that patients can manage their care at home and understand discharge instructions, to communicate the staffs’ care and concern for patients after they leave the hospital, and to enhance patients’ impression and overall satisfaction with the hospital experience.

Follow-up calls are made 24-48 hours after discharge. Evidence suggests that the phone call can be used to gather data, facilitate symptom management, and clarify instructions for the patient and family. This research found that patients who received follow-up phone call at 24 and 72 hours after discharge experienced improved symptom management, decreased anxiety, and better physical function within the first 72 hours post discharge. Patients commented that even when they had a problem, “I knew my nurse would be calling this afternoon, so I waited for her.” Continued monitoring impact of the discharge phone calls continues to be assessed through measures of patient satisfaction responses and relevant quality and readmission data.

**Dedicated Resources**

The CNO recognized that a critical success factor for the Innovation Unit initiative was to provide dedicated project support. Towards that end, each of the twelve Innovation Units were assigned a Project Manager. The Project Manager expectations were as follows:

*Project Support Expectations:*
- Each Innovation Unit will have dedicated project support for a minimum of 8-hours per week (project staff will also be required to attend 2 hours of project meetings each week).
Attachment TL 4EO.1 is a set of minutes from the weekly Innovation Unit Project Manager meetings.

- Project staff will be assigned to support to 1-2 Innovation Units
- Primary responsibilities of the project support person will include:
  - Coordination of weekly unit based multidisciplinary meetings
  - Daily presence on the clinical unit(s).
  - Collection and documentation of improvement initiatives/ideas
  - Assistance in collecting and analyzing data
  - Participation in weekly project support meetings to share best practices, identify barriers, provide updates on unit progress.
- Other project support staff will be assigned to provide assistance across all of the Innovation Units.

The unit-level and centralized project manager staff are highlighted in blue on the retreat participant rosters (Attachment TL 4EO.f)

In addition, the CNO was able to secure financial resources from MGH President to roll-out the Innovation Unit initiative. To-date, approximately $360,000 has been spent (Attachment TL 4EO.m). Please note that the Attending Nurse role is designed to be budget neutral. Additional staff were not provided to Innovation Units.

**Education and Communication**

To create an environment of success, consistent understanding of the principles, concepts, and interventions guiding innovation, is essential. The Norman Knight Nursing Center for Clinical & Professional Development (Knight Center) at MGH worked to create an educational plan to accompany the “rollout” of the Innovation Units. Based on feedback from planning retreats and other forums, the Knight Center designed a 2-hour workshop to provide staff on Innovation Units with a comprehensive overview of the selected Innovation Unit interventions. Online modules were created to review information about handover procedures (SBAR); hourly safety rounds; discharge readiness; the discharge follow-up phone call program; and effective use of welcome packets.

Knight Center professional development specialists were assigned to provide onsite coaching, mentoring, and unit-based education to staff on the Innovation Units as needed (Attachment TL 4EO.f – educators and evaluation staff are highlighted in green). Additional educational content areas included a focus on the operationalization of the attending nurse role, conflict resolution and management, and discharge planning.

An Attending Nurse Working Group was created (Attachment TL 4EO.n) to address the concerns associated with role implementation and meets weekly for one hour. This forum is used as a “think tank/support group” for Attending Nurses as they get more immersed in their new role. Attachment TL 4EO.o contains a set of meeting minutes and Attachment TL 4EO.p is an email from the CNO to her executive team sharing her impressions of a meeting she held with the Attending Nurses.

In addition, on the 1st and 3rd Wednesdays of each month the entire group of Innovation Unit retreat participants (Attachment TL 4E).f meets to share best practices, provide updates and
review evaluation data. Examples of Innovation Unit update presentations can be found for Lunder 9 Oncology in Attachment TL 4EO.q and Ellison 16 Medicine in Attachment TL 4EO.r.

Communication

A myriad of communication vehicles were and continue to be used to communicate key information about the Innovation Unit initiative. They include the development of a web-based Innovation Unit portal page (Attachment TL 4EO.s) which is an integral component of Patient Care Service’s Excellence Every Day Portal Page. This site provides easy access to Innovation Unit profiles and contacts; toolkits to implement various interventions; dashboard metrics; best practices; news features, and relevant literature. For access to the portal, visit http://www.mghpcs.org/Innovation_Units/index.asp.

The CNO used her column in Caring Headlines in January 2012 for setting the stage for the launch of Innovation Units (Attachment TL 4EO.t) and providing an update about how the roll-out of the Innovation Units was going in the May 10, 2012 issue (Attachment TL 4EO.u). A special issue of Caring Headlines was also produced in February 16, 2012 (Attachment TL 4EO.v). This issue has served as an invaluable guide for sharing information about this initiative.

Lastly, Innovation Unit progress reports have been developed to present updates to leadership and staff throughout the Hospital about the work of the Innovation Units (Attachment TL 4EO.w and Attachment TL 4EO.x).

4. Describe the measurement used to evaluate the outcomes and the impact.

Outcomes and Evaluation

The success of Innovation Units is being measured by a series of predetermined metrics related to length of stay, patient satisfaction, staff satisfaction, quality and safety, and certain nursing-sensitive indicators. A mixed method multidimensional approach to evaluating outcomes will be used and facilitated by nurse scientists in the Yvonne L. Munn Center for Nursing Research and the Department of Quality and Safety within Patient Care Services (PCS). Measures obtained pre, during, and post implementation of the Innovation Unit interventions are ongoing and have provided an opportunity to make corrections that might lead to revisions of earlier assumptions. The table below provides examples of both qualitative and quantitative measures used during all phases of the evaluation process.

<table>
<thead>
<tr>
<th>Evaluation Measures: Pre, During, and Post Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantitative</strong></td>
</tr>
<tr>
<td>Culture of Safety Survey</td>
</tr>
<tr>
<td>Patient Satisfaction Survey data</td>
</tr>
<tr>
<td>Patients Perceptions of Feeling Known (PPFKN) survey</td>
</tr>
<tr>
<td>Revised Perceptions of the Practice Environment (RPPE) scale</td>
</tr>
<tr>
<td>Quality indicators</td>
</tr>
<tr>
<td>Length of stay</td>
</tr>
</tbody>
</table>
Metrics are displayed by each Innovation Unit on a dashboard that categorizes data in the following areas: quality and safety; infection control; patient satisfaction; staff satisfaction; and, throughput and efficiency. The same metrics are also captured and displayed for non-Innovation Units to allow for comparison between with like units.

The Yvonne L. Munn Center for Nursing Research Team is currently conducting focus groups and surveys to get feedback about the Innovation Units. A comprehensive evaluation report will be presented at the September 13, 2012 Innovation Unit retreat (Attachment TL 4EO.y). However, Patient Experience and Length of Stay Reduction data present impressive early signals that the Innovation Unit interventions are impacting the efficiency, effectiveness and patient and family-centeredness aspects of care delivery.

The Patient Experience

HCAHPS indicators are tracked by the hospital on ongoing basis. The HCAHPS measures are key metrics for measuring MGH’s efforts to improve the patient experience and are also a part of the key metrics being used to track the impact of interventions on Innovation Units. In 2012, both the hospital as a whole and the Innovation Units as a group are seeing improvement in HCAHPS measures over the previous year. The hospital overall is seeing improvement in all measures except one (MD Communication) and the magnitude of improvement ranges between .2 and 3.1 points in the Top Box score. On average, the measures are improving at a rate of 1.45 points over the previous year. Improvement at this rate would outpace that of most hospitals in the US. The Innovation Units (the six units for which HCAHPS data is available) are seeing improvement in all indicators except one (Staff Responsiveness) and the magnitude of improvement ranges between .7 and 6.5 points Attachment TL E04.z. On average, these measures are improving at a rate of 3.58 points per year. This is a rate that is double that of the hospital as a whole and demonstrates an improvement rate that would be at the highest quartile for rate of improvement when compared against other hospitals. This early evidence seems to point to the efficacy of the chosen interventions being implemented on Innovation Units in terms of their impact on the patient experience.

Length of Stay Reduction

MGH routinely tracks Average Length of Stay (ALOS), measured by the total number of patient days divided by the total number of discharges over a given time period. Preliminary data show the Innovation Units experienced a decline in ALOS. Specifically, during the current Fiscal Year (FY 2012) for the time period between October 1, 2011, to March 19, 2011, the official kickoff of the Innovation Units, ALOS was 5.39 days, and from March 19 to date (time of writing, August 10, 2011) ALOS was 5.20 days, a 3.4% decrease. For reference, the FY11 (October 2010 through September 2011) ALOS for the innovation units in aggregate was 5.49 days. By improving overall efficiency of care delivery, the aim is to sustain reductions in ALOS over time.
Attending Nurse Role

The biggest impact on care design has been due to the implementation of the Attending Nurse role. Anecdotally, Attending Nurses are sharing that redundancies are being eliminated and reporting major shifts in discharge by time of day and length of stay. In addition, patients and families have indicated that the liaison role played by Attending Nurses during their hospital and post-discharge is helpful.

“As an Attending Nurse, one of our primary goals is to increase or strengthen patient relationships; establishing strong patient relationships earlier in the health care process has been very successful. I credit the ability to meet some of the patients preoperatively very helpful in this endeavor.”

“One of my most memorable patient relationship building experiences came from meeting a surgical candidate preoperatively. Throughout the patient’s stay, I remained a constant in his care, and in keeping him and the family up-to-date. As we had established a bond early on, I was considered the family’s “go-to person,” someone they relied on and trusted. Whether I gave them new information regarding the plan of care or just stopped in to meet additional family members, my presence was appreciated. The patient was later readmitted for unrelated reasons to a different unit. The family made it a point to inform me that the patient was readmitted and asked if I could go and visit. The work put into establishing an early relationship with the patients during their hospital stay has proven to be most valuable.”

“When I introduce myself as the Attending Nurse to patients and families [and] … I get to the part that I will follow up with phone calls; this seems to make me a more influential part of their thinking and care. For patients who have been here for some time, it can be stressful to think about going home. … I have found that the follow up phone calls prove beneficial to the patients.

“When I call patients at home, even though they know I will call, they are always surprised that I have followed through. The phone calls usually are short and to the point when patients have no questions or issues. They are always thankful to the staff for the wonderful care that they have received and in awe at how respectful and professional staff all are. Where the phone calls are most influential are when the patients do have questions about their discharge or are
experiencing difficulties whether major or minor. Additionally, the nurses who have cared for the patients are always curious how they are adjusting at home. The phone calls just create an additional linkage; they are our patients.”

“The Attending Nurse position has opened up a lot of opportunity for me to grow personally and professionally. There is still a lot to learn from the Attending Nurse experience, but I believe it can be a standard of care.”

The preceding examples highlight the commitment and strategies two Attending Nurses use in the development of relationship with and care of patients. Ultimately, however Attending Nurses are charged to cross traditional organizational boundaries and find solutions that coordinate care throughout the continuum. The Attending Nurse role helps to solidify nurses as the lynchpin in promoting cost effective, high-quality, safe, patient-centric care delivery within an interdisciplinary team. When nurses are put in a position to be influential and empowered, they can optimize their authority, communication traits, knowledge-based competence and status during this time of change to efficiently identify, implement, and lead innovation in practice.

Redesigning patient care delivery models and introducing change and innovation is a long and involved process and requires constant monitoring. This is not work that nursing can do alone — it requires an organization-wide commitment to viewing this redesign initiative as a priority. All must remain committed to keeping the staff participating in the work as informed, motivated, and involved as possible. Innovation Unit staff should be engaged in dialogue and identify those interventions to be adopted, adapted, or abandoned.
August 2011

Dear Colleagues,

Over the course of the past few months, many clinicians and administrators have come together to address the challenges of rising health care costs and the call for us to be more efficient while maintaining or improving clinical outcomes and patient satisfaction. We are now ready to pilot the strategies and tactics that are an outgrowth of the discussions that occurred under the umbrella of the Partners Patient Affordability Direct Care initiative. While numerous recommendations have been generated, there is none more exciting and daunting than the idea of piloting Innovation Units. Innovation Units have the goal of redesigning how we structure care delivery by testing new and creative ideas that ensure seamless transitions, improved communication regarding the plan of care with the patient and family, and within the care team. Today we write to solicit unit leaders to apply to become members of the first wave of Innovation Units.

The attributes of an Innovation Unit may be described as having increased continuity of care, increased caregiver productivity, interdisciplinary team and teamwork, new/improved used of technology, physical environment redesign, patient and family focus and value, increased clinician time with patients, and a focus on the organizations goals and mission.

Important metrics for our work are reducing 30-day readmissions, preventing avoidable ED visits, decreasing unnecessary hospital days, and addressing over-use, under-use and mis-use of medications, tests and expensive hospital resources. Very important outcomes include enhanced nurse and physician communication and responsiveness to patient and family needs and expectations. These as well as other metrics will be used to evaluate success, recognizing that models on innovation units may differ depending upon the idea being tested and therefore have varying impact on metrics.

Proposed ideas must incorporate the concepts of continuity of care with an expectation that during the first round of pilots, an attending nurse will over see the coordination of care addressing all of the needs of the patient and care team. The attending nurse will be an experienced nurse who works full time (5 days per week/8 hour shifts). The model builds upon the key research of Relationship Based Care that is built upon a framework that demonstrates that chaos during hospitalization settles down when the healthcare team is truly focused on the patient. Relationship Based Care is comprised of three key value based relationships:

- the care provider’s relationship with the patient and family
- the care provider’s relationship with self (self-awareness), and
- the care provider’s relationship with colleagues.

Important core components of a new delivery model include:

- care coordination that enhances timely throughput
- standardized methodology for hand-offs across the care continuum, and
- consistent interdisciplinary rounds.
Each pilot must have nurse, physician and appropriate health professional discipline central to the patient outcome, team leaders/champions responsible for guiding the project design and implementation, and accountable for project deliverables and timeline.

Proposals should be submitted to the Direct Care Steering Committee, chaired by Jeanette Ives Erickson, RN and Scott McDougal, MD using the format in the attached document (Innovations Unit Proposal). This proposal should be no more than 1-2 pages in length. Please forward project proposals to Jeanette Ives Erickson by September 1, 2011.

All proposals will be reviewed. Once reviewed, submitters will be notified as to whether their proposal meets the criteria and goals for an innovation unit. The team leaders of proposals that meet requirements will be invited to present and discuss their proposal with the Steering Committee. Once accepted, all pilot unit team members will be invited to participate in a core curriculum educational program.

**Timeline:**
- September 1: Innovation Unit proposal submissions due
- September 20: Selection of Innovation Units: team leaders meet with Steering Committee and discuss proposals
- October 1: Innovation Unit teams begin implementation planning
- October 15: Implementation begins

Sincerely yours,

[Signature]

Jeanette Ives Erickson
Massachusetts General Hospital

Innovations Unit Proposal

Innovation Unit Location: Submission Date:

Submitter Name(s):

Submitter Email Address: Submitter Phone:

MGH Patient Care Delivery Model of the Future:
The attributes of an Innovation Unit are described as having increased continuity of care, increased caregiver productivity, interdisciplinary team and teamwork, new/improved use of technology, physical environment redesign, patient and family focus and value, increased clinician time with patients, and a focus on the organization's goals and mission.

The model builds upon the key research of Relationship Based Care (see Appendix A) that is built upon a framework that demonstrates that chaos during hospitalization settles down when the healthcare team is truly focused on the patient. Relationship Based Care is comprised of three key value based relationships:

- the care provider’s relationship with the patient and family
- the care provider’s relationship with self (self-awareness), and
- the care provider’s relationship with colleagues.

Proposal for Implementation: What aspects of our new model will you target for advancement? It is important to reflect on the current model and what will change based upon this work. Please describe.

Please describe how the following will be integrated into your project:

- Continuity: care coordination that enhances timely throughput
- Interdisciplinary rounds
- Patient- and Family-Centered Care
- Enhanced efficiency: How will costs be reduced?
Outcomes Measures: As you look at the dashboard what percent improvements will you achieve:

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Target</th>
<th>% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noise reduction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanliness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsiveness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls reduction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure Ulcer Reduction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restraint free environment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Satisfaction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmission Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Leadership:
- RN Leader:
- MD Leader:
- Health Professions Leader(s):
- Team Members:

Nurse Attending Role:
- Estimated number of RNs that will move to five 8-hour shifts: _____
  - Baseline data (current)
    - # that are advanced clinicians ______
    - # that are clinical scholars ______
    - # that are masters-prepared ______

Timeline:
- Start date:
- Key milestones:

Please submit completed proposal to Jeanette Ives Erickson, RN, @ jiveserickson@partners.org by September 1, 2011

Revised: August 8, 2011 v2
Appendix A: Literature search: Care Delivery Models including Relationship-Based Care

Care delivery model: infrastructure for organizing and delivery care to patients and families.

Three elements to care delivery (Manthey)

1. Clear roles
   - Clarity of responsibility and authority
   - Responsibility and authority is always commensurate
   - Assume responsibility for managing the care of a caseload of patients over a legitimate period of time

2. Healthy interpersonal relationships
   - Therapeutic relationship with the patient: nurse-patient relationship is at the core
   - Healthy interpersonal relationships among colleagues
   - Relationship with self (reflective practice)

3. Adequate and appropriate resources
   - Need to be honest about the workload and its relationship to resources.
   - Must change way we think about staffing and resources.
   - Need to identify the most important needs that need to be met within the context of the available resources.

Leadership

- Develops professional practice and practice environment.
- Sets the tone.
- Established ground rules for interpersonal relationships at the unit level.
- Premise: healthy work environments are most directly affected by the way the staff treats each other.
- Role models for the staff.
- Accountable and responsible for designing and implementing processes on each unit that support the tenets of the practice model and for ensuring that individual patient outcomes are maximized.
- Designer, teachers and stewards

Goal

- High-performing interdisciplinary teams that deliver safe, effective, patient-centered, timely efficient and equitable care.

Principles

- Care delivery should always be: patient and family focused, evidence-based, accountable and autonomous, coordinated and continuous.
- Being “highly present” is key.
- All health care providers must be permitted to practice to the fullest extent of their knowledge and competence.
- Each care team member functions fully within their defined scope of practice/expertise.
- Patient and family care is provided by a designated nurse who assumes accountability and responsibility to ensure continuity of care for each encounter
- Care is patient-focuses: every team member is committed to meet the needs of every patient assigned to the team; greater focus on the patient.
- Continuity of the nurse-patient relationship is a basic precept.
- Every patient deserves and experienced nurse.
- Every novice nurse deserves mentoring from an experienced nurse.
- Every patient deserves the opportunity to participate in the planning of his/her care.
- Sharpened focus on the patient.
- Quality and safety are an integral component of practice.
- Advancements in technology create opportunity for improved provider communication and efficiency
- Work intensity decreased with improved work distribution processes and team support
- Transitions/handoffs are smooth/seamless.
- View discharge as a transition.
• Care is dependent on solid handoffs, skilled communication, plans of care, and interdisciplinary relationships that bridge across multiple settings and care episodes.
• Professional nursing expectations such as autonomy, accountability and collaboration have a greater impact on the outcomes of a care delivery model than anything else. (levers).
• Nurses believe they have the right to make decisions regarding provision of care.
• Model requirements:
  o Simplifying complex processes
  o Clarifying roles of caregivers
  o Providing expert guidance in ongoing care delivery
  o Continuous learning
  o Meaningful documentation
  o Technology integration
  o Collaborative practice
  o Continuous communication
  o Ongoing innovation
• Key domains
  o Quality and safety
  o Healing environment
  o Research and evidence-based practice
  o Professional development and education

Challenges
• Aging population with increasingly complex medical conditions and a more informed and demanding patient population.
• Fragments care due to different silos of providers and settings of care.
• Poor handoffs
• Care redundancy
• Episodic healthcare worker shortages

Outcomes
• Improved clinical outcomes
• Decreased medical errors
• Reduction of unnecessary tests and procedures
• Dashboard of clinical quality, safety, cost, throughput and satisfaction measures

New role of nurse facilitator/coordinator/integrator:
• Elevated role from caregivers to care integrators.
• Have the accountability, authority and responsibility for integrating patient care management and achieving successful patient outcomes.
• 24/7 accountability for directing/managing individualized care for each patient: individual care planning is central to the patient.
• Requires “presence” – working five 8-hour shifts vs. 10-12 hour shifts.
• Primary contact for physicians and other members of the interdisciplinary team
• Primary liaison for patients and families and actively engage them in the care plan.
• Mentor other team members (RNs and clinical support staff).
• Patient advocate
• Case management component (manage transitions).
• Knowledge worker – nonrepetitive, nonroutine work that entails substantial levels of cognitive activity.
• System thinkers
• Thinking in action
Massachusetts General Hospital
Innovations Unit Proposal

Innovation Unit Location: Lunder 9 Submission Date: 9/1/11

Submitter Name(s): Barbara Cashavelly MSN, RN, AOCN and Panos Fidias, MD
Submitter Email Address: bcashavelly@partners.org Submitter Phone: 8-5900 (Lunder 9)

Proposal:
On Sept 7, 2011 PH21 will be moving to Lunder 9. There will be 2 designated oncology units. Lunder 9 will admit identified oncology patients: lymphoma, multiple myeloma, solid tumors and sarcoma patients. BMT/Leukemia patients will primarily be admitted to Lunder 10. Patients admitted to Lunder 9 will require complex oncology care which includes phase 1 clinical trials, complex chemotherapy regimens, biotherapy, targeted therapy, radiation therapy, proton therapy and palliative care. The complexity of care provided to these patients consists of management of symptoms, side effects or complications related to their disease or treatment. Pain management, emotional and spiritual support, patient and family education, palliative care and end of life care are also part of the care provided. Our goals are to provide compassionate, expert individualized care to our patients and families affected by cancer.

Lunder 9 unit has 32 Medical Oncology beds. All rooms are private beds that are centrally monitored, visible from the nurse stations outside the patient rooms and also contain a nurse station inside each room. Therefore nursing care observation can be provided at 3 locations: centrally at the clinical work areas, the interaction zone and the nurse station within each patient room. The floor is designed into two cores of support space in sub-units that have 16 beds each. This allows the nurse to have fewer steps in their provision of care. The patient rooms have been designed for patient safety, staff observation and family and patient centered care. Having an identified oncology unit for our cancer patients will provide the patient and family oncology expertise and patient and family centered care from the oncology multidisciplinary care team.

Team Coverage: Lunder 9 has 18, Team 3 covered beds and 14 Oncology Nurse Practitioner covered beds. The Oncology NPs will be unit based and will be working directly with the staff throughout each day. The NPs will provide 24/7 care to 14 patients. Having the NPs on the unit will enhance continuity, teamwork and collaboration. Team 3 will cover 18 beds.

Multidisciplinary Rounds: Multidisciplinary Rounds occur every morning with Team 3, NPs, Case Manager, Physical Therapy, Social Work, Staff RN, Attending RN, Resource RN, and Attending MD Rounders. Patients are presented, plan of care is discussed and discharge plan/date is reviewed. The RN Attending and team members will follow through to coordinate the appropriate plan of care.

Attending Rounders: The system involves 3 Attending Rounders on service for continuous 2 weeks. Each Rounder is responsible for a subset of oncology patients. The subset groups are called Red, White and Blue teams. The Rounders are visible on the unit each day covering their patients and working with the multidisciplinary team. This can enhance continuity with patient and family care, collaboration and teamwork.

Attending RN Role: The Attending RN will be responsible for 16 patients which will be on one side of the unit. She/he will work with the primary care team to coordinate and integrate care. They will attend the Multidisciplinary Rounds with the team, identify the daily needs, coordinate the care, collaborate with the Attending Rounder, Staff RN, Case Manager, Team 3 or NP and outside services. The discussion will be focused on the plan for the day, goals of care, discharge disposition and identified date. They will be on the unit in the clinical area working with the patients. They will be visible to the RNs and care team.

The Attending RN will also be a clinical resource for the RNs and support staff caring for the 16 patients. With new graduate nurses and RN residents, having a consistent resource “go-to person” is important for their practice development. They will work with the RN to assist with patients and families about the daily plan and discharge plan. This may include hands on care, psychosocial support or patient education. Patient education will be an important piece of their practice—education may include but not limited to

Revised: August 8, 2011 v2
chemotherapy treatments, disease information, fall risk information, home supports and resources to name a few.

The Nurse Attending will document each day about the ongoing plan and update each day. This will not take the place of the staff RN’s note. This will provide the overall plan and update to the entire team on a daily basis.

When the patient is being discharged, the Nurse Attending will call the outpatient provider (NP or MD) about the plan, provide a pass-off and address any outstanding issues. The RN attending will also place a call to the patient at home within 48 hours to follow up on progress.

Please describe how the following will be integrated into your project:

- Continuity: care coordination that enhances timely throughput. This will be achieved with consistent Attending Rounders for 2 weeks. The presence at Multidisciplinary rounds will help facilitate decision making with plan for the day, GOC and discharge planning. The RN attending will be able to facilitate the care coordination and consistency.
- Interdisciplinary rounds – The rounds will include Attending rounder, Resource RN, Attending RN, Team 3, NP, staff RN, Social worker, Physical Therapy and Case Manager.
- Patient- and Family-Centered Care: The plan of care will focus around the goals of the patient and family. The environment and structure of Lunder 9 is patient and family centered.
- Enhanced efficiency: Decision making for the plan and goals of the day will be made in morning rounds. There will be next steps for coordination with the Attending RN and care team. The attending RN can streamline processes and provide efficiency for the team. As a result, costs can be reduced.

Outcomes Measures:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Current</th>
<th>Target</th>
<th>% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Communication</td>
<td>76.7%</td>
<td>80%</td>
<td>3%</td>
</tr>
<tr>
<td>Physician communication</td>
<td>82.2%</td>
<td>85%</td>
<td>3%</td>
</tr>
<tr>
<td>Noise reduction</td>
<td>59.5%</td>
<td>62%</td>
<td>3%</td>
</tr>
<tr>
<td>Cleanliness</td>
<td>56.7%</td>
<td>66%</td>
<td>10%</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>61.6%</td>
<td>64%</td>
<td>3%</td>
</tr>
<tr>
<td>Falls reduction</td>
<td>2.9%</td>
<td>2.0%</td>
<td>3%</td>
</tr>
<tr>
<td>Pressure Ulcer Reduction</td>
<td>6.3%</td>
<td>4.3%</td>
<td>2%</td>
</tr>
<tr>
<td>Restraint free environment</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Staff Satisfaction</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>18.8%</td>
<td>16%</td>
<td></td>
</tr>
</tbody>
</table>

Leadership:
- RN Leader: Barbara Cashavelly RN
- MD Leader: Panos Fidias MD
- Health Professions Leader(s):
- Team Members: CNS, Case Manger, Social Work,

Nurse Attending Role:
- Estimated number of RNs that will move to five 8-hour shifts: 2
  - Baseline data (current)
  - # that are advanced clinicians
  - # that are clinical scholars 1
  - # that are masters-prepared

Time line – start date October

Revised: August 8, 2011 v2
Proposal for Implementation: What aspects of our new model will you target for advancement? It is important to reflect on the current model and what will change based upon this work. Please describe. Care providers relationships with families and patients on Ellison 16 are driven by the current model of Patient Family centered care. On Ellison 16 relationships often suffer with the inordinate amount of tasks relegated to RN’s in the form of ever changing doctor’s orders, electronic documentation, inability to schedule patients for transport on and off the unit for testing and readapting to each new teams method of rounding, working and communicating.

One complicated task the RN faces on a daily basis is the safe, effective discharge of their patients. Knowing and understanding the patient, family and social situation is imperative to a successful discharge that ensures the patient and /or family has appropriate resources and can manage the condition at home and with appropriate outpatient follow up and care

In an effort to reduce hospital readmissions Ellison 16 committed to the IHI STAAR initiative in September of 2009. Several methodologies were employed in an attempt to impact our readmission rate. Coordinated efforts between nursing, pharmacy, case management, and representatives from the Department of Medicine defined problem areas to address. Pilots included a pharmacy discharge call program, increase in VNA referrals and identification of high risk patients admitted to Ellison 16.

As part of the IHI initiative a Discharge Nurse (DN) care delivery role was developed and refined over the past 13months. The development of this role, along with the ongoing refinement of the role, has taken place with the input of the staff, physicians and IHI multi-disciplinary team. With the work of the DN the Ellison 16 LOS and pre-noon discharge rates have been positively impacted, and our readmission rates have dropped slightly, while statewide readmission rates continue to remain unchanged.

The Attending RN role of the Innovation project is the logical next step for the DN role. Currently the DN creates initial relationships with high risk patients and families along with the staff RN, attends Multidisciplinary rounds, communicates with private MD’s regarding discharge issues or problems, works with Case Management on complicated discharge, assists the RN’s in gathering appropriate Educational material for the patients or families and manages demographic statistics. As an Innovation Unit the DN would transition into the Attending RN (ARN) role and assume increased authority and control over coordination of patient care.

The Ellison 16 staff would have enhanced mentoring and education in transitioning from task oriented work to controlling their work flow and enhancing one on one time with patients and families

On October 5th Ellison 16 and the Bullfinch Medical Group (BMG) begins a Hospitalist Pilot Program. This collaborative practice will enhance patient experience and allow quality patient care to continue within the confines of the new ACGME guidelines. We believe this presents a unique opportunity to utilize Ellison 16 as both an Innovation unit and a control group to
measure impact on LOS, pre-noon discharges, readmission rates, patient and staff satisfaction, as well as continuity of care
Our proposal is to compare the metrics of all BMG patients and identified high risk patients currently followed by the Discharge RN as Innovation unit patients as compared to all other patients admitted to Ellison 16

Please describe how the following will be integrated into your project:

- **Continuity: care coordination that enhances timely throughput**: Establish and create process for daily handoff communication of BMG patients being discharged from Ellison 16 to provide seamless transition from inpatient to outpatient status, specifically to impact the BMG patient population

- **Interdisciplinary rounds**: Routinely address functional status, anticipated discharge date, barriers to discharge, patient family communication. 4PM huddle to identify discharge plans that have changed, update the communication board in Nurses Station to reflect anticipated discharge date.

- **Patient- and Family-Centered Care**: Daily visit by the ARN, establishment of individualized teaching plans, early appropriate consults, follow up with outpatient service providers

- **Enhanced efficiency: How will costs be reduced?** Improved bed turnover with increased pre noon discharges and decreased LOS. Improved communication of all team members to reduce unnecessary lab tests

**Outcomes Measures**: As you look at the dashboard what percent improvements will you achieve:

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Target</th>
<th>% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Communication</td>
<td>77.4%</td>
<td>78.8%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Physician communication</td>
<td>80.4%</td>
<td>80.9%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Noise reduction</td>
<td>39.7%</td>
<td>58%</td>
<td>4%</td>
</tr>
<tr>
<td>Cleanliness</td>
<td>65.5%</td>
<td>71.7%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>66.1%</td>
<td>61.4%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Falls reduction</td>
<td>2.96%</td>
<td>2%</td>
<td>.96%</td>
</tr>
<tr>
<td>Pressure Ulcer Reduction</td>
<td>3.1%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Restraint free environment</td>
<td>0%</td>
<td>0%</td>
<td>---</td>
</tr>
<tr>
<td>Staff Satisfaction</td>
<td>3.06%</td>
<td>&gt;2.91%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>17.8%</td>
<td>16.5%</td>
<td>0.55%</td>
</tr>
</tbody>
</table>
Leadership:
- RN Leaders: Kathryn Hall, MS, ANP-BC / Jacqueline Collins, MS, ACNS-BC
- MD Leader: Daniel Hunt MD
- Health Professions Leader(s): Jessica Smith RN, Sarah Keegan RN
- Team Members: Senior Residents, Interns, All Ell 16 RN’s, Case Managers, OT/PT

Nurse Attending Role:
- Estimated number of RNs that will move to five 8-hour shifts: ___0___
  - Baseline data (current)
    - # that are advanced clinicians ___2___
    - # that are clinical scholars ___1___
    - # that are masters-prepared ___7___

Timeline:
- Start date: October 15
- Key milestones:
  3 months (Jan 2012) 6 months (April 2012) 9 months (July 2012)
Evaluate Metrics as noted above (LOS, Pre-noon discharges, Readmit rates, Dashboard metrics, etc)
comparing Intervention (Innovation) to Control Populations.
Evaluation of Staff Satisfaction- RN and MD- Evolution of Discharge RN to Attending RN role (Tool
development)
Tracking of Safety Reports
Ongoing use of Sharepoint site (tracking of patients) – use of technology
Patient Affordability
Direct Care: Inpatient Units
Innovations Unit Retreat
December 12, 2012 7:30am – 2:30pm
Liberty Hotel, Ballroom, 2nd Floor

7:30a Setting the Stage:
- Background
- The changing healthcare landscape
- Strategic vision
- Direct patient care
- Recommendations
- Targets
- Translating the work at MGH
- The Patient Journey
- Throughput and length of stay
- Relationship-Based Care: Philosophical frame for a new care delivery model
- Innovation Units
- Attending Nurse Role
- Connection to 2012 Strategic Plan

9:30a Break

10:00a Break-out Groups: Appoint a Facilitator & Recorder
- Unit Rounding
- Family engagement in plan of care
- Opportunities to improve key quality indicators
- Opportunities to improve the environment of care
- Opportunities to improve patient satisfaction scores

11:00a Break-out Groups: Report-outs

11:30a Lunch

12:30p Reconvene in Unit Teams for Innovation Unit discussions: Appoint a Facilitator & Recorder
- Educational needs
- Physician alignment
- Refinement of proposal
- Worries

2:00p Break-out Groups: Report-outs

2:30p Adjourn
Patient Affordability
Direct Care: Inpatient Units
Innovations Unit Retreat
December 19, 2012, 7:30am – 2:30pm
Liberty Hotel, Ballroom, 2nd Floor

7:30a Summary of December 12 Innovation Unit Retreat
- Guiding Principles for Innovation Units
- Attending nurse role
- In Scope (boundaries)
- Non-negotiables
- Overview of selected draft checklists and data
- Q & A

9:00a Break

9:20a Break-out groups (by Innovation Unit)
- Critically-review Innovation Unit proposal
- Rounding Checklist
- Discharge Checklist
- Patient Discharge Checklist
- Follow-up Telephone Calls
- HCAHPs: Overall patient satisfaction scores

11:30a Lunch

12:30p Panels: What roles can our colleagues play to support innovation units?
- Ambulatory Care
- Support Departments: Pharmacy, Admitting, IV team, Case Management
- Health Professions: Physical Therapy, Occupational Therapy, Respiratory Care, Social Services, Speech/Language Pathology and Chaplaincy

2:00p Implementation
- Patient Compact
- Education plan
- Joint Commission plan
- Communication plan
Patient Affordability
Direct Care: Inpatient Units
Innovations Unit Retreat
January 23, 2012, 7:30am – 2:30pm
Liberty Hotel, Ballroom, 2nd Floor

7:30 am   Overview of Day

7:45 am   Innovations in Care Delivery

9:00   Improving Patient Satisfaction: How to Define Improvements in HCAHPS Scores
   Presented by Rick Evans, Senior Director, Service
   ▪ Responsiveness
   ▪ Nurse Communication
   ▪ Quiet at Night
   ▪ Cleanliness
   ▪ Discharge Planning

10:00 Break

10:20 am   Improving Performance on Quality Indicators:
   Presented by Keith Perleberg, RN, Director, PCS Office of Quality & Safety
   ▪ Pressure Ulcers
   ▪ Falls
   ▪ Medication Errors
   ▪ Central Line Infections
   ▪ Ventilator Associated pneumonia
   ▪ Unlabeled Specimens

11:20 am   Break-out groups: Team-based:
   ▪ Identify quality, satisfaction and financial goals.
   ▪ How will you target improvements?

12:00 pm   Lunch

1:00 pm   Break-out groups: Implementation plans for standardized innovations

2:00 pm   Implementation Timeline and needs

2:30 pm   Adjourn
## Innovation Unit (IU) Retreats

### Participant Listing

**Dates:** December 12 & 19, 2011; January 23, 2012

<table>
<thead>
<tr>
<th>Name/Credential</th>
<th>MGH Role(s)</th>
<th>Innovation Unit Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeff Adams, RN, PhD</td>
<td>Director, Center for Innovations in Care Delivery; Nurse Scientist</td>
<td>Evaluation</td>
</tr>
<tr>
<td>Hasan Alam, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Gail Alexander, RN</td>
<td>Professional Development Specialist, Knight Center</td>
<td>Education</td>
</tr>
<tr>
<td>Jonathan Alpert, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Neila Altobelli, RRT</td>
<td>Respiratory Therapist</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Michelle Anderson, RN</td>
<td>Staff Nurse, Surgery</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Chris Annese, RN</td>
<td>Staff Specialist</td>
<td>IU Project Manager</td>
</tr>
<tr>
<td>Lori Appleman, RN</td>
<td>Staff Nurse, Pediatrics</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Paul Arpino, RPh</td>
<td>Pharmacist</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Gaurdia Banister, RN, PhD</td>
<td>Executive Director, Institute for Patient Care</td>
<td>Education &amp; Evaluation</td>
</tr>
<tr>
<td>Lourdes Barros, MSW, LICSW</td>
<td>Clinical Team Leader, Social Services</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Henry Benoit, RRT</td>
<td>Respiratory Therapist</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Marcy Bergeron, RN</td>
<td>Nursing Director, Bulfinch Medical Group</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Elizabeth Bishop, RN</td>
<td>Staff Nurse, Medicine</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Barbara Blakeney, RN</td>
<td>Innovations Specialist, Center for Innovations in Care Delivery</td>
<td>IU Project Manager</td>
</tr>
<tr>
<td>Andrea Bonanno, PT, DPT</td>
<td>Clinical Specialist, Physical Therapy</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Sharon Bouvier, RN</td>
<td>Nursing Director, Vascular Surgery</td>
<td>IU Nursing Director</td>
</tr>
<tr>
<td>Tony Branch</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
<tr>
<td>Kelly Brown, RN</td>
<td>Staff Nurse, Surgery</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Lisa Brugnoli-Semeta, RN</td>
<td>Nursing Director, Back Bay Health Center</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Diane Burnham, RN</td>
<td>Patient Advocate</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Betty Ann Burns Britton, RN</td>
<td>Staff Nurse, Oncology</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Debra Burke, RN</td>
<td>Associate Chief Nurse</td>
<td>Executive Oversight</td>
</tr>
<tr>
<td>Rich Cambria, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Theresa Capodilupo, RN</td>
<td>Nursing Director, Surgery</td>
<td>IU Nursing Director</td>
</tr>
<tr>
<td>Kathy Carr, RN</td>
<td>Staff Nurse, Cardiac ICU</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Barbara Cashavelly, RN</td>
<td>Nursing Director, Oncology</td>
<td>IU Nursing Director</td>
</tr>
<tr>
<td>Heather Chaffee, RN</td>
<td>Staff Nurse, Ellison 9 CCU</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Gina Chan, RN</td>
<td>Staff Nurse, Vascular Surgery</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Lin-Ti Chang, RN</td>
<td>Staff Specialist</td>
<td>IU Project Manager</td>
</tr>
<tr>
<td>Richard Channick, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Gino Chisari, RN</td>
<td>Director, Norman Knight Nursing Center</td>
<td>Education</td>
</tr>
<tr>
<td>Mandi Coakley, RN</td>
<td>Staff Specialist</td>
<td>IU Project Manager</td>
</tr>
</tbody>
</table>

**Key:**
- Departmental Link
- Education & Evaluation Support
- Project Support Staff (unit based and centralized)
<table>
<thead>
<tr>
<th>Name/Credential</th>
<th>MGH Role(s)</th>
<th>Innovation Unit Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audrey Cohen, CCC-SLP</td>
<td>Speech/Language Pathologist</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Clare Cole, RN</td>
<td>Clinical Nurse Specialist, Mother/Newborn</td>
<td>IU Clinical Nurse Specialist (CNS)</td>
</tr>
<tr>
<td>Jacqui Collins, RN</td>
<td>Clinical Nurse Specialist, Medicine</td>
<td>IU CNS</td>
</tr>
<tr>
<td>Maryann Columbia, RN</td>
<td>Staff Nurse, Family/Newborn</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Pat Connors, RN</td>
<td>Clinical Nurse Specialist, Mother/Newborn</td>
<td>IU CNS</td>
</tr>
<tr>
<td>Erin Cox, RN</td>
<td>Clinical Nurse Specialist, Vascular Surgery</td>
<td>IU CNS</td>
</tr>
<tr>
<td>Mary Cramer</td>
<td>Director, Process Improvement</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Tricia Crispi, RN</td>
<td>Professional Development Specialist, Knight Center</td>
<td>Education</td>
</tr>
<tr>
<td>Jonathan Cronin, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Connie Cruz, RN</td>
<td>Clinical Nurse Specialist, Psychiatry</td>
<td>IU CNS</td>
</tr>
<tr>
<td>Emily Curran, RN</td>
<td>Staff Nurse, Blake 12 ICU</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Jena Delgado, RN</td>
<td>Staff Nurse, Medicine</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Awilda Del Valle</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
<tr>
<td>Marianne Ditomassi, RN</td>
<td>Executive Director, PCS Operations</td>
<td>Executive Oversight</td>
</tr>
<tr>
<td>Diane Doherty, RN</td>
<td>Staff Nurse, Orthopaedics</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Bob Dorman, PT, DPT</td>
<td>Physical Therapy Specialist</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Joanne Empoliti, RN</td>
<td>Clinical Nurse Specialist, Orthopaedics</td>
<td>IU CNS</td>
</tr>
<tr>
<td>Sue Evangelista, RN</td>
<td>Staff Nurse, Surgery</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Rick Evans</td>
<td>Director, Service</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Roberta Raskin Feldman, RN</td>
<td>Professional Development Specialist</td>
<td>Education</td>
</tr>
<tr>
<td>Panas Fidias, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Gayle Fishman, RN</td>
<td>Senior Project Specialist</td>
<td>Project Support Staff</td>
</tr>
<tr>
<td>Denise Flaherty</td>
<td>Patient Advocate</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Eileen Flaherty</td>
<td>Staff Specialist</td>
<td>Project Support Staff</td>
</tr>
<tr>
<td>Brian French, RN, PhDe</td>
<td>Director, Simulation Center</td>
<td>Education</td>
</tr>
<tr>
<td>Taraza Funderburg</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
<tr>
<td>Theresa Gallivan, RN</td>
<td>Associate Chief Nurse</td>
<td>Executive Oversight</td>
</tr>
<tr>
<td>Trish Galvin</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
<tr>
<td>Helena Gautreau, RN</td>
<td>Project Manager, Information Systems</td>
<td>IU Project Manager</td>
</tr>
<tr>
<td>Marie Elena Gioiella, LICSW</td>
<td>Director, Social Services</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Sheila Golden-Baker, RN</td>
<td>Professional Development Specialist, Knight Center</td>
<td>Education</td>
</tr>
<tr>
<td>Tessa Goldsmith, CCC-SLP</td>
<td>Associate Director, Speech/Language Pathology</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Dan Gordon</td>
<td>Administrative Manager, Orthopaedics</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Susan Gordon, RN</td>
<td>Staff Nurse, Cardiac ICU</td>
<td>IU Attending Nurse</td>
</tr>
</tbody>
</table>

Key:
- Departmental Link
- Education & Evaluation Support
- Project Support Staff (unit based and centralized)
<table>
<thead>
<tr>
<th>Name/Credential</th>
<th>MGH Role(s)</th>
<th>Innovation Unit Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amy Giuliano</td>
<td>Senior Project Specialist, Quality &amp; Safety</td>
<td>Evaluation</td>
</tr>
<tr>
<td>Stephanie Green, RN</td>
<td>Staff Nurse, Medicine</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Peter Greenspan, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Shauna Harris, RN</td>
<td>Staff Nurse, Family/Newborn</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Jeff Hickey</td>
<td>HR Generalist</td>
<td>Departmental link</td>
</tr>
<tr>
<td>Vickie Hubachek, RN</td>
<td>Staff Nurse, Family/Newborn</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Jeff Huffman, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Dan Hunt, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Matt Hutter, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Esther Israel, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Jeanette Ives Erickson, RN</td>
<td>Chief Nurse</td>
<td>Executive Oversight</td>
</tr>
<tr>
<td>James Januzzi, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Kathy Johnson</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
<tr>
<td>Dottie Jones, RN, EdD</td>
<td>Director, Nursing Research</td>
<td>Evaluation</td>
</tr>
<tr>
<td>Bob Kacmarek, RRT</td>
<td>Director, Respiratory Care</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Linda Kane</td>
<td>Patient Advocate</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Joan Kaufman, RN</td>
<td>Manager, Case Management</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Rev. John Kearns</td>
<td>Staff Chaplain, Chaplaincy</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Sarah Keegan, RN</td>
<td>Staff Nurse, Medicine</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Jennifer Killip, RRT</td>
<td>Respiratory Therapist</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Janet Kleimola, RN</td>
<td>Staff Nurse, Pediatrics</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Linda Lacke</td>
<td>Senior Project Manager, PCS</td>
<td>Project Support Staff</td>
</tr>
<tr>
<td>Stacey Larkin, RN</td>
<td>Staff Nurse, Family/Newborn</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Kathleen Lorraine, RN</td>
<td>Professional Development Specialist, Knight Center</td>
<td>Education</td>
</tr>
<tr>
<td>Lauren Lebrun</td>
<td>Administrative Fellow</td>
<td>Project Support Staff</td>
</tr>
<tr>
<td>Robin Lipkis-Orlando, RN</td>
<td>Director, Patient Advocacy</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Martha Lynch, MS, RD</td>
<td>Assistant Director, Nutrition and Food Services</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Hannah Lyons, RN</td>
<td>Clinical Nurse Specialist, Oncology</td>
<td>IU CNS</td>
</tr>
<tr>
<td>Colleen Macauley, RN</td>
<td>Post-Discharge Follow-up, Medicine</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Janet Madden, RN</td>
<td>Clinical Nurse Specialist, Neonatal ICU</td>
<td>IU CNS</td>
</tr>
<tr>
<td>Christing Majocha, RN</td>
<td>Staff Nurse, Blake 12 ICU</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Christine Marmen</td>
<td>Education Project Specialist, Knight Center</td>
<td>Education</td>
</tr>
<tr>
<td>Keith Marple</td>
<td>Administrative Fellow</td>
<td>Project Support Staff</td>
</tr>
<tr>
<td>Sandra Masiello, RN</td>
<td>Staff Nurse, Family/Newborn</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Mary McAuley, RN</td>
<td>Nursing Director, Blake 12 ICU</td>
<td>IU Nursing Director</td>
</tr>
<tr>
<td>Jim McCarthy</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
</tbody>
</table>

Key:  
- Departmental Link  
- Education & Evaluation Support  
- Project Support Staff (unit based and centralized)
<table>
<thead>
<tr>
<th>Name/Credential</th>
<th>MGH Role(s)</th>
<th>Innovation Unit Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann McDonald</td>
<td>Director, Finance (Partners)</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Christine Grady McKee, RN</td>
<td>Clinical Nurse Specialist, Pediatrics</td>
<td>IU CNS</td>
</tr>
<tr>
<td>Mary Ellen McNamara, RN</td>
<td>Staff Nurse, Cardiac IU</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Elaine McNeil, RN</td>
<td>Staff Nurse, Vascular Surgery</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Brenda Miller, RN</td>
<td>Nursing Director, Pediatrics</td>
<td>IU Nursing Director</td>
</tr>
<tr>
<td>Ray Mitrano, RPh</td>
<td>Supervisor, Pharmacy</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Stella Moody</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
<tr>
<td>Lisa Morrissey, RN</td>
<td>Nursing Director, Main OR</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Jackie Mulgrew, PT</td>
<td>Clinical Specialist, Physical Therapy</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Janet Mulligan</td>
<td>Nursing Director, IV Team</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Kathy Mullin, RN</td>
<td>Staff Nurse, Medicine</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Susan Mulloy, RN</td>
<td>Staff Nurse, Family/Newborn</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Kim Murphy, RN</td>
<td>Staff Nurse, Pediatrics</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Patricia Murphy, RN</td>
<td>Nurse Manager, Internal Medical Associates</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Kathie Myers, RN</td>
<td>Nursing Director, Orthopaedics</td>
<td>IU Nursing Director</td>
</tr>
<tr>
<td>Wayne Newell</td>
<td>Director, Volunteers</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Anabela Nunes</td>
<td>Director, Interpreter Services</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Mary O’Brien, RN</td>
<td>Professional Development Specialist, Knight Center</td>
<td>Education</td>
</tr>
<tr>
<td>Angela Oliver</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
<tr>
<td>Rosemary O’Malley, RN</td>
<td>Staff Specialist</td>
<td>IU Project Manager</td>
</tr>
<tr>
<td>Ben Orcutt</td>
<td>Senior Manager, Admitting</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Kristen Parlman, PT, DPT</td>
<td>Physical Therapist</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Scott Parsons</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
<tr>
<td>Kristin Patrick, RN</td>
<td>Staff Nurse, Oncology</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Keith Perleberg, RN</td>
<td>Director, Office of Quality &amp; Safety</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Donna Perry, RN</td>
<td>Professional Development Manager</td>
<td>IU Project Manager</td>
</tr>
<tr>
<td>Georgia Peirce</td>
<td>Project Manager</td>
<td>Project Support Staff</td>
</tr>
<tr>
<td>June Peterson, RN</td>
<td>Professional Development Specialist, Knight Center</td>
<td>Education</td>
</tr>
<tr>
<td>Judy Pines</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
<tr>
<td>Lori Powers</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
<tr>
<td>Lori Pugsley, RN</td>
<td>Nursing Director, Family/Newborn</td>
<td>IU Nursing Director</td>
</tr>
<tr>
<td>Stephanie Kierstead Quinn, MSW, LICSW</td>
<td>Clinical Social Worker, Social Services</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>George Reardon</td>
<td>Director, Clinical Support Services</td>
<td>Executive Oversight</td>
</tr>
<tr>
<td>Steve Reardon</td>
<td>Patient Advocate</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Calvin Richardson</td>
<td>Administrative Fellow</td>
<td>Project Support Staff</td>
</tr>
<tr>
<td>Laura Riley, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Harry Rubash, MD</td>
<td>Physician</td>
<td>IU Medical Director</td>
</tr>
<tr>
<td>Katrina Scott</td>
<td>Staff Chaplain, Chaplaincy</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Peggy Settle, RN</td>
<td>Nursing Director, NICU</td>
<td>IU Nursing Director</td>
</tr>
<tr>
<td>Logan Monahan Sharma, OTR/L</td>
<td>Occupational Therapist</td>
<td>Departmental Link</td>
</tr>
</tbody>
</table>

Key:  
- Departmental Link  
- Education & Evaluation Support  
- Project Support Staff (unit based and centralized)
<table>
<thead>
<tr>
<th>Name/Credential</th>
<th>MGH Role(s)</th>
<th>Innovation Unit Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denise Sidorowicz</td>
<td>Administration Director, Chelsea Health Center</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Donna Slicis, RN</td>
<td>Staff Nurse, Blake 12 ICU</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Jessie Smith</td>
<td>Partners Continuing Care</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Mary Ellin Smith, RN</td>
<td>Professional Development Manager</td>
<td>Education</td>
</tr>
<tr>
<td>Colleen Snydeman, RN</td>
<td>Nursing Director, Cardiac ICU</td>
<td>IU Nursing Director</td>
</tr>
<tr>
<td>Katie Stakes, RN</td>
<td>Clinical Nurse Specialist, Pediatrics</td>
<td>IU CNS</td>
</tr>
<tr>
<td>Susan Stengrevics, RN</td>
<td>Clinical Nurse Specialist, Cardiac IU</td>
<td>CNS of IU</td>
</tr>
<tr>
<td>Jean Stewart, RN</td>
<td>Staff Nurse, Orthopaedics</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Tina Stone, RN</td>
<td>Nursing Director, Psychiatry</td>
<td>IU Nursing Director</td>
</tr>
<tr>
<td>Michael Sullivan, DPT</td>
<td>Director, Physical Therapy</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Nancy Sullivan</td>
<td>Director, Case Management</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Laura Sumner, RN</td>
<td>Professional Development Specialist</td>
<td>Education</td>
</tr>
<tr>
<td>Karen Tanklow, MSW, LICSW</td>
<td>Clinical Director, Social Services</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Lee Ann Tata, RN</td>
<td>Nursing Director, Medicine</td>
<td>IU Nursing Director</td>
</tr>
<tr>
<td>Dawn Tenney, RN</td>
<td>Associate Chief Nurse</td>
<td>Executive Oversight</td>
</tr>
<tr>
<td>Mary Ann Thadeu</td>
<td>Director, Finance (Partners)</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Jim Travers</td>
<td>Operations Manager</td>
<td>Operations Manager</td>
</tr>
<tr>
<td>Maureen Tully, RN</td>
<td>Staff Nurse, Family/Newborn</td>
<td>IU Attending Nurse</td>
</tr>
<tr>
<td>Carmen Vega-Barachowitz, CCC-SLP</td>
<td>Director, Speech/Language Pathology</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Karen Waak, PT, DPT</td>
<td>Clinical Specialist, Physical Therapy</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Deborah Washington, RN</td>
<td>Director, Diversity</td>
<td>Departmental Link</td>
</tr>
<tr>
<td>Carolyn Washington</td>
<td>Operations Manager</td>
<td>IU Operations Manager</td>
</tr>
<tr>
<td>Kevin Whitney, RN</td>
<td>Associate Chief Nurse</td>
<td>Executive Oversight</td>
</tr>
</tbody>
</table>

Key:  
- Departmental Link  
- Education & Evaluation Support  
- Project Support Staff (unit based and centralized)
Email Exchange between MGH CNO and MGH Associate Chief, Pharmacy

From: Ives Erickson, Jeanette, R.N., D.N.P.  
Sent: Saturday, August 13, 2011 8:32 AM  
To: Arpino, Paul A.  
Cc: Ditomassi, Marianne, R.N., D.N.P.  
Subject: Re: Care Redesign and Innovation Units

Paul, thank you.  
We are very excited about the potential for this work. I am very glad that you and our other colleagues are participating. As I look at your suggested metrics, I am wondering if we have baseline data. If not, how difficult do you think it will be to collect? Also, are there national benchmarking standards?  
Many thanks

On Aug 11, 2011, at 8:41 PM, "Arpino, Paul A." <PARPINO@PARTNERS.ORG> wrote:  

Hi Jeanette,

I just wanted to thank you for extended an invitation to the pharmacy to participate in this process. I also wanted to confirm with you that the Decentral Pharmacy Team is on board and willing to participate in as many of the Innovation Unit Pilots as possible.

I did touch base with a few Nurse Directors after yesterday's meeting about Pharmacist participation on their unit and they think it is great that pharmacy is part of this important work. I hope we are included early on in the Unit's process even if the targeted outcome may not be at face value considered "pharmacy related" (e.g. noise reduction). Pharmacy metrics that may be of value in this process include pharmacist order approval time, delivery time and waste can be part of the information included in the work. We may also be able to play a key role in aiding the team in facilitating the discharge process as it relates to medication education and procurement.

I also wanted to let you know that much of your presentation yesterday resonated with me because of what we are working towards in the Decentral Pharmacy Team. Especially the idea of decentralizing our services across the units and not just in the ICUs so that we can better meet Nursing, Physician and patient care needs. We are also looking into ways to improve our pass off procedures and have already made several changes to our process to enhance efficiency.

I am looking forward to continued collaboration on this and other projects with you and your team.

Thanks, Paul
Innovation Unit Retreat Summary from December 12, 2011 Retreat

“Patient Journey” Framework

Before | During | Post
--- | --- | ---
Admission Process: ED, Direct Admits, Transfers | Patient Stay: Direct Patient Care, Treatments, Procedures, Clinical Support, Operational Support | Discharge Process
Preadmission Care
Support Functions: Finance, Information Systems, HR

Goal: High-performing interdisciplinary teams that deliver safe, effective, timely, efficient and equitable care that is patient and family centered.

Where Are There Opportunities to Reduce Costs Across These Processes of Care?

Key Themes: Morning Breakout Session 12/12

- Educational Priorities
  - Educate staff on relationship based care. What does it mean to “know your patient?”
  - Clarification of roles on the interdisciplinary care team- “We are the Village”
  - Educate all staff on key quality metrics: how to access, interpret and impact outcomes
  - Caring for caregivers: Resiliency

Key Themes: Morning Breakout Session 12/12

- Improving Patient and Family Engagement
  - Commit to providing relationship based care that is patient and family centered
  - Educate patients/families regarding what it means to be involved in their own care
  - Make patient Bill of Rights and Patient Compact visible and accessible to patients and families
  - Set goals with the patient/family on admission and daily
  - Include patients and families in daily rounding as part of the care team

Key Themes: Morning Breakout Session 12/12

- Improving Physician Engagement
  - Seek multiple forums to get MD input and buy in
  - Engage MDs in Patient Compact (as well as all caregivers)
  - Maximize communication. Assist the MDs to see themselves as integral to the Innovation process
  - RN/MD partnership to serve as role model relationship
  - Include Quality Indicator education as part of resident orientation

Key Themes: Morning Breakout Session 12/12

- Improving the Environment of Care
  - Need to create and sustain a caring environment for patients and caregivers
  - Encourage a shared sense of ownership over clinical areas, everyone respecting common space
  - Stress importance of noise management: implement unit quiet hours, consider VOALTE on innovation units, minimize overhead paging
  - Maximize opportunities to de-clutter units
Key Themes: Morning Breakout Session 12/12

- Improving Patient Satisfaction Scores
  - Enhance relationship based patient and family centered care
  - Make continuity a priority
  - Make HCAHPS data a useful tool for staff in evaluating unit performance
  - Implement technology to improve communication and care coordination (VOALTE, Electronic White Boards)
  - Engage Service Improvement Team

Innovation Unit Afternoon Session Themes

Educational Needs

- For Staff – Background and What It Means
  - Relationship-based care (Why)
  - Innovation Units and their goals (What)
  - Attending Nurse role (Who)
  - Changes for other roles (How)
  - Metrics, measures, timelines (When)
  - For Patients/Families – Role and Expectations

Team Alignment

- If Takes A Village...
  - How do we get buy-in from all role groups?
    - Internal, External
    - Inpatient, Outpatient
    - Day Shift, Night & Wk End Shifts

- MDs
  - How do we open lines of communication between roles and disciplines to coordinate care?
  - Will we change our rounds to reflect the new focus and roles?

Refinement of Proposal

- Goals
  - Patient Population & Needs
- Roles
  - Discharge Checklists
- Measures
  - Feedback Mechanisms
- Teams
  - Rounding Checklists

Innovation Unit Afternoon Session Wordle

Inpatient Care Delivery Model

"Innovation Units"

The care model recommendations require transformational change. This cannot occur at the risk of our patients. For some changes we will need to "design, test, validate and replicate" in innovation units to be designated at each entity.

Innovation units allow changes to the care model to be tested and outcomes measured.

Guiding Principles

- Care delivery should always be: patient- and family-focused, evidence-based, accountable and autonomous, coordinated and continuous.
- Being "highly present" and knowing the patient is key.
- Inpatient and family care is provided by a designated nurse and physician who assume accountability and responsibility to ensure continuity of care for each encounter.
- Continuity of the team is a basic precept.
- Every novice team member deserves mentoring from an experienced clinician.
- Every patient deserves the opportunity to participate in the planning of his/her care.
- Advancements in technology create opportunity for improved provider communication and efficiency.

Relationship Based Care: Care Team Model

Features/Guidelines For New Model

1. Knowing the patient – manage a patient population – access to info across the continuum (needs to be electronic)
2. Coordination of care – knowing who’s responsible; review plan daily = consistency and reliability
3. Consistency of teams – improved performance of teams
4. Building plan of care around the patient; patient care & teaching aligned. Entire team knowing what the plan is each day.
5. Clinical support aligned around patient populations rather than transactions
6. Learn lessons from the past

Consistency = Continuity = Coordination = Efficiency/Quality
Delivery of Care

- Model requirements:
  - Simplifying complex processes
  - Clarity of roles of caregivers
  - Meaningful interventions: overuse, underuse, misuse
  - Technology integration
  - Relationship based care
  - Ongoing innovation
  - Continuum based

- Key domains
  - Quality and safety
  - Healing environment
  - Research and evidence-based practice
  - Professional development and education

Building Increased Accountability into Existing Roles

Responsible Nurse/Attending Nurse ➔

Expand staff nurse role.
- Accountable for patient/family continuity and progression along the developed overall plan of care from admission to discharge
- Ensures, along with the Attending MD, that patient care meets the unit’s clinical standards and vision of patient- and family-centered care
- Develops and revises the patient care goals with the clinical care team daily
- Coordinates meetings with clinicians for timely decision making and connects nurses to optimize handoffs across the continuum
- Is the primary bedside communicator with the patient and family, discussing plan of the day, care progress, potential discharge, and answers questions/teaches/coaches

Domains of Practice: Attending Nurse

Clinical Coordinator
- Accountable for working with all members of the team to design, coordinate and evaluate the plan of care and achievement of patient, system and process outcomes.
- Utilizes evidenced-base practices to ensure care is safe, efficient and effective.
- Identifies and implements best practices to promote patient- and family-focused care.

Facilitator
- Identifies and resolves barriers to promote timely hand-offs and efficient throughput of patients.

Mentor
- Serves as a role model for interdisciplinary problem solving.

Innovation Units: Non-Negotiables

- Engagement by the entire team
- Role of the Attending Nurse
  - Continuity achieved through 8-hour shifts and systems improvements
  - Interdisciplinary rounds and rounding check list
  - High risk clinical rounds
  - Patient/family involvement in plan of care
  - Discharge planning begins on admission
  - Focus on hand-offs
  - Interventions: (examples)
    - Discontinuation of Foley catheters earlier
    - Enhanced pain management
    - Restraint usage and compliance

In Scope

Establish Innovation Units to Test Elements of Care
- Evaluated on:
  - Number of new ideas or innovations being tested
  - Innovation unit inpatient cost per case mix-adjusted discharge
  - Overall patient satisfaction raw scores
  - Support of throughput and length of stay enhancements
Rounding Checklist (Quality checklist for ACD)

Overview: The quality checklist was developed to assist clinicians during interdisciplinary rounds.

- **Purpose:**
  - to guide clinicians about key quality metrics that must be addressed on a frequent basis.
  - Serves as a reminder to clinicians of those measures which should be monitored or considered for a specific diagnosis.
  - Anticipated discharge or transfer date is noted at the top of the form and should be discussed during daily interdisciplinary rounds.

- **Examples:**
  - include ventilator-assisted pneumonia,
  - central lines and indwelling urinary catheters.

- **Versions:**
  - ICU
  - General care

Patient Hand-offs

**Communicate**

- Patients are seen by a large number of people and in many settings
  - A safety risk is created at each interval
- Hand-offs that are not standardized might not include all of the essential information, or the information may be misunderstood.
- Breakdown in communication is the leading root cause of sentinel events in the US

Hand-Over Communication

**Goal:** Ensure patient care continuity and safety

- Passing patient-specific information:
  - From one caregiver to another
  - From caregiver to patient and family
  - Transfer of information from one type of organization to another or to the patient’s home

**SBAR:** Hand-Off Communication Tool
This format should be used whenever a “hand off” of patient responsibility occurs, i.e. shift to shift report, etc.

- **S-Situation:** Identify yourself and position, patient’s name and the current situation. Describe what is going on with the patient.
- **B-Background:** State the relevant history and physical (H&P), physical assessment pertinent to the problem, treatment/clinical course summary and any pertinent changes.
- **A-Assessment:** Offer your conclusion about the present situation.
- **R-Recommendations:** Explain what you think needs to be done, what the patient needs and when.

Verify any critical information received, review the history, seek clarification, ask questions, and read back critical test results.

Patient Hand-Over

**Information includes:**

- Patient’s current condition
- Recent changes in condition
- Ongoing treatment
- Possible changes or complications that occur

Discharge Planning/Discharge Readiness Tool

- Guide proactive discharge planning
- Comprised of:
  - General Information
  - Work-up
  - Functional Requirements
  - Other Information
  - Education
  - Post-Discharge
  - Discharge Information
**Patient “Going Home” Checklist**

List of questions to guide patients for discharge:
- Do I have clean, comfortable clothes to wear?
- Do I have keys to my home?
- Is there food for me to eat at home?
- Is it the right food for my diet?
- Who is coming to pick me up?
- Do I need someone to help me at home?
- Have these arrangements been made?
- Do I have all the prescriptions/medications I will need?
- Will I need any special equipment?
- Is the special equipment there and ready for me to use?
- Have I received my discharge instructions to care for myself at home?
- Will I be following up with other doctors or specialists when I get home?
- Who are they?
- Will I need home care services after I leave?
- Have these services been arranged?
- What else should ask my doctor, nurse, or therapist?
- Who can I call if I have concerns or questions after I get home?
- The date of my follow-up appointment is:
- My doctor’s phone number is:

**Discharge Follow-up Call Program**

### Guidelines:
- 100% of inpatients patients being discharged to home will be asked to consent to receiving a discharge follow-up call.
- Calls should be made within 24-48 hours.
- We estimate 3-5 calls per day per nurse or attending nurse.
- Average call time is 3-5 minutes.
- Standard is two attempts to reach patient.
- Scripts are recommended.

### Standard Procedure:
1. At discharge, patient is asked if they would consent to receiving a discharge call. If YES, a Discharge Call Report Form is filled in with name, phone number, discharge date and unit. This can be done by nurse or OA.
2. Completed Discharge Call Report Forms are gathered by the OA each day and sent to Office of Patient Advocacy.
3. Each day, staff making calls retrieve an assigned number of forms and make the calls. Calls are made according to the script provided. The feedback from the calls is logged directly onto the forms.
4. Issues and/or complaints may arise during the call. In such cases, the guidelines below should be followed:
   a) For clinical issues and questions, the patient should be referred to their primary provider if the person making the call cannot address the issue directly.
   b) Complaints about the hospital or its services should be logged into Event Reporting system.
   c) Any actions in response to questions or complaints should be documented on the Discharge Call Report Form. Specifically, the type of referral made and any type of contact made on behalf of the patient or their concern should be documented.
5. Forms are reviewed weekly by the Office of Patient Advocacy and analyzed for patterns and issues. Feedback from calls is shared with staff at staff meetings and huddles. Feedback is also used for recognition.
6. The identified patterns and trends will be shared with Directors and the Patient Care Services Executive Committee (PCSEC).
7. All forms are kept in a file on the unit. Forms may be requested on rounds and during tracing.
8. Each month, the Office of Patient Advocacy submits a report to PCSEC that includes, at a minimum, the number of calls made and number of patients reached. Other data from the calls may also be part of the report.
9. The Innovation Unit will also publish dashboard data on number of discharge calls made on a monthly basis.
10. The Service Improvement Department will begin to trend satisfaction levels of patients who receive discharge calls.

### In Scope

**Establish Innovation Units to Test Elements of Care**
- Evaluated on:
  - Number of new ideas or innovations being tested
  - Innovation unit inpatient cost per case mix-adjusted discharge
  - Overall patient satisfaction raw scores
  - Support of throughput and length of stay enhancements

### FY12 October YTD Inpatient Cost Per CMAD

<table>
<thead>
<tr>
<th>Month</th>
<th>Actual vs. Prior Year</th>
<th>Trend to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct</td>
<td>1.6%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Sep</td>
<td>1.4%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Aug</td>
<td>1.2%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Jul</td>
<td>1.0%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Jun</td>
<td>0.8%</td>
<td>3.9%</td>
</tr>
<tr>
<td>May</td>
<td>0.6%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Apr</td>
<td>0.4%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Mar</td>
<td>0.2%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Feb</td>
<td>0.0%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Jan</td>
<td>-0.2%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual vs. Prior Year</th>
<th>Trend to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Inpatient Care Costs</td>
<td>5.5%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Indirect Inpatient Care Costs</td>
<td>4.4%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Ancillary Costs</td>
<td>3.3%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>
Inpatient Cost per Case Mix Adjusted Discharge – FY11

<table>
<thead>
<tr>
<th>Case-mix Adjusted Cost per Discharge</th>
<th>$0</th>
<th>$5,000</th>
<th>$10,000</th>
<th>$15,000</th>
<th>$20,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery White 7</td>
<td>$6,783</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ortho White 6</td>
<td>$6,738</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oncology Lunder 9</td>
<td>$6,483</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatrics Ellison 18</td>
<td>$6,929</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatrics Ellison 17</td>
<td>$6,944</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine Ellison 16</td>
<td>$7,823</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular Bigelow 14</td>
<td>$5,173</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrics Blake 13</td>
<td>$8,181</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psych Blake 11</td>
<td>$7,541</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Case Mix determined by MS DRG weights.

In Scope

Establish Innovation Units to Test Elements of Care

- Evaluated on:
  - Number of new ideas or innovations being tested
  - Innovation unit inpatient cost per case mix-adjusted discharge
  - Overall patient satisfaction raw scores
  - Support of throughput and length of stay enhancements

HCAHPS Overall Patient Satisfaction Data

Key Measures:
- Nurse Communication
- MD Communication
- Responsiveness
- Discharge Planning
- Pain Management
- Cleanliness
- Quiet

H-CAHPS Inpatient Scores – FY 2011

Inpatient 2012 PCS Focus Areas

| Nurse Communication Composite | 80.5% | 78.1% | 79.5% | 78.6% | 81.3% | 78.9% | 78.9% |
| MD Communication Composite    | 82.3% | 81.6% | 83.2% | 80.5% | 78.2% | 87.4% | 76.3% | 90.9% |
| Staff Responsiveness Composite| 81.1% | 82.7% | 81.5% | 80.2% | 78.4% | 71.4% | 54.4% | 87.4% |
| Discharge Information Composite| 81.6% | 81.8% | 82.5% | 80.8% | 78.8% | 60.8% | 53.3% | 88.9% |
| Room Cleanliness Item          | 92.4% | 88.7% | 91.3% | 87.7% | 82.8% | 55.3% | 84.9% | 71.7% |
| Noise Item                     | 82.3% | 62.9% | 89.8% | 58.9% | 83.7% | 34.8% | 16.4% |
| Pain Management Composite      | 78.3% | 70.9% | 85.1% | 71.8% | 71.9% | 74.3% | 70.2% | 69.0% |

Note: Psych, Blake 11 not included in H-CAHPS survey population.

H-CAHPS Inpatient Scores – FY 2011

Inpatient 2012 PCS Focus Areas

| Nurse Communication | 70% | 59% | 59% | 60.3% |
| Info Provided by Doctor | 70% | 72% | 53% | 61.2% |
| Staff Responsiveness | 80% | 66% | 53% | 59.1% |
| Room Cleanliness | 78% | 46% | 59% | 51.0% |
| Noise | 61% | 37% | 34% | 44.2% |

Note: Data reflect “top-box” % - the most positive response option.
### In Scope

**Establish Innovation Units to Test Elements of Care**
- Evaluated on:
  - Number of new ideas or innovations being tested
  - Innovation unit inpatient cost per case mix-adjusted discharge
  - Overall patient satisfaction raw scores
  - Support of throughput and length of stay enhancements

### If We Do It Right: A New Way of Being

- Improve quality and safety
- Improve Satisfaction
- Improve Clinical Outcomes
- Adopt Best Practices in more timely fashion
- Enhance retention and on-boarding
- Improve care continuity
- Ensure practice is evidence based
- Improve financial outcomes
  - For the patient and family
  - For the hospital and provider
  - Improve Compliance outcomes

### To Do List

- Complete forms: Pre
- Education plan: Pre and post
- Signage: Pre
- Communication tool kit: Pre
- Cultural competence: when ready
- MD meetings: pre
- EED portal: Easy launch
- Welcome packet: when ready
- Technology proposal: When ready and funded
- Awards and Recognition: When ready
- SBAR form: pre
- Patient Education material: languages and readability as discovered
- Patient Compact: When ready
- Resiliency Training

### Communications: Goals

- Inform and educate
  - Innovation Unit staff,
  - patients/families/visitors

- Raise awareness of the work and progress being made within PCS, MGH and Partners communities

- Facilitate communications between and among unit staff

- Optimize communications between Innovations Units

### Communications: Target Audiences

- Unit staff
  - All disciplines
- Patients, families and visitors
- PCS, MGH and Partners communities
- General public
- Greater nursing community

### Communications: Possible Strategies (initial and ongoing):

- Launch—“Town Meeting”: (Jeanette)

- Staff sessions—hold interdisciplinary and/or discipline-specific unit-based “town meetings” to present, discuss with staff: (Associate Chiefs and Directors)

- Orientation—Include in General Orientation (Gino) and Unit orientation (Clinical specialists and OMs)

- Innovation Unit 1-0-1—develop an education toolkit to inform and educate staff, (portions to be used with patient/family/visitor); Draft completed (Gino)
## Communications: Possible Strategies

### In-unit:
- Patient “welcome” packet—presented to patients/families upon admission (start with standard basics and supplement as appropriate);
  - standard items might include:
    - ARN “business card” (contact info and brief 1-3 lines about the role and a “pledge” to patient/family)
    - FAQ specific to patient/family/visitor (Rick Evans with small committee)
    - Tray liners—patient-specific messaging about activities (Georgia)
    - Innovation e-Bulletin—provide regular updates about activities, operations, milestones, lessons learned, best practices (Georgia)
    - Forums—ongoing discussion sessions to bring together leadership (Use Wed 11am time)

### Operational:
- Handoffs—Introduce selected hand-off tool for universal (draft done)
- Patient Rooms—White board or other device (sign) to provide patient/family with care team contact information (unit staff)
- Patients/Families—“Going Home Checklist” introduced at outset of hospitalization (draft done)
- E-Community—Create a dynamic virtual space for exchanging information, ideas, documents, best practices and promoting two-way communications, asynchronous discussions, etc. (Georgia)

### General:
- Dedicated Caring column—regular, high-level updates (Susan)
- Complementary Hotline and Fruit Street Physician coverage (Georgia)
- Excellence Every Day focused portal page (Georgia)
- Posters—general visibility/awareness presence in high-traffic areas (Georgia)
- Nursing-specific media: mid-term outreach (ADVANCE for Nurses, Nursing Spectrum, AJN) (Georgia)
Innovation distinguishes between a leader and a follower.

- Steve Jobs

“Innovation Units” Framework: Your Improvements

Before | During | Post
--- | --- | ---
Pre-admission Care | Patient Stay; Direct Patient Care, Tests, Treatments, Procedures, Clinical Support, Operational Support | Discharge Process
Admission Process: ED, Direct Admits, Transfers | | Discharge Process
Discharge Process | Post Discharge Care

**Intervention**

- Enhances Clinical Data Collection Pre-Admit
- Create Innovation Unit Welcome Packet
- Revise Domains of Practice
- Interdisciplinary Team Rounds
- Electronic Whiteboards
- Voalté Communication Technology
- Portable Devices: hand-held/Tablet
- Discharge Planning Readiness Tool
- Discharge Follow-up Call Program

**Intervention**

- Relationship Based Care
- Increased Accountability through Attending RN role
- Hand-over Rounding Checklist

Innovating Care at MGH

**Goal:** To improve the quality of care delivered to patients

**Aspirations:** High performing interdisciplinary teams that deliver safe, effective, efficient, timely, equitable, that is patient and family centered

**Evidence:** Standardization of processes and care reduces variation and introduces a systematic approach to improving quality and safety in the inpatient setting

**Change:** Identify and prioritize hazards and opportunities for standardization, then implement evidence based methods to rectify the problem

Guiding Principles

- Care delivery should always be: patient- and family-focused, evidence-based, accountable and autonomous, coordinated and continuous.
- Being “highly present” and knowing the patient is key.
- Inpatient and family care is provided by a designated nurse and physician who assume accountability and responsibility to ensure continuity of care for each encounter.
- Continuity of the team is a basic precept.
- Every novice team member deserves mentoring from an experienced clinician.
- Every patient deserves the opportunity to participate in the planning of his/her care.
- Advancements in technology create opportunity for improved provider communication and efficiency.

Inpatient Care Delivery Model

**“Innovation Units”**

The care model recommendations require transformational change. This cannot occur at the risk of our patients. For some changes we will need to “design, test, validate and replicate” in innovation units to be designated at each entity.

Innovation units allow changes to the care model to be tested and outcomes measured.
### Delivery of Care

- **Model requirements:**
  - Simplifying complex processes
  - Clarity of roles of caregivers
  - Meaningful interventions: overuse, underuse, misuse
  - Technology integration
  - Relationship based care
  - Ongoing innovation
  - Continuum based

- **Key domains**
  - Quality and safety
  - Healing environment
  - Research and evidence-based practice
  - Professional development and education

### Relationship-Based Care

**Philosophy, Theory and Intervention (Intervention 1)**

1. Knowing the patient – manage a patient population – access to info across the continuum
2. Coordination of care – knowing who’s responsible; review plan daily = consistency and reliability
3. Consistency of teams – improved performance of teams
4. Building plan of care around the patient; patient care & teaching aligned. Entire team knowing what the plan is each day.
5. Clinical support aligned around patient populations rather than transactions
6. Learn lessons from the past; learn from benchmarking

**Consistency = Continuity = Coordination = Efficiency = Patient Centered Communication, Responsiveness**

### In Scope

Establish Innovation Units to Test Elements of Care

- Evaluated on:
  - Overall patient satisfaction raw scores
  - Innovation unit inpatient cost per case mix-adjusted discharge
  - Support of throughput and length of stay enhancements
  - Driven by:
    - Number of new ideas or innovations being tested

### Inpatient 2011 Focus Areas

**Partners P4P, PCS Goals, & MGPO QI Program**

<table>
<thead>
<tr>
<th>Inpatient H-CAHPS</th>
<th>2011 YTD (as of 9/21/11)</th>
<th>CY11 Target</th>
<th>2011 YTD vs. CMS %ile</th>
<th>Better or Worse/Msdn %tile 2011YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor Communication</td>
<td>81.5%</td>
<td>80.9%</td>
<td>&lt;81.5%</td>
<td>*Partners P4P</td>
</tr>
<tr>
<td>Nurse Communication</td>
<td>79.1%</td>
<td>78.8%</td>
<td>Note</td>
<td>*Partners P4P</td>
</tr>
<tr>
<td>Staff Responsiveness</td>
<td>64.0%</td>
<td>61.4%</td>
<td>&lt;64.0%</td>
<td>*Partners P4P</td>
</tr>
<tr>
<td>Room Cleanliness</td>
<td>69.6%</td>
<td>71.7%</td>
<td>&lt;69.6%</td>
<td>*MGPO QI Program</td>
</tr>
</tbody>
</table>

MGPO QI Program: MD Communication Term 2, 2011 varies by department (measurement period: June-August 2011). MGH-wide target: 82.9%

Note: Data reflect “top-box” % - the most positive response option

### H-CAHPS Inpatient Scores – FY 2011

**Inpatient 2012 PCS Focus Areas**

| Patient Communication Composite | 79.1% | 82.3% | 82.3% | 82.3% | 82.3% | 82.3% | 82.3% | 82.3% | 82.3% | 82.3% |
| MD Communication Composite | 82.1% | 83.3% | 83.3% | 83.3% | 83.3% | 83.3% | 83.3% | 83.3% | 83.3% | 83.3% |
| Staff Responsiveness Composite | 82.1% | 82.1% | 82.1% | 82.1% | 82.1% | 82.1% | 82.1% | 82.1% | 82.1% | 82.1% |
| Discharge Information Composite | 51.5% | 53.1% | 53.1% | 53.1% | 53.1% | 53.1% | 53.1% | 53.1% | 53.1% | 53.1% |
| Room Cleanliness Item | 73.4% | 73.4% | 73.4% | 73.4% | 73.4% | 73.4% | 73.4% | 73.4% | 73.4% | 73.4% |
| Noise Item | 61.5% | 61.5% | 61.5% | 61.5% | 61.5% | 61.5% | 61.5% | 61.5% | 61.5% | 61.5% |
| Pain Management Composite | 88.6% | 88.6% | 88.6% | 88.6% | 88.6% | 88.6% | 88.6% | 88.6% | 88.6% | 88.6% |

*Psych. Intl. 11 not included in H-CAHPS survey population

### Pediatric Survey Inpatient Scores – FY 2011

**Pediatric 2012 PCS Focus Areas**

| Nurse Communication | 73% | 57% | 53% | 60.3% |
| Info Provided by Doctor | 71% | 72% | 55% | 61.2% |
| Staff Responsiveness | 76% | 66% | 59% | 59.7% |
| Discharge Information | 76% | 49% | 39% | 51.6% |
| Room Cleanliness | 66% | 37% | 34% | 44.2% |
| Noise | 66% | 55% | 57% | 40.8% |
| Pain Management | 66% | 55% | 57% | 40.8% |
Direct Cost per Case-Mix Adjusted Discharge – Sept-Nov 2011

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery White 7 (CMI=2.055)</td>
<td>$4,727</td>
</tr>
<tr>
<td>Ortho White 6 (CMI=1.651)</td>
<td>$4,897</td>
</tr>
<tr>
<td>Oncology Lunder 9 (CMI=1.139)</td>
<td>$4,569</td>
</tr>
<tr>
<td>Pediatrics Ellison 10 (CMI=0.290)</td>
<td>$15,929</td>
</tr>
<tr>
<td>Pediatrics Ellison 17 (CMI=0.554)</td>
<td>$6,367</td>
</tr>
<tr>
<td>Medicine Ellison 16 (CMI=0.116)</td>
<td>$4,347</td>
</tr>
<tr>
<td>Vascular Bigelow 14 (CMI=0.115)</td>
<td>$4,759</td>
</tr>
<tr>
<td>Obstetrics Blake 13 (CMI=1.274)</td>
<td>$17,213</td>
</tr>
<tr>
<td>Psych Blake 11 (CMI=1.472)</td>
<td>$9,687</td>
</tr>
<tr>
<td>NICU Blake 10 (CMI=0.698)</td>
<td>$8,033</td>
</tr>
</tbody>
</table>

Source: PHS Finance (AP21 DRG case weights)

Throughput and LOS

- Join forces with LOS committee as plans are developed
- Measure LOS and thru-put impact
  - Interdisciplinary Rounding
  - Awareness of Discharge date on admission
  - Discharge Check list
  - Family engagement
  - Attending Nurse Role

```
“Progress always involves risks. You can’t steal second base and keep your foot on first base.”
- Frederick B. Wilcox
```

Intervention 2: Attending Nurse Role

**Responsible Nurse/Attending Nurse**

1. Expand staff nurse role.
   - Accountable for patient/family continuity and progression along the developed overall plan of care from admission to discharge
   - Ensures, along with the Attending MD, that patient care meets the unit’s clinical standards and vision of patient- and family-centered care
   - Develops and revises the patient care goals with the clinical care team daily
   - Coordinates meetings with clinicians for timely decision making and connects nurses to optimize handoffs across the continuum
   - Is the primary bedside communicator with the patient and family, discussing plan of the day, care progress, potential discharge, and answers questions/teaches/coaches

**Timely, Efficient, Effective, Explorable Communication, Responsiveness Throughput**

Intervention 3: Hand-Over Communication

**Goal**: Ensure patient care continuity and safety

- Passing patient-specific information:
  - From one caregiver to another
  - From caregiver to patient and family
  - Transfer of information from one type of organization to another or to the patient’s home
**Patient Hand-Over**

Information includes:

- Patient’s current condition
- Recent changes in condition
- Ongoing treatment
- Possible changes or complications that occur

**SBAR: Hand-Off Communication Tool**

This format should be used whenever a “hand off” of patient responsibility occurs, i.e. shift to shift report, etc.

**S**-Situation: Identify yourself and position, patient’s name and the current situation. Describe what is going on with the patient.

**B**-Background: State the relevant history and physical (H&P), physical assessment pertinent to the problem, treatment/clinical course summary and any pertinent changes.

**A**-Assessment: Offer your conclusion about the present situation.

**R**-Recommendations: Explain what you think needs to be done, what the patient needs and when. Verify any critical information received, review the history, seek clarification, ask questions, and read back critical test results.

---

**SBAR Rounding & Handover Worksheet**

- To improve the quality of rounds and handovers, more structure is required
- SBAR represents a philosophy for transitions, not a checklist
- Form can be used to document or simply to structure the rounding & handover process
- See packet for full-size version

**Possible Use as PEPL Note Template**

- Template in PEPL created from SBAR form content with headers, formatting removed
- PEPL note available to view and edit by RNs and other disciplines
- Not a permanent part of record. Note disappears at end of encounter.
- Must improve staff coordination and simplify documentation to justify significant ARN time investment

---

**Intervention 4: Clinical data collection pre-admit**

- Pre-admission clinical data collection, along with screening and patient education, are key components of “knowing our patients”
- Current data collection standards and tools vary for different populations (e.g. ED, Same-Day Surgery, Transfers)
- Action Step: Multi-disciplinary Tiger Team with Admitting to draft standard clinical data collection tool

**Intervention 5: Welcome Packet**

- Create Innovation Unit Welcome Packet
- Inform patients and families of goals
- Invite feedback
- Include Compact
- Include Patient Discharge list

Action Step: Tiger Team with Service Improvement
**Intervention 6: Domains of Practice**

**Domain of practice**
- A sphere of activity or knowledge
- The perspective and territory of the discipline: Includes subject matter of a discipline, the main agreed-on values and beliefs, the central concepts, the phenomena of interest and the methods used to provide answers in the discipline.

**Format:**
- Goal statement – foci of the discipline
- Central practice components (domains of practice)

**Action Step:**
- Each clinical discipline should review Domain of Practice description and revise, as appropriate, to position each respective discipline for the future. (Draft domain of practice if one has not been developed).
- Disciplines: Nursing, Chaplaincy, Child-Life, Medical Interpretation, Occupational Therapy, Pharmacy, Physical Therapy, Respiratory Care, Social Work, Speech-Language Pathology

---

**Intervention 7: Interdisciplinary Team Rounds (IDT)**

**Why did we target IDTs as an intervention?**
- Prior to Innovation Units, we did not have a formal mechanism for daily communication between all members of the care team
- Communication is fragmented and untimely
- Not all members of the care team had a clear picture of the patient’s planned course.

---

**Purpose of Interdisciplinary Team Rounds**

Pull together key members of the care delivery team on a daily basis to:
- Identify care gaps and improve care progression (delays in treatment, IV to PO transition, removal of lines, pain management, timely discharge decision)
- Build a more holistic approach to patient care plan (e.g., more long-term needs discussed for frequent flyers)
- Prevent patients from falling through the cracks
- Help identify potential patient/family satisfaction issues for early intervention

---

**Interdisciplinary Team Rounds: Structure**

- Occur daily during morning rounds
- Medical Record and hand-over sheets are used real-time to review patient’s data:
  - Address timely care issues (e.g., Foley alert)
  - Write basic orders as appropriate (order physical therapy consult for ambulation status)
- Each participant is responsible to bring forth questions/issues/barriers and work with IDT group to resolve during rounds when possible
- Patient is part of the Team

---

**Interdisciplinary Team Rounds: Participants**

- Patient’s Nurse
- Attending Nurse
- Case Management
- Therapists (specialty specific)
- Pharmacists
- Chaplains
- Physician/NP/PA
- Patient and Family
- Others??

---

**Sample IDT Full Team Checklist for Discharge**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Physician</th>
<th>Pharmacy</th>
<th>Nursing</th>
<th>Care Mgmt</th>
<th>Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with PCP</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge appointments ordered</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge appointments made</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation for initial/follow-up arranged</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication reconciliation, prescriptions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to obtain medications or meds in hand</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge instructions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication teaching – anticoagulation, aspirin, Fentanyl, long-acting narcotics, 3 or more chronic meds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication with SNF, LTAC, infusion, home care</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical equipment needed</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Home medication use (transition to home meds)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home care needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education – condition specific</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---
**Interventions 8, 9, & 10: Enabling Technology**

- Electronic Whiteboards
- Voalté Communication Technology
- Portable Devices: Hand-helds/ Tablets

**Action Step:** Tiger teams underway

---

**Intervention 11: Discharge Planning/Discharge Readiness Tool**

- Guide proactive discharge planning
- Comprised of:
  - General Information
  - Work-up
  - Functional Requirements
  - Other Information
  - Education
  - Post-Discharge
  - Discharge Information

---

**Discharge Checklist**

- Literature supports the use of checklists in the hospital discharge process.
- Checklists can assist in addressing omissions and interruptions in workflow.
- Programs are cited as using tools and workflow procedures, including checklists, from other industries and applying them directly to the health care setting (e.g. Formula 1 racing/pit crews, LEAN principles from Toyota)

**Action Step:** Partners Continuing Care is drafting a Discharge Checklist. We will give them our draft

---

**Intervention 12: Discharge Follow-up Call Program**

**Guidelines:**
- 100% of patients in the inpatient setting being discharged to home will be asked to consent to receiving a discharge follow-up call.
- Calls should be made within 24-48 hours
- We estimate 3-5 calls per day per nurse or attending nurse
- Average call time is 3-5 minutes
- Standard is two attempts to reach patient
- Scripts are recommended

**CBCeds Electronic Whiteboard**

Currently in use on Lunder 6-10 and Blake 12

---

**Voalté**

- iPhone and web application for sending/receiving instant messages to specific individuals or groups. Users can write their own message or use the Quick Messages available in the system.
- Voalté iPhones send/receive phone calls over MGH secure wifi (no cell plan used).
- Sender selects staff they are trying to reach via a list with their name/role and picture so no need to memorize who is carrying which phone

---

**Intervention 11: Discharge Planning/Discharge Readiness Tool**

- Guide proactive discharge planning
- Comprised of:
  - General Information
  - Work-up
  - Functional Requirements
  - Other Information
  - Education
  - Post-Discharge
  - Discharge Information

---

**Discharge Checklist**

- Literature supports the use of checklists in the hospital discharge process.
- Checklists can assist in addressing omissions and interruptions in workflow.
- Programs are cited as using tools and workflow procedures, including checklists, from other industries and applying them directly to the health care setting (e.g. Formula 1 racing/pit crews, LEAN principles from Toyota)

**Action Step:** Partners Continuing Care is drafting a Discharge Checklist. We will give them our draft

---

**Intervention 12: Discharge Follow-up Call Program**

**Guidelines:**
- 100% of patients in the inpatient setting being discharged to home will be asked to consent to receiving a discharge follow-up call.
- Calls should be made within 24-48 hours
- We estimate 3-5 calls per day per nurse or attending nurse
- Average call time is 3-5 minutes
- Standard is two attempts to reach patient
- Scripts are recommended

---

**CBCeds Electronic Whiteboard**

Currently in use on Lunder 6-10 and Blake 12
**Discharge Follow-up Call Program**

**Standard Procedure:**
1. At discharge, patient is asked if they would consent to receiving a discharge call. If YES, a Discharge Call Report Form is filled in with name, phone number, discharge date, and unit. This can be done by nurse or OA.
2. Completed Discharge Call Report Forms are gathered by the OA each day and sent to Office of Patient Advocacy.
3. Each day, staff making calls retrieve an assigned number of forms and make the calls. Calls are made according to the script provided. The feedback from the calls is logged directly onto the forms.
4. Issues and/or complaints may arise during the call. In such cases, the guidelines below should be followed:
   a) For clinical issues and questions, the patient should be referred to their primary provider if the person making the call cannot address the issue directly.
   b) Complaints about the hospital or its services should be logged into Event Reporting system.
   c) Any actions in response to questions or complaints should be documented on the Discharge Call Report Form. Specifically, the type of referral made and any type of contact made on behalf of the patient or their concern should be documented.

**Conceputal Schema**

**“Patient Journey” Framework: Progress-to-date**

**March 2012**

<table>
<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If We Do It Right: A New Way of Being**

- Improve quality and safety
- Improve satisfaction
- Improve clinical outcomes
- Adopt best practices in more timely fashion
- Enhance retention and on-boarding
- Improve care continuity
- Ensure practice is evidence based
- Improve financial outcomes
  - for the patient and family
  - for the hospital and provider
- Improve compliance outcomes

---

[Image of Conceptual Schema with Innovation Cluster Focus Areas and Roles & Structures]

[Image of “Patient Journey” Framework with Intervention before during and post]

[Table for March 2012 with dates and events]
“We experience the essence of care in the moment when one human being connects to another. When compassion and care are conveyed through touch, a kind act, through competent clinical interventions, or through listening and seeking to understand the other’s experience, a healing relationship in created. This is the heart of Relationship-Based Care.”

“Relationship-Based Care, A Model for Transforming Practice”, Mary Koloroutis, 2004.

1. **Overview**

“By virtue of its numbers and adaptive capacity, the nursing profession has the potential to effect wide-reaching changes in the health care system. Nurses’ regular, close proximity to patients and scientific understanding of care processes across the continuum of care give them a unique ability to act as partners with other health professionals and to lead in the improvement and redesign of the health care system and its many practice environments.”

To meet the current challenges in healthcare, it is necessary to evaluate our present patient care delivery and create new innovative methods to transform the delivery for improvement and overall satisfaction. Delivering more integrated, patient-centered, evidence-based care while preserving our standards of quality will also enhance efficiency.

The attending nurse will facilitate this new delivery of patient care with the entire healthcare team. The attending nurse is a consistent patient/family and health care team contact supporting the staff nurse. These coordinated efforts are continuous throughout a patient’s care.
2. Definitions

2.1. Attending Nurse is the staff nurse developing and coordinating the team’s strategic clinical plan for the inpatient admission. The attending nurse works 8 hour days/5 days per week.

2.1.1 Assumes responsibility for the care of the inpatient while s/he is in this role, not necessarily for the entire length of stay as the inpatient location may change.

2.1.2 Assures the team and the process of care establishes and sustains continuous, caring relationship with patients/families; this relationship may begin before hospital admission or on hospital admission and continue after discharge with follow-up.

2.1.3 Develops a comprehensive patient care assessment and patient care plan using Relationship-Based Care principles.

2.1.4 Facilitates a comprehensive patient care plan from all members of the healthcare team.

2.1.5 Ensures progression and consistent use of patient care plan through completion.

2.1.6 Integrates all members of the care team into the care of each and every patient

2.2. Coverage

2.2.1. When the attending nurse is not on duty, other clinicians will be assigned to facilitate the comprehensive patient care plan.

2.2.2. Other clinicians are defined as other members of the healthcare team.

2.3. Covering Attending

2.3.1. The clinician in charge of the immediate management of the patient at any specific point of time.

2.3.2. This clinician must be clearly identifiable at any point in time.

2.3.3. This clinician must be promptly reachable by caregivers and clinical staff.

2.3.4. This clinician is determined by time such as weekend coverage or by location or the nature of the care such as periods of care in specialized patient care units.
3. Responsibilities

3.1. Attending Nurse Responsibilities

3.1.1. Identifies and uses best practices to promote patient- and family-focused care.

3.1.2. Identifies and resolves barriers to promote hand-offs, interdisciplinary collaboration and efficient throughout of patients.

3.1.3. Ensures, with Attending MD, that the patient care meets the unit’s clinical standards.

3.1.4. Develops and revises the patient care goals with the clinical care team daily.

3.1.5. Coordinates meetings with clinicians for timely decision-making and connects clinicians to optimize handoffs across the continuum.

3.1.6. Communicates with the patient and family, discussing plan of the day, care progress, potential discharge, and answers questions/teaches/coaches.

3.1.7. Serves as a role model for interdisciplinary problem solving.

3.1.8. Transmits all key information to covering clinician(s) in an efficient, comprehensive manner when handoffs are required.

3.1.9. Organizes twice daily care team huddles including at a minimum the attending MD and RN, house staff and staff nurse. It is suggested to meet at a minimum early morning and late afternoon to evaluate the patient, update the plan of care, ensure the plan is understood by all care members and communicate with the patient/family.

3.1.10. Meet with family on a continuous basis regarding plan of care, disposition, goals of treatment, palliative care, end of life issues.

3.1.11. Meet weekly with all members of the healthcare team to design, coordinate and evaluate the plan of care.
4. **UNIT SPECIFIC GUIDELINES (TO BE DEVELOPED BY EACH INNOVATION UNIT)**

4.1. Number of attending nurses
4.2. Number of patients in attending nurse responsibility
4.3. Specific outcomes and measures to be improved

5. **PRINCIPLES OF RELATIONSHIP BASED CARE**

5.1. Care delivery should always be: patient- and family-focused, evidence-based, accountable and autonomous, coordinated and continuous.
5.2. Being “highly present” and knowing the patient is key.
5.3. Patient and family care is provided by a designated nurse and physician who assume accountability and responsibility to ensure continuity of care for each encounter. Continuity of the team is a basic precept.
5.4. Every novice team member deserves mentoring from an experienced clinician.
5.5. Every patient deserves the opportunity to participate in the planning of his/her care.
5.6. Advancements in technology create opportunity for improved provider communication and efficiency.

6. **OTHER AREAS OF INTEREST**

6.1 Increases data collection on key clinical information (e.g., medication reconciliation, advance directives, discharge data)
6.2 Works collaboratively to establish support service standards (e.g., bed turn around, phlebotomy timing)
6.3 Implements predetermined staffing standards

**REFERENCE**


December 5, 2011
Domains of Practice

Nutrition

Dietetics is defined as “the integration and application of principles derived from the sciences of food, nutrition, communication, and biological, physiological, behavioral, and social sciences to achieve and maintain optimal human health.” (American Academy of Nutrition & Dietetics)

Domains of Nutrition Practice

- Assess patients’ current nutrition status. Identify nutrition issues. Plan and provide evidence-based interventions to meet the patients’ nutritional needs and promote healing and recovery. Communicate the inpatient nutrition plan to the patient and family members. Contribute to the discharge summary to facilitate continuity of care. Assist in coordinating patients’ discharge needs.

- Monitor and evaluate interventions and modify as needed.

- Communicate and collaborate with other health care providers to optimize patient care.

- Communicate and collaborate with patient food service to meet established nutrition goals.

- Provide education to patients and families for discharge. Recommend outpatient nutrition services to patients needing additional education after discharge.

- Educate dietetic interns and other health care providers.

- Promote professional development through ongoing continuing education.
**Innovation Unit Project Manager Meeting**

April 12, 2012

Meeting Minutes

Present: Marianne Ditomassi, Linda Lacke, Bryan Jones, Mandi Coakley, Chris Annese, Helena Gautreau, Cindy Sprogis, Lori Pugsley, Barbara Cashavelly, Georgia Peirce, Keith Marple, Barbara Blakeney, Gayle Fishman, Eileen Flaherty

Patient and Family Notebook Update:

- Hearing positive feedback from the innovation units. Patients are using it, even at home after discharge.
- Will begin conducting patient and staff interviews to gather additional feedback on the Patient and Family Notebooks. The process for the interviews is still being created. There is a plan to enter the interview data into Qualtrics to assist with analysis and identification of themes.

Discharge Phone Calls Update:

- Blake 13 and White 7 began piloting discharge follow up calls this week. Initial feedback is that it is going well. Rick Evans meeting with Big 14 to set them up as the next pilot unit. Goal is for Big 14 to start next week. Goal will be to implement the paper D/C phone follow up phone call process on 2-3 innovation units every 2 weeks.
- Bryan Jones and Melissa Marinace will collect the scripts/call documentation weekly. The data will be collected, analyzed and reported.
- Rick Evans and Keith Jennings are working to put together an implementation team for the online system.
- Currently collecting survey responses regarding who across MGH makes discharge phone calls to patients. There has been tremendous response to the survey- over 250 respondents to date.

Intervention Unit Updates:

- White 7: Actively engaged in trying to implement quiet hours. Plan to fully implement in about two weeks. Acknowledged the challenge of trying to include all staff who work on the unit and interact with staff. For example, the time of quiet hours conflicts with the time PT is scheduled to see patients. Discussion at the meeting reinforced that any progress towards creating protected quiet time on the unit has benefits to both the patients and the staff, as there is often no ideal time for quiet hours. Need to work with obstacles. Some intervention is better than intervention (eg 75% of unit is quiet).
- Group discussed the options for collecting qualitative and quantitative data on the effectiveness of quiet hours. One idea was to collect data on number of staff who enter patient rooms during quiet hours pre and post implementation. Baseline data is important. Lori Pugsley shared that Blake 13 conducted a pre and post implementation survey for patients and staff. She will make that survey available to those interested. She also noted that signage is key to success of quiet hours.
- Lunder 9: Barbara shared the positive impact that has occurred as a result of increased collaboration with Spaulding Cambridge. Staff from Spaulding Cambridge have been attending Innovation meetings with Lunder 9. The enhanced relationship has led to the implementation of initiatives to support
handovers between our institutions. Barbara also shared an interest in starting to follow patients from Lunder 9 through their stay at Spaulding to see how they do. What can we learn?

- Lunder 9 also described impressive success with daily “Care Coordination Rounds.” These are multidisciplinary rounds that have created increased opportunity to proactively address patient needs. Some of the disciplines attending these rounds are nursing, OT, PT, Palliative care, Nutrition, Patient Advocacy. Some of the anecdotal impacts are:
  - These rounds have led to an increase in OT consults (perception is that staff now have a better idea of what OT does). Want to measure number of consults pre and post the implementation of Care Coordination Rounds.
  - PT feels they are getting consults at the “right time”.
  - *These rounds are supporting Relationship Based care for the team - staff can feel it evolving and developing
- Patient Advocacy has been rounding on some of the Innovation units. Consensus is that this has been incredibly helpful in proactively addressing patient issues and concerns. Patient advocates are hearing about patient issues earlier. In one example, Patient Advocacy’s early involvement and collaboration with Social Services and Case Management with a complex patient played a big role in expediting this patient’s discharge.
- Blake 13 has been dialoguing on how to measure gains in efficiency. As staff are feeling an improvement in unit efficiency (e.g. improvement in D/C readiness, general calmness and sense or being organized) they are realizing that LOS may not reflect these improvements, as their patients LOS is much pre-determined. What else can we measure?
- Lori Pugsley also described the positive impact on continuity that 8 hour shifts has played.
- A concern was also brought forward with regards to summer vacation coverage and what impact this may have on the ARN role. A suggestion was made to bring this issue to the ARN Friday meeting for discussion. In addition, this raises questions for the NDs and ACs regarding sustainability, backup plans, and number of ARNs needed to be trained on each unit.
- Discussion regarding the ARN role also included the risk of role confusion. How do we protect the role as it is development? How can we keep the ARN from being pulled in too many directions? Prevent burnout?
- It would be helpful to know which units have combined the ARN with the Resource RN responsibilities and which have not.
- Another suggestion was to begin tracking and documenting “how” interventions are being implemented. What are the actual steps needed?
- All of the innovation units and staff are encouraged to begin journaling and documenting “Innovation Moments”. It is critical that we do not lose these valuable stories and early successes.
- HCAHPS data is put out quarterly. We’ll ask Rick Evans if there are any ways to access HCAHPS-like data more real-time. Barbara Blakeney noted that there is often a lag between a process improvement and seeing the improvement in outcomes.
- Website – NDs find very useful. Staff under-utilizing? Will monitor what staff might need from the website and reconfigure accordingly.
## Innovation Unit Expenses

**MHG Patient Care Services**

Updated as of August 1, 2012

<table>
<thead>
<tr>
<th>Innovation Expenses</th>
<th>Description/Notes</th>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Planning/Retreats</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retreat 12/12/11</td>
<td></td>
<td>12/12/12</td>
<td>$14,481</td>
</tr>
<tr>
<td>Retreat 12/19/11</td>
<td></td>
<td>12/19/12</td>
<td>$13,450</td>
</tr>
<tr>
<td>Retreat 1/23/12</td>
<td></td>
<td>01/23/12</td>
<td>$14,384</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td>$42,315</td>
</tr>
<tr>
<td><strong>Enabling Technology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Toughbooks</td>
<td></td>
<td>02/06/12</td>
<td>$78,792</td>
</tr>
<tr>
<td>30 Toughbook Batteries</td>
<td></td>
<td>02/06/12</td>
<td>$3,237</td>
</tr>
<tr>
<td>12 Toughbook Chargers</td>
<td></td>
<td>02/06/12</td>
<td>$4,289</td>
</tr>
<tr>
<td>C-Beds Electronic White Boards</td>
<td>Capital Fund</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In room White Board</td>
<td></td>
<td>04/05/12</td>
<td>$16,969</td>
</tr>
<tr>
<td>Voalte Implementation</td>
<td>Charged to MG3416</td>
<td></td>
<td>$27,720</td>
</tr>
<tr>
<td>Discharge Follow Up Calls</td>
<td>Program Contract</td>
<td></td>
<td>$110,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td>$241,007</td>
</tr>
<tr>
<td><strong>Printing/Forms</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IKON printing</td>
<td>Reference Binders</td>
<td></td>
<td>$2,007</td>
</tr>
<tr>
<td>Caring Headlines- Special Edition</td>
<td>1,500 Re-order</td>
<td></td>
<td>$3,469</td>
</tr>
<tr>
<td>Innovation Signage</td>
<td>Entrance and Placards</td>
<td></td>
<td>$363</td>
</tr>
<tr>
<td>Signage holders</td>
<td>03/06/12</td>
<td>$23</td>
<td></td>
</tr>
<tr>
<td>Patient Welcome Packets</td>
<td>Initial order (4,500)</td>
<td>02/27/12</td>
<td>$2,154</td>
</tr>
<tr>
<td>Patient Welcome Packets</td>
<td>Reorder (4,500)</td>
<td>05/09/12</td>
<td>$2,334</td>
</tr>
<tr>
<td>Patient Welcome Packets</td>
<td>OB English and Spanish</td>
<td></td>
<td>$345</td>
</tr>
<tr>
<td>SBAR</td>
<td>Chart Guide</td>
<td></td>
<td>$783</td>
</tr>
<tr>
<td>SBAR</td>
<td>Staff pocket guide</td>
<td></td>
<td>$593</td>
</tr>
<tr>
<td>Innovation Handbook</td>
<td>Reference for staff</td>
<td>06/06/12</td>
<td>$2,604</td>
</tr>
<tr>
<td>Notebooks and Labels</td>
<td>For journaling</td>
<td></td>
<td>$81</td>
</tr>
<tr>
<td>ARN Business Cards (30 sets)</td>
<td>Box of 500 $24.10</td>
<td></td>
<td>$723</td>
</tr>
<tr>
<td>Graphic Designer</td>
<td>Diagram</td>
<td>02/11/12</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td>$15,978</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Materials</td>
<td></td>
<td></td>
<td>$70</td>
</tr>
<tr>
<td>Videotaping Production</td>
<td></td>
<td></td>
<td>$1,100</td>
</tr>
<tr>
<td>Refreshments</td>
<td></td>
<td></td>
<td>$1,000</td>
</tr>
<tr>
<td>Resiliency Training</td>
<td></td>
<td></td>
<td>$2,500</td>
</tr>
<tr>
<td>Communications Coaching</td>
<td></td>
<td></td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td>$9,670</td>
</tr>
<tr>
<td><strong>Other Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEU Coop Staff</td>
<td>2 FTEs x 6 months</td>
<td></td>
<td>$38,480</td>
</tr>
<tr>
<td>OS/USA Uniforms</td>
<td>For FY12</td>
<td>04/03/12</td>
<td>$10,296</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td>$48,776</td>
</tr>
<tr>
<td><strong>Unit Specific Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunder 9- Taxi Voucher</td>
<td>Transportation to Spaulding</td>
<td></td>
<td>$48</td>
</tr>
<tr>
<td>Lunder 9- Welcome Letter</td>
<td>cost/yr</td>
<td></td>
<td>$2,884</td>
</tr>
<tr>
<td>Ellison 17</td>
<td>Yacker Tracker</td>
<td></td>
<td>$60</td>
</tr>
<tr>
<td>Ellison 18</td>
<td>Yacker Tracker</td>
<td></td>
<td>$60</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td>$3,052</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$360,798</td>
</tr>
</tbody>
</table>
Good Afternoon,

Congratulations on accepting the position of Attending Registered Nurse (ARN). This new role brings great opportunities as well as challenges. The Institute for Patient Care is committed to your success by offering weekly "brown bag lunch" sessions which will focus on:

- **Support** - being the "pioneer" is often challenging, we are committed to assist you as you integrate the ARN role on your unit and MGH.
- **Resources** - you will be faced with situations you might not have faced before, we are committed to giving you the knowledge, skill and resources to successfully address those situations.
- **Mentoring** - you are all moving out of your comfort zones and we are committed to developing your leadership skills.

The weekly "brown bag" lunches begin **Friday March 23rd from 12-1:00 pm in Founders 311**

We look forward to working with you.

Gino Chisari, RN Director, Norman Knight Nursing Center for Clinical and Professional Development
Barbara Blakeney, RN, Innovations Specialist
Mary Ellin Smith, RN, Institute for Patient Care
From: Chisari, Roger Gino, R.N., D.N.P.
Sent: Monday, March 26, 2012 4:40 PM
To: Chan, Gina Jooen; McNeil, Elaine M., R.N.; Morton, Sally E., R.N.; Evangelista, Susan E., R.N.; Anderson, Michelle A., R.N.; Burns-Britton, Betty Ann, R.N.; Patrick, Kristen Leigh, R.N.; Keegan, Sarah Anne; Smith, Jessica; Bishop, Elizabeth, R.N.; Stewart, Jean M, R.N.; Brown, Kelly, R.N.; Doherty, Diane M, R.N.; Appleman, Lori, R.N.; Masiello, Sandra Jean, R.N.; Hubacheck, Victoria, R.N.; Kabat, Stacey; Kleimola, Janet, R.N.; Bobola, Deborah, R.N.; Rosenblum, Karen T., R.N.; Gordon, Susan A., R.N.; Carr, Kathleen, R.N.; McNamara, Maryellen, R.N.; Slicis, Donna M., R.N.; Curran, Emily S., R.N.; Chaffee, Heather, R.N.; Majocha, Christie J.; Harris, Shauna S., R.N.
Subject: RE: Attending Registered Nurses Meeting Recap of March 23, 2012

Date/Time/Location
Friday March 23, 2012, 12:00 pm - 1:00 pm, Founders 325

Presiding
Gino Chisari

Attending Nurses
Jessica Smith, Karen Rosenblum, Gina Chan, Lori Appleman, Donna Slicis, Diane Doherty, Jean Stewart, Betty Ann Burns-Britton, Sally Morton, Susan Evangelista, Sandy Masiello, Elizabeth Bishop, Kristen Patrick, Stacey Kabat, Janet Kleimola, Kathleen Carr

Project Support
Mary Ellin Smith and Barbara Blakeney

Discussion
- Everyone introduced themselves and gave a brief description of their unit.
- The group spent a considerable amount of time discussing how things went during the first “official” week. Some of the discussion points included, but are not limited to:
  - Role conflict, mainly between the ARN and resource nurse
  - More work in being an ARN than expected
  - The units are busy and the role is in fluctuation
  - Being a change agent takes skill and is challenging
  - How do we turn a philosophy into a culture
  - How do we overcome resistance from those around us
  - The role of ARN requires management skills
  - The ARN has the potential for becoming a "catch-all" role
  - How do we keep motivated
  - How to be more of a strategic thinker
• Gino validated with the group the themes from the discussion, which are skills related to:
  • Change Management
  • Leadership
  • Conflict Resolution

**Next Steps**
• Gino announced that Jeanette is attending on April 6 and Mary Crammer on April 13 who will begin a discussion on change management
• Gino will work with Mary Ellin and Barbara to create an infrastructure to further support the group and maximize the time together.

**Reminder**
Next meeting is Friday March 30 at noon in Founders 311 with guests; Georgia Peirce and Keith Marple who will lead a discussion around communication needs.
From: Ives Erickson, Jeanette, R.N., D.N.P.

Sent: Thursday, March 01, 2012 7:51 PM

To: PCS Executive Committee; Chisari, Roger Gino, RN, DNP; Adams, Jeffrey M., RN, PhD; Jones, Dorothy A, RN

Subject: Meeting with attending nurses

As I indicated at a recent PCSEC meeting, I met this past Tuesday with 18 of the 30 attending nurses. This 2 hour meeting was a real high! In the room were representatives from every unit and over 200 years of healthcare experience.

They are engaged, excited and nervous, but not crazy about change. Our dialogue included all of the ideas they have started to implement (they are ahead of us)! They shared ideas, reflected on the retreats, described potential on how to share best practices and how they want to connect going forward.

They felt the educational sessions were beneficial and would like classes on:
Conflict resolution,
Cultural competence,
Helping the family in crisis,
Resiliency training,
More on improving Patient satisfaction, discharge planning, risk assessment, and warm handoffs.

They are excited about the possibility of using technology and wonder about using face time or Skype to meet. They are interested in the photo part of Voalte for sharing, etc.
It was a great session and I look forward to the work.
LUNDER 9
INNOVATION RE-DESIGN

Who is Lunder 9?

Lunder 9
New Medical Oncology Unit

Opened Sept 9, 2011
- Increased to 32 beds
  - Green side 16 beds
  - Yellow side 16 beds
- Adaptation to
  - size
  - new environment
  - Increased activity and workflow
  - patient population

Lunder Building
Communication and Noise Reduction

Voalte – Jan 2011, Pilot project
PH21/Wh 11
- Staff and patient feedback influenced decision
- Implemented Dec 2011
- Less overhead paging
- Direct communication

Electronic White Board
- Documentation room, green and yellow side.
- Updates via c-beds

All’s Quiet on the Lunder Floor

- Welcoming Environment
- Rubber flooring throughout, provides cushioning and quietness
- Interactive zones instead of one central nurses station
- Full-glass sliding doors on the patient rooms provides natural light and visibility, keeps out noise
- Ambient noise sensors, alarms adjust with level of noise in environment

Lunder 9 Innovation Team

- Betty Ann Burns-Britton, ARN
- Kristen Patrick, ARN
- Hannah Lyons, CNS
- Rose Mary O’Malley, RN
- Peter Dowling, CM
- Elese Gettings, CM
- Jan Filteau, CM
- Christina Kim, NP
- Logan Sharma, OT
- Andrea Bonanno, PT
- Stephanie Quinn, SW
- Renee Reynolds, RD
- Katrina Scott, Chaplain
- Linda Kane, PI Advocacy
- Tony Rancho
- Trish Galvin, OM
- Kathleen Larrivee, RN
Our Oncology Patients

Oncology Case types
- 40% GI
- 20% Lung
- 20% Lymphoma
- 10% Head/Neck
- 8% Sarcoma
- 2% Breast
- Advanced Disease
- Medically complex, High acuity
- Chemotherapy treatments
- Urgent admissions, increased ADT
- Complex psycho-social/spiritual needs
- End Of Life

Lunder 9 Oncology Teams

- Team 3 Residents -14 beds
- Oncology NP team -18 beds
- Oncology Attendings
  - Red, White, Blue teams
  - Rotate every 2 weeks
- Multi-disciplinary team:
  - 2 Case Managers
  - Social Work
  - Palliative Care NP
  - 2 Physical Therapists
  - Occupational Therapist
  - Nutrition
  - Chaplain
  - Patient Advocate

Lunder 9 Changes

- New Unit
- New workflow
- New Teams
- Adjustment to size and space
- Different Oncology Population

Innovation=opportunity

Lunder 9 Innovation Redesign

- Step back and re-assess
- Who are we?
- Shape the new unit practice
- Look at the continuum of care for our pts
- Relationship-Based Care

ARN Role

- Betty Ann Burns Britton RN (green side)
- Kristen Patrick RN (yellow side)
  - Work 5 days/week 7a-3:30
  - Follows 16 patients

Challenges
- Staff buy-in and understanding of role
- Something new in the middle of change
- Patient assignment or resource responsibilities

Successes
- Provides continuity and follow-up
- Knows the patient/family, coordinates with the team
- Staff acknowledging that role benefits the needs of the patient

Lunder 9 Innovation Opportunities

- RN Attending Role
- Care Coordination Rounds
- Cancer Center Outpatient collaboration
- Spaulding Cambridge collaboration
Care Coordination Rounds

Multidisciplinary Team
- ARN, Staff RN, CM, SW, PT, OT, Nutrition, Palliative Care NP, Chaplain, Patient Advocacy

Goal: Team participates, coordinates and plans care of patient and family.

Challenges
- Staff Buy-in, Why 2 sets of rounds?
- Did not understand the benefit
- Timing, gathering all of the disciplines

Successes!!
- Staff love it, time to advocate for their patient
- Team collaboration, Able to plan next steps as a team
- Empowers and instills confidence in new nurses
- Support and validation from the team
- Brainstorm comprehensive plan of care for complex patients

PT and OT:
- "We understand the roles of each team member."
- "ARNs improve timing of consults--we see the right patient at the right time."

SW:
- "Patient concerns, worries and stressors are addressed as early as possible."

Chaplain:
- "Team is invaluable in identifying the spiritual needs of our patients/families"

Case Manager:
- "It's great to directly coordinate with the ARN and RN when discharging a complex patient!"

ARN:
- "The OT is like a detective - She asks great questions...I have learned a lot from her!"

Cancer Center Outpatient Collaboration

- Bridging the Continuum of Care
- Bridge relationships with outpatient oncology clinicians
- Meeting with Yawkey Infusion Triage RNs and ARN's regarding collaboration, admissions and pass-offs

Spaulding Cambridge Collaboration

- 2 week observation by PCC Physical Medical Rehab provider.
- Assessment of oncology pt population
- Determine need for embedded PCC clinician and overlapping collaborative care model
- Lunder 9 Innovation team site visit to Spalding Cambridge
- Spaulding Cambridge Case Managers observational day with Lunder 9 Case Managers

Spaulding Cambridge Collaboration

- Spaulding Nursing Leadership team attended a Lunder 9 Innovation Team meeting
- Warm hand-offs/follow up phone calls for patients transferred from MGH to SC
- Ongoing weekly meetings with Spaulding Cambridge clinicians
- Next Steps
  - Identify pts for SC through CCR and weekly SC meeting
  - Determine need for PCC embedded clinician

The Triple Aim Goals of MGH-SC Collaboration

Quality
- Reduce preventable readmissions
- Provide seamless/appropriate care

Cost
- Reduce costs/penalties associated w readmissions
- Reduce LOS for L9 patients

Patient Experience
- Improved Continuity of Care
- Improved Pt/family expectations
- Improved Patient Satisfaction scores
Old Care Delivery Model

- Social Worker
- Private Oncologist
- Nurses
- Occupational Therapist
- Physical Therapist
- Chaplain
- Case Manager
- Palliative Care
- Residents

New Relationship-Based Care Model

Care Coordination Rounds

- Outpatient Oncologist (OO)
- Palliative Care NP
- SW
- Chaplain
- Pt Advocacy
- RN

Medical Rounds

- Goals of Care
- Plan of Care

Innovation Next Steps

- Expand/orient the ARN role to other staff RNs
- Ongoing collaboration with Spaulding Cambridge, determine embedded clinician
- Begin discharge phone calls
- SBAR implementation
- Pt/Family Notebook with “Welcome to Lunder 9” letter with photos of the care team
- Begin collaboration with SNF – Life Care of Stoneham

Patient Story

Relationship-Based Care

- Know our patients
- Coordination of care
- Consistency of team
- Building plan of care
- Clinical support for patient
INNOVATION UNIT

Ellison 16, General Medicine

April 18, 2012

Ellison 16

- 36 bed General Medical unit
- Admitted by:
  - Private Attendings
  - Bulfinch Medical Group (BMG) Attendings
  - Bigelow Teaching Service
  - Team 4
  - Team 5

Ellison 16 Pre-Innovation Initiatives

- Reduce readmissions (May 2009 - present)

Patients readmitted within 30 days of discharge
Baseline: 19.0%
Current: 17.2%

- Medical Service LOS and Pre-noon Discharge Initiative (March 2011-present)

Medical Service Initiative: LOS / Pre-noon Discharge

- Early commitment to Multidisciplinary Rounds
- Afternoon Huddles to identify next day discharges
- Estimated Discharge Date in PEPL
- Commitment to C-beds
- Enhanced communication with Patients / Families re: Discharge

IHI Initiative: Discharge Nurse Role

1. Facilitate / coordinate discharge activities for high risk patients being discharged home who meet inclusion criteria:
   - 10 medications or more
   - Any patient with diagnosis/reason for admission of:
     - CHF
     - Pneumonia
     - Acute Renal Failure
     - Atrial fibrillation
     - Cancer Pain
     - Dehydration
     - UTI
     - Change in mental status

2. Identify potential patients for pre-noon discharges at MTD rounds and after 4pm huddle

3. Work closely with Pharmacy:
   - Provide pharmacist with high risk patient list for Post Discharge Phone Calls
     - Patients who received phone calls had less readmissions
   - Refer patients to Pharmacist for Pre-Discharge Visits
     - Provides medication reconciliation and counselling services
     - Reviews final medication list with patient and/or caregiver
IHI Initiative: Discharge Nurse Role

Goals:
- Make discharge process more efficient and patient-centered
- Enhance patient education and improve patient satisfaction
- Reduce preventable readmissions to Ellison 16

Impact:
- Increased satisfaction of patients, staff nurses, MDs
- Greater awareness of patient discharge plans
- Increased communication between caregivers, patients and families
- Increased understanding of barriers related to discharge
- Decreased LOS and pre-noon discharges

Attending Nurse Role

ARN Role Responsibilities:
- ARN rounds daily prior to Interdisciplinary Rounds
- Clarifies patient / family goal for day and documents on whiteboard
- Ensures patient / family voice heard at Interdisciplinary Rounds (relationship-based care)
- Facilitates patient / family utilization of Patient & Family Notebook
- Delivers heightened level of care coordination and continuity

Ellison 16 Unit Based Interventions

- ND/CNS Daily Rounds on all new admissions
- ND/CNS/ARN Weekly Length of Stay Rounds
  - Greater than 7 day LOS
  - Enhance communication/planning with Attending MD
- Engage Ellison 16 Clinical Ethics Nurse Residents
  - Staff nurses supporting ARNs and other RNs at bedside
- Calls to Post Acute Facilities
  - 2-4 hrs post discharge

Next Steps

- Continued leadership / engagement of staff in Innovation effort
- Continuous evaluation of interventions already underway
- Participate in efforts to enhance transitions in care:
  - Identification of “preferred” SNF providers
  - Increased referrals to Home Care and “Connected Care”
  - Collaboration with Bulfinch Medical Group outpatient practice
- Collaborate with Rick Evans and George Reardon on noise reduction
Overview: The MGH Innovation Unit

Massachusetts General Hospital (MGH) is dedicated to providing every patient and family with the safest and highest-quality care possible. As part of this ongoing commitment, the hospital has established 12 Innovation Units to identify and study innovations that will help the hospital raise an already high standard even higher. We're looking at ways to ensure that the experience of every patient and family at MGH goes smoothly from start to finish. That they know who is taking care of them and how they can be reached. And, when they're ready to go home, everyone feels prepared.

Each Innovation Unit is testing twelve care interventions. For example the new role of “Attending Nurse” is designed to coordinate the delivery of patient care with the entire healthcare team. The Attending Nurse will check in and review each patient’s health plan with them every day. Patients and families will also receive a newly-developed “Patient & Family Notebook,” with pages for them to note questions they want to review with the care team. And we’re designing new ways to help prepare patients to make a smooth return home.

TOOLBOX

- 12 Interventions at a glance
- Cbeds Electronic Whiteboard sample
- Conceptual Schema
- Domains of Practice
- In the Literature
- Innovation Unit Leadership
- Patient Journey Framework

“Innovation in service delivery and organization is a novel set of behaviors, routines and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness of users’ experience and are implemented by planned and coordinated actions.” (Greenholgh, 2005)
### MGH INNOVATION UNITS

**Complete list of Innovation Unit Leadership**
- Bigelow 14 Vascular Surgery
- Blake 10 Neonatal ICU
- Blake 11 Psychiatry
- Blake 12 ICU
- Blake 13 Newborn Family
- Ellison 9 Cardiac ICU (CICU)
- Ellison 16 General Medicine
- Ellison 17 & 18 Pediatrics
- Lunder 9 Oncology
- White 6 Orthopaedics & Oral-Maxillofacial
- White 7 Surgery/Trauma

**Clinical Support Service Presentation**

### INTERVENTIONS

#### Throughout the Patient Experience
- Relationship Based Care
- Increased Accountability through Attending RN (ARN) role
- Handovers

#### Pre-Admission
- Pre-Admission Data Collection
- Innovation Unit Patient & Family Notebook

#### During Hospitalization
- Revised Domains of Practice
- Interdisciplinary Team Rounds
- Whiteboards: Electronic, In-Room
- Portable Devices
- Electronic Communication
- Discharge Readiness Toolkit

#### Post-Discharge
- Discharge Follow-up Phone Calls

### RELATED TOPICS
- Education
- Evaluation
- Innovation Resources
- CMS Innovation Advisors Program

### IN THE NEWS
- Nursing Experts Release Guiding Principles for Patient Engagement
- Robert Wood Johnson Foundation
- Noisy hospitals need Rx for quiet as patients rest, Associated Press
- Nurses leading through innovation, The American Nurse
- ‘Innovation advisers’ appointed to improve care, costs, Bend Bulletin
- Massachusetts General Implements Voaltés Communication System, Consumer Electronics Net
- ‘Innovation advisers’ chosen for ideas to improve health care, cut costs, The Washington Post
- Innovation Is A State of Mind, Forbes
Facing the future with ingenuity and innovation

focusing on consistency, continuity, and coordination of care

Our bicentennial celebration reminded us that our work over the past 200 years has been ground-breaking; we have led the evolution of health care as we know it. While our accomplishments are numerous and well documented, our work is by no means done. As we channel our efforts to ensure equitable care and access to all, we must continue to provide care that is safe, timely, efficient, effective, and centered around the needs of patients and families. In past issues of Caring Headlines and at Nursing Grand Rounds, I’ve talked about designing a new patient-care delivery model and about re-designing disease-specific care. While cost-containment and efficiency are part of this work, the real goal is improving patient care. If we do this right, I know we’re going to discover something as revolutionary as any of our past accomplishments.

This past year, I’ve spent time talking with many of you, interviewing patients and families, benchmarking other healthcare organizations, and researching the literature. I believe that re-designing care will require transformational change—change that cannot occur at the risk of our patients. Some of these changes will be ‘designed, tested, validated, and replicated’ on innovation units. Just as the name implies, innovation units are settings specifically created to test change and measure outcomes. If we don’t like what we see, we re-calculate, re-group, or abandon the idea altogether. Our work on innovation units is geared toward improving clinical outcomes, enhancing patient- and staff-satisfaction, and reducing costs and lengths of stay. The core principles behind innovation units are:

- Care is patient- and family-focused, evidence-based, accountable, autonomous, coordinated, and continuous
- Clinicians are highly present and know the patient
- Care is provided by designated nurses and physicians who assume accountability to ensure continuity
- Continuity of the team is a basic precept
- Every novice team member is mentored by an experienced clinician
- Every patient has the opportunity to participate in the planning of his/her care
- Technological advancements create opportunities for improved communication and efficiency

Based on my conversations with you, our goals for innovation units are:

- Knowing the patient
- Coordination of care (consistency and reliability)
- Consistency of teams
- Building a plan of care around the patient where patient care and teaching are aligned
- Clinical support aligned around patient
- Learn from experience

Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse

continued on next page
Jeanette Ives Erickson (continued)

Success will depend on our ability to improve quality and safety, create healing environments, integrate research and evidence-based practice into care delivery, and ensure opportunities for professional growth and education.

The graphic below illustrates the process of care before, during, and after hospitalization. Continuity will be enhanced by standardizing wherever possible, such as using rounding check sheets, hand-off guidelines; and standardized systems for the transfer of information upon admission and discharge.

We expect our work on innovation units to reduce lengths of stay and re-admissions. One intervention we’re exploring is the use of follow-up phone calls to ensure patients adhere to discharge instructions and have the resources they need at home.

As we move forward with this work, the tenets of relationship-based care will inform our efforts. Engaging patients and families as key members of the care team will help us identify over-use, under-use, and misuse of resources.

Nearly 150 clinicians and support staff within Patient Care Services are involved with this work. They have developed rounding check lists, a patient discharge check list, a discharge readiness form, and a post-discharge telephone follow-up program. In the spring, 12 innovation units will go live with these ‘tests of change’: (Bigelow 14, Vascular; White 7, Surgical; Lunder 9, Oncology; Ellison 16, Medical; White 6, Orthopaedics; Ellison 17 and 18, Pediatrics; Blake 13, Obstetrics; Blake 10, Neonatal ICU; Blake 11, Psychiatry; Ellison 9, Cardiac; and Blake 12, Neuroscience ICU).

This is an exciting time in the evolution of care delivery. I will keep you informed as this work unfolds. For more information, or if you have questions, thoughts, or ideas, please e-mail me or call 6-3100. Thank-you.

Update
I am pleased to announce that Brenda Miller, RN, has accepted the position of nursing director for the Ellison 17 and 18 pediatric units.

Patient Journey Framework

Before
Pre-admission care
Admission process: ED, direct admits, transfers

During
Patient stay; direct patient care; tests; treatments; procedures; clinical support; operational support
Discharge process

After
Post-discharge care

Support functions: Finance, Information Systems, Human Resources

Goal: High-performing, inter-disciplinary teams that deliver safe, effective, timely, efficient, and equitable care that is patient- and family-centered

Where are there opportunities to reduce costs across these processes of care?

In this Issue

Holidays at MGH......................................................... 1
Jeanette Ives Erickson................................................ 2
• Innovation and Ingenuity
Tourette's Syndrome............................................... 4
Clinical Narrative .............................................. 6
• Robert Ferdinand, RN

Knight Nursing Center........................................ 8
• Embracing Technology as a Learning Tool
Fran Donovan Remembered................................. 9
Fielding the Issues........................................... 10
• New Pain-Assessment Tool
Announcements............................................ 11
Innovative Recycling.................................... 12

(Cover photos by Paul Batista, Joe Ferraro, and Michelle Rose)
Jeanette Ives Erickson

Innovation Units
an update

real change cannot be achieved through business as usual. Meaningful change comes from new ideas, new ways of thinking, and new ways of doing business. Which is why, on March 19, 2012, we launched 12 innovation units in an attempt to challenge existing paradigms and test new ways to deliver care. We’re using this opportunity to create new care-delivery models to quickly determine whether new ideas should be adopted or abandoned.

The 12 innovation units are: Bigelow 14, Vascular; White 7, Surgical; Lunder 9, Oncology; Ellison 16, Medical; White 6, Orthopaedics/Oral & Maxillofacial/Urology; Ellison 17 and 18, Pediatrics; Blake 13, Obstetrics; Blake 10, Neonatal ICU; Blake 11, Psychiatry; Ellison 9, Cardiac ICU; and the Blake 12 ICU.

Because interest in this initiative is so high, I’d like to use this column to provide a brief, early update. As of May 1st, with only a few exceptions, most innovation units have adopted all of the test interventions, which include:

- building relationship-based care into educational curriculum
- implementing new attending nurse role
- enhancing hand-over communication including use of SBAR tool (Situation; Background; Assessment; Recommendations)
- enhancing pre-admission data-collection including a revised Admitting Face Sheet
- creating a Welcome Packet for patients
- updating domains of practice to ensure across-the-board understanding of each discipline’s scope of practice
- implementing inter-disciplinary team rounds to ensure effective communication between all members of the care team
- making use of supporting technology, including specially programmed cell phones, electronic whiteboards, and portable electronic devices (laptops)
- being proactive in discharge planning and readiness including implementation of a new discharge checklist tool
- implementing new Discharge Follow-up Phone Call Program

Some innovation units have implemented additional interventions, such as Quiet Hours, providing dedicated time and/or space for reduced noise and minimal interruptions. This supports the relationship-based care intervention, respecting patients’ need for rest and a calm, healing environment. One unit is using signs that say: “Quiet time: resting is healing.” The pediatric units will be hanging a painting created by their artist-in-residence that reads, “Quiet please. Children are healing.”

continued on next page
Anecdotal feedback from participating units speaks louder than statistics. This is what we’re hearing:

- Having a dedicated patient advocate allows us to address issues more proactively
- The visibility of our patient advocate has been great for patients and staff
- Operations associates and unit service associates are now wearing role-identifying uniforms to make it easier and less confusing for patients and families
- A re-admitted patient returned to MGH with an up-to-date Patient-Family Notebook. The re-admitting physicians found this enormously helpful
- Attending nurses are connecting with late admissions in the Pre-Admission Testing Area to ensure continuity. Patients and staff are thrilled with this intervention
- Having an attending nurse’s business card and contact information enhances patient satisfaction
- The SBAR (Situation, Background, Assessment, and Recommendations) communication format is being used in e-mails and notes as well as during hand-offs. Even unit service associates are using it
- Weekly staff meetings provide a great forum for capturing questions and feedback and brainstorming solutions

These are precisely the kind of outcomes we were hoping for and the kind of proactive problem-solving we expected. It’s exhilarating to be part of something new—something that enhances care for patients and families and streamlines cumbersome systems. Staff on the innovation units are energized by this important work, and I’m energized by their passion and determination to succeed. I’ll keep you informed as we continue to learn and adapt our care and services. In the meantime, for more information, visit the Innovations Unit Web Portal at www.mghpcs.org/innovation_units.

An update on Care Re-Design Teams

Related to our work around innovation units and re-thinking the way we deliver care, MGH recently launched five more care re-design teams that will focus on chronic obstructive pulmonary disease; back pain; premature neonates; psychosis; and rheumatoid arthritis. These new teams join the 11 existing teams that have been working over the past year to streamline systems, eliminate duplication, and decrease costs. The existing teams are: acute myocardial infarction (heart attack); coronary bypass surgery; colon cancer; diabetes; primary care; stroke; endovascular procedures; lung cancer; total joint replacement; transplantation; and vaginal delivery. These multi-disciplinary teams have generated numerous recommendations about how systems can operate more effectively and efficiently. For more information about care re-design and patient affordability, go to: http://priorities.massgeneral.org/.
“All human development, no matter what form it takes, must be outside the rules; otherwise we would never have anything new.”

— Charles Kettering, American inventor, engineer, and businessman
Jeanette Ives Erickson

Innovation units

leading the way to transformational change

The need for improvement has driven progress since the beginning of time. Hence the adage: “Necessity is the mother of invention.” At MGH, we have led the healthcare industry in forward-thinking since our beginning in 1811, constantly searching for better ways to deliver care. Today, we’re on the cusp of yet another groundbreaking advancement, driven by the need to make care more effective, efficient, and affordable for patients and families.

Many of you have heard me talk about the work we’re currently doing under the umbrella of the Partners Patient Affordability Direct Care initiative, specifically, the inception of innovation units. Innovation units are designated inpatient care units that will be used as testing grounds for change, allowing us to create new care-delivery models and quickly determine whether new ideas should be adopted, adapted, or abandoned.

Twelve units have been selected to participate in this grand experiment: Bigelow 14, Vascular; White 7, Surgical; Lunder 9, Oncology; Ellison 16, Medical; White 6, Orthopaedics; Ellison 17 and 18, Pediatrics; Blake 13, Obstetrics; Blake 10, Neonatal ICU; Blake 11, Psychiatry; Ellison 9, Cardiac ICU; and the Blake 12 ICU.

Work on innovation units is geared toward improving clinical outcomes, enhancing patient- and staff-satisfaction, and reducing costs and lengths of stay. The goal for each innovation unit is to:

- increase continuity of care
- increase caregiver productivity
- increase inter-disciplinary teamwork
- re-design the physical environment of care
- focus on patient and family values
- increase time spent with patients
- focus on organizational goals and mission

This work will be guided by the principles that:

- care is patient- and family-centered, evidence-based, accountable, autonomous, and continuous
- clinicians are highly present and know the patient

continued on next page
Jeanette Ives Erickson (continued)

- Care is provided by designated nurses and physicians who assume accountability to ensure continuity.
- Continuity of the team is a basic precept.
- Every novice team member is mentored by an experienced clinician.
- Every patient has the opportunity to participate in the planning of his/her care.
- Technological advancements create opportunities for improved communication and efficiency.

The graphic below illustrates the process of care before, during, and after hospitalization. Continuity will be enhanced by standardization wherever possible, such as the use of rounding check sheets, hand-over guidelines; and standardized systems for the transfer of information upon admission and discharge.

Success will depend on our ability to improve quality and safety, create healing environments, integrate research and evidence-based practice into care delivery, and ensure opportunities for professional growth and education.

continued on next page
At the heart of the innovation-unit roll-out is a series of interventions generated by exhaustive discussions at retreats, in break-out sessions, and in informal conversations with staff and leadership throughout Patient Care Services (and the hospital at large). These interventions represent what we consider ‘top-priority’ actions in order to achieve the highest levels of consistency, continuity, and efficiency as we move forward with this work. The interventions we’ll be focusing on include:

- Building relationship-based care into educational curriculum
- Implementing the new attending nurse role
- Enhancing hand-over communication including the use of SBAR tool (Situation; Background; Assessment; Recommendations)
- Enhancing pre-admission data-collection including a revised Admitting Face Sheet
- Creating a Welcome Packet for patients
- Re-visiting and updating domains of practice to ensure across-the-board understanding of each discipline’s scope of practice
- Implementing inter-disciplinary team rounds to ensure effective communication between all members of the care team
- Making use of supporting technology, including electronic whiteboards, Voalté phones, in-room whiteboards, and portable electronic devices (Toughbooks)
- Being proactive in discharge planning and readiness including implementation of a new discharge Checklist tool
- Implementing new Discharge Follow-up Phone-Call Program

Because these interventions are central to our work, I’d like to briefly address each one of them.

**Relationship-based care**

Relationship-based care is more than an intervention; it’s a philosophy, a way of thinking about care-delivery. Relationship-based care stresses three important tenets: the caregiver’s relationship with the patient and family; the caregiver’s relationship with his or her colleagues; and the caregiver’s relationship with him- or herself (self-awareness). In an organization that provides relationship-based care, every member of the team:

- knows the patient and has access to information across the continuum
- plays a part in coordination of care, knows who’s responsible, and reviews the plan daily

---

Lunder 9 inter-disciplinary team discusses ways to implement innovation-unit interventions on their unit.
“When all think alike, no one is thinking very much.”
—Walter Lippmann, writer, Pulitzer Prize winner

- builds the plan of care around the patient
- aligns patient care and teaching
- aligns support around patient populations rather than transactions
- learns lessons from the past

The attending nurse role
Expanding on the staff nurse role, the attending nurse is accountable, along with the attending physician, for ensuring that patient care meets clinical standards and for the continuity and timely progression of care from admission to discharge. (For more information about the attending nurse role, see page 10.)

Enhancing hand-over communication
This intervention has to do with passing patient information from caregiver to caregiver; from caregiver to patients and families; and from MGH to other organizations or to the patient’s home. It relies heavily on the SBAR (Situation, Background, Assessment, and Recommendations) communication tool that ‘prompts’ caregivers to provide complete information during hand-overs. This intervention should be thought of, not as the introduction of a new tool, but as implementation of a new standard of practice.

Enhancing pre-admission data-collection
One goal of innovation units is to better know the patients we care for. To ensure continuity and accurate information-gathering for all patient populations, an inter-disciplinary Tiger Team is creating a new Admitting Face Sheet, including anticipated discharge date and projected discharge disposition, to better inform inter-disciplinary care-planning.

Welcome packets
We’re in the process of developing a Welcome Packet for patients (and families) to provide them with basic, relevant information, invite feedback for improvement, and help set discharge expectations and preparation.

Domains of practice
With implementation of inter-disciplinary rounds, having a greater understanding of the domains of practice of our colleagues in other disciplines is key. Toward that end, I’ve asked each discipline (Nursing, PT, OT, Respiratory Care, Social Work, Speech-Language Pathology, Chaplaincy, etc.) to review and update their domains of practice so we can share this information in various forums, including the Excellence Every Day web portal.

Inter-disciplinary team rounds
Currently, there’s no formal mechanism for daily communication between all members of the care team. Inter-disciplinary rounds will bring all members of the team together on a daily basis to identify obstacles to the progression of care, create a more holistic approach to care-delivery, and ensure that issues are shared and addressed in a timely manner.

Supporting technology
Efficient, well-coordinated care depends on staff’s ability to communicate effectively. Having the right tools makes communication faster and easier. Staff on innovation units will be equipped with specially programmed iPhones (Voalté phones) and portable, wireless laptops to make access to, and dissemination of, information more efficient. And in-room whiteboards and electronic whiteboards at nurses’ stations will enhance our ability to know our patients and coordinate their care.

Discharge planning and readiness
We are in the process of developing a discharge Checklist tool... stay tuned, more to come.

Discharge Follow-up Phone Call Program
In an effort to reduce hospital re-admissions and ensure patients understand discharge instructions, we will be implementing a Discharge Follow-up Phone Call Program. All patients will be invited to participate. We’re in the process of developing a questionnaire, guidelines, and a training curriculum.

The success of innovation units will be measured by pre-determined metrics related to length of stay, patient satisfaction, staff satisfaction, quality and safety, and certain nursing-sensitive indicators.

This is an ambitious undertaking, and we’re highly motivated to succeed. It’s not an exaggeration to say we’re on the cusp of a whole new way of delivering care. If we do this right, we can look forward to increased patient and staff satisfaction, better clinical outcomes, better quality and safety outcomes, and better financial outcomes for patients, families, and the hospital.

I look forward to working with all of you on this groundbreaking initiative. For more information, or if you have questions, thoughts, or ideas, please e-mail me or call 6-3100.
“Discovery consists of seeing what everybody has seen and thinking what nobody has thought.”
— Albert von Szent-Gyorgyi, biochemist, recipient of the Nobel-Prize

Innovation unit inter

- Build relationship-based care into educational curriculum
- Implement new attending nurse role
- Enhance hand-over communication including use of SBAR tool (Situation; Background; Assessment; Recommendations)
- Enhance pre-admission data-collection including a revised Admitting Face Sheet
- Create a Welcome Packet for patients
- Re-visit and update domains of practice to ensure across-the-board understanding of each discipline’s scope of practice
“There ain’t no rules around here. We’re trying to accomplish something.”
—Thomas Edison, inventor

ventions at a glance

- Implement inter-disciplinary team rounds to ensure effective communication between all members of the care team.
- Make use of supporting technology, including in-room whiteboards, Voalté phones, electronic whiteboards, and portable electronic devices (Toughbooks).
- Be proactive in discharge planning and readiness including implementation of a new discharge Checklist tool.
- Implement new Discharge Follow-up Phone Call Program.
“The essential part of creativity is not being afraid to fail.”

— Edwin Land, inventor and co-founder of the Polaroid Corporation

The attending nurse
an innovative new role for nurses

Of all the interventions being implemented as part of the roll-out of innovation units, the attending nurse role seems to have generated the most curiosity. The role of attending nurse is just one strategy we’re employing to deliver more integrated, patient-centered, evidence-based care while preserving the highest standards of quality and safety. Because so many people have expressed an interest, following are some components of this new role. The attending nurse:

- facilitates care with the entire healthcare team. He/she is a consistent contact for patients, families, and the healthcare team throughout the patient’s care
- develops and coordinates the team’s strategic clinical plan for the duration of the inpatient hospitalization
- works eight-hour days, five days a week to promote continuity and visibility
- ensures that the team and the process of care sustains a continuous, caring relationship with patients and families that may begin before admission and continue after discharge
- develops a comprehensive patient care assessment and plan using the principles of Relationship-Based Care
- facilitates a comprehensive care plan among all members of the healthcare team
- integrates all members of the care team into the care of every patient
- identifies and uses best practices to promote patient- and family-centered care
- identifies and resolves barriers to promote seamless hand-overs, inter-disciplinary collaboration, and efficient patient throughput
- ensures, with attending physician, that patient care meets clinical standards
- develops and revises patient-care goals with the clinical team daily
- coordinates meetings for timely, clinical decision-making and optimal hand-overs across the continuum
- communicates with patients and families around the plan of care, answers questions, teaches, and coaches
- serves as a role model for inter-disciplinary problem-solving
- organizes care-team huddles which include the attending nurse and physician, house staff, and staff nurses
- meets with family on a continuous basis regarding the plan of care, disposition, goals of treatment, palliative care, end-of-life issues
- meets weekly with all members of the team to design, coordinate, and evaluate the plan of care

Unit-specific guidelines for the attending nurse role will be developed by each innovation unit individually regarding number of attending nurses, number of patients within the attending nurse responsibility, and specific desired outcomes to be achieved.

For more information about this new role, call The Norman Knight Nursing Center for Clinical & Professional Development at 6-3111.
“In all affairs, it’s a healthy thing to hang a question mark on the things you have long taken for granted.”

— Bertrand Russell, British mathematician and philosopher

One attending nurse prepares for her new role

When Karen Rosenblum, RN, staff nurse on the Blake 11 Psychiatry Unit, first heard that her unit was selected to be an innovation unit, she knew she wanted to be involved. Said Rosenblum, “I knew it was an opportunity to expand my practice and be an advocate for patients.” Blake 11 nursing director, Tina Stone, RN, and clinical nurse specialist, Connie Cruz, RN, agreed. So Rosenblum is now in the process of preparing for the role of attending nurse.

Rosenblum compares the attending nurse role to that of a navigator. “When you consider all the systems that patients and clinicians encounter in the course of a hospitalization, it can be daunting. Having a navigator to guide your progress can not only be comforting but can have a tremendous impact on outcomes and patient satisfaction. I’ve always been a systems thinker, and I think that will be important as we look at ways to make processes more efficient.”

Just as important as systems thinking are Rosenblum’s skills as an expert clinician, her clinical knowledge, and ability to work effectively with all members of the team. Rosenblum believes that working five days a week will give patients a ‘familiar face’ and ensure continuity of the care plan. Developing an inter-disciplinary plan and implementing it in a timely and efficient manner will challenge all members of the team to think and work together in new ways. Rosenblum is excited to pioneer this new role and work with the Blake 11 team in this new capacity.

Says Rosenblum, “So many of these interventions are going to have a positive impact on patients and families. I’m looking forward to implementing the Discharge Follow-up Phone Call program on our unit. I can see where it would really help prevent re-admissions.”

For more information about this new role, call The Norman Knight Nursing Center for Clinical & Professional Development at 6-3111.
Several years ago, nursing director, Kathie Myers, RN, and clinical nurse specialist, Joanne Empoliti, RN, implemented inter-disciplinary rounds on the White 6 Orthopaedics Unit. The goal was to ensure a coordinated plan of care for patients by involving all disciplines in morning rounds. Myers recalls, “At first, I spent a great deal of time just making sure everyone showed up. But I knew once they did, they’d appreciate the value of having everyone together to share information.” White 6 has been selected to be an innovation unit where their inter-disciplinary rounding will be key to ensuring timely, coordinated care for all patients.

Every weekday morning, nurses, case managers, physical and occupational therapists, social workers, and either a nurse practitioner or physician review patients on the unit and have input into their plan of care and discharge.

Physical therapist, Catherine Royal, PT, says, “Inter-disciplinary rounds keeps everyone on the same page. We identify the target discharge date and discuss the post-hospital plan. Having everyone together at the same time, we all hear the same information and can craft our schedules accordingly in a way that’s best for the patient. It has definitely improved communication.”

Inter-disciplinary rounds on White 6 will be led by Jean Stewart, RN, and Kelly Brown, RN, who will share attending-nurse responsibilities for patients on their unit. Stewart has participated in inter-disciplinary rounds since their inception but notes that being an attending nurse has changed the way she presents patients.

Says Stewart, “By the time rounds begin, I’ve already consulted with nurses, so I’m better able to address any issues that arise during rounds. And because I have more in-depth knowledge about patients and their conditions, I’m better prepared to support patients and families as we work toward recovery and a timely discharge.”

For more information about how inter-disciplinary rounds were implemented on White 6, call Kathie Myers at 6-5319.

“You cannot discover new oceans unless you have the courage to lose sight of the shore.”
— Anonymous

Inter-disciplinary rounds
ensuring all disciplines are on the same page

At inter-disciplinary rounds on White 6, (top photo l-r): Joan Mathews, OTR/L, occupational therapist; Brianne Lynch, PT, physical therapist; Jean Stewart, RN, attending nurse; Karen Smith, RN, case manager; Robert Dorman, PT, physical therapist; and Joanne Empoliti, RN, clinical nurse specialist (front).
Innovation Units 101
the educational plan

Because a consistent understanding of the principles, concepts, and interventions, guiding the work of innovation units is so important, and in order to create an environment of success, The Norman Knight Nursing Center for Clinical & Professional Development has created an educational plan for the roll-out of innovation units. Based on feedback from retreats and many other forums, the Knight Nursing Center has developed a two-hour workshop, which began earlier this month and will be videotaped and disseminated to staff on all innovation units. (Contact hours will be offered for nurses.)

HealthStream Modules have been created to review:
- Hand-Over procedures (SBAR)
- Rounding and the 7Ps
- Discharge Readiness
- Discharge Follow-up Phone Call Program
- Welcome Packets

The Knight Nursing Center is available to provide on-demand education as needed on:
- the attending nurse role
- conflict-resolution and management
- Discharge/Follow-up Call Program
- other topics as necessary

An Attending Nurse Working Group has been created, which will hold weekly, one-hour, facilitated meetings. This forum will be used as a kind of think-tank/support group for attending nurses as they get more immersed in their new role.

A one-time leadership workshop will be offered to nursing directors, clinical nurse specialists, and medical leadership to provide better understanding of their roles in creating and supporting staff as they embark on this new model of care-delivery.

Professional development specialists from the Knight Nursing Center will be available for educational support and to collaborate with designated units. These specialists will be communication liaisons between innovation teams and the Knight Nursing Center. Staff should feel free to seek their guidance as necessary.

The educational component of the innovation unit roll-out began February 7, 2012, and will run through March 10th. HealthStream modules are currently available. On-demand education is now available. Individuals in the Attending Nurse Working Group and Leadership Workshop will be notified of start dates. And educational support from the Knight Nursing Center is on-going.

For more information, call 6-3111.
Monthly Progress Report – April 2012

What’s Happening This Month

March 19, 2012 marked the official launch of Massachusetts General Hospital’s Innovation Units Initiative. Twelve inpatient units began implementing 12 interventions that will revolutionize the way we deliver care with the overarching goal of providing high-quality care while reducing costs.

The Innovation Units are:

<table>
<thead>
<tr>
<th>MGH Innovation Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bigelow 14 Vascular Surgery</td>
</tr>
<tr>
<td>White 7 General Surgery</td>
</tr>
<tr>
<td>Ellison 16 Medicine</td>
</tr>
<tr>
<td>Blake 11 Psychiatry</td>
</tr>
<tr>
<td>Ellison 17 Pediatrics</td>
</tr>
<tr>
<td>Lunder 9 Oncology</td>
</tr>
<tr>
<td>Blake 13 Newborn Family</td>
</tr>
<tr>
<td>Ellison 9 Cardiac Intensive Care Unit (CICU)</td>
</tr>
<tr>
<td>White 6 Orthopaedics/Oral-Maxillofacial/Urology</td>
</tr>
<tr>
<td>Blake 12 Intensive Care Unit (ICU)</td>
</tr>
<tr>
<td>Ellison 18 Pediatrics</td>
</tr>
<tr>
<td>Blake 10 Newborn Intensive Care Unit (NICU)</td>
</tr>
</tbody>
</table>

The Patient Journey/Patient-Centered Care is the framework driving the initiative. The diagram below depicts the overall goals, critical junctures in that journey, and the 12 Interventions.
# Innovation Unit - Status Report

**Massachusetts General Hospital - Patient Care Services**

**Reporting Period: FY12 April**

## Interventions

<table>
<thead>
<tr>
<th>Throughout Admission</th>
<th>Relationship-Based Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Nurse (# on/shift; days/times)</td>
<td>2/days 5 days/wk 2/day-eve M-F 1/day-eve M-F 1/shift 24/7 1/day-eve M-F 1/night 2/day-eve M-F 1/day Sat-Sun 2/day M-F 8:00a-4:30p 1/day M-F 7a-3:30p 2/day M-F 7a-3p</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Handover Communication</th>
<th>Pre-Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Admit Data Collection</td>
<td>patient/family notebook &amp; discharge envelope (&quot;welcome packet&quot;)</td>
</tr>
<tr>
<td>Patient/Family Notebook &amp; Discharge Envelope (&quot;Welcome Packet&quot;)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During Admission</th>
<th>Domains of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interdisciplinary Team Rounds</td>
<td>9:00am 10:00-11:00am M-F 10:00-11:00am 7:30-10:00am Surg 8:45am, Med 2:15pm Surg 8:30am, Med 2:00pm 8:45am 7:30-8:30am 7:45am &amp; 9:15pm 8:45am 8:00-10:00am 8:30am</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Whiteboards: Electronic</th>
<th>Whiteboards: In-Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portable Devices - Toughbooks</td>
<td>Paper Pilot; excludes Baker Service (NPs follow-up)</td>
</tr>
<tr>
<td>Discharge Readiness Checklist</td>
<td>Paper Pilot in progress</td>
</tr>
</tbody>
</table>

## Additional Unit-Based Interventions/Process Improvement Initiatives

- **3pm Rounds for tomorrow's discharges; target time frames for discharge: to home = 10:00am; interfacility = 12:00pm**
- **Care Coordination Rounds; Post-Discharge Medication List to Longitudinal Medical Record; "Warm handoffs" to Spaulding Cambridge**
- **Piloting "Yacker Trackers" for noise reduction; pilot Unit Service Associate communicating about cleaning efforts**
- **Include cue-based feeding (outside of regular feeding times); review weekly growth as an indicator for other interventions or progress toward discharge**
- **Quiet Hours - creation of "Quiet, the Children are Healing" signage**
- **Weekly discharge planning group led by ARN, Case Mgr. Daily afternoon mini-rounds with ARN/CM/Residents/Social Workers**
- **Partner with PATA to educate patients/develop relationship prior to admission. Dedicated Education Unit (DEU) students to research noise effects on patients, implement Quiet Hours**
- **Piloting discharges at specific times; Staff emails using SBAR format**
- **Family Meeting within 48 hours of admission; Nurse Navigator Role for STEMI patients**
- **Most patients discharged from ICU go to general med/surg unit. Plan for ARN to visit patient on in-patient units instead of discharge phonecall**
- **Weekly Unit-based newsletter; SBAR format for notes written in Nurse PEPL**
**Intervention Implementation Status (see summary grid attached)**

The original 12 interventions are well underway. During the month of April, **Whiteboards** (In-Room Patient Whiteboards, and Electronic Nurse Station Whiteboards) are being installed. The **Voalte phones** will go live in the May. In development are items for the **Discharge Readiness Toolkit**. Two units, Blake 13 Family/Newborn and White 7 Surgery, have rolled out the paper pilot version of the **Discharge Follow-up Phone calls**, with two more units about to join this pilot. While these pilots are taking place, the details of the phone call management software installation are being worked out. The remaining eight interventions are up and running on all Innovation Units!

**Additional Interventions**

- **Quiet Hours** – based on results from the HCAHPS survey, many of the Innovation Units are implementing Quiet Hours – dedicated times/spaces on the units for reduced noise and interruptions to patients. This intervention embodies relationship-based patient-centered care as it respects the patient’s need for rest to heal, and creates a calming environment for the patient, families and staff. Units are investigating interventions from the literature. One item is an electronic device comparable to a traffic light that signals the noise level on the unit (“Yacker Tracker”). Blake 13 (Newborn Family) has been using signage on the unit and on patient doors indicating “Quiet Time: Resting is Healing” with wonderful results. Soon Ellison 17 and 18 (Pediatrics) will be hanging a beautiful painting by their Artist-in-Residence that states, “Quiet Please – the Children are Healing.”

- **Patient Advocacy and Interdisciplinary Rounds** – having Patient Advocates dedicated to the units has allowed them to be integrated into the unit’s Care Team so they can address issues proactively, before they escalate. Here are some examples:
  
  - “The Patient Advocate, Social Worker and Case Manager worked collaboratively to pull together a smooth and timely discharge for a very complex patient.” (White 6 Orthopedics/Oral Maxillofacial/Urology)
  - “The Patient Advocate attends our Care Coordination Rounds about three times a week. It is nice to have a dedicated Patient Advocate that knows the unit and patient population. Prior to this Innovation work - we were calling "The Patient Advocacy Office" not Linda - our Patient Advocate. The visibility of our Patient Advocate on the unit has been great not only for the patients but also for staff. She is identified as a member of the team.” (Lunder 9 Oncology)

- **Clinical Support Services** have embraced the Innovation Units Initiative by creating some interventions of their own. Applying Relationship-Based Care to Operations Associates (OAs) and Unit Service Staff (USAs), “patients feeling known” means that patients feel that staff are familiar to them. Beginning the end of April, these staff will be wearing new role-identifying uniforms. This will improve access to better service and assistance for patients and families. In addition, OAs will have a renewed
focus on **Patient Satisfaction** (patient/family greetings and escort to room) and USAs will increase efforts on **Cleanliness** (tent cards, scripting, patient interviews, checklists).

---

**Education and Training**

“**Innovation 101**”, a two-hour seminar-style overview of the initiative, was offered to Innovation Unit staff and affiliated partners. Twenty-two of these seminars were provided in February and March. In addition, **HealthStream modules** are also available on an ongoing basis. “Innovation 101” is available in video format, and there are modules for each of the interventions. **Development Specialists** have been assigned to each Innovation Unit for customized training support. The **Attending Nurses weekly meetings** are facilitated by education specialists who monitor and guide the development of this unique role. As a result of just a few of these meetings, specialists in Process Improvement and Change Management/ Resiliency will be working with the Attending Nurses in the coming weeks.

---

**In the Spotlight – The Innovation Units Web Portal**

The Innovations Unit Web Portal can be found at [www.mghpcs.org/innovation_units](http://www.mghpcs.org/innovation_units). It provides an overview of the initiative, headlines, details about the Innovation Units, program Dashboard, “In the Literature” (published works regarding innovation in healthcare and specific interventions), and more.

In just the first two weeks of operation, the web portal received over 1300 hits from over 1200 individual users. Visitors are from around the US and other countries. In addition, major search engines, including Google and Bing, have indexed the website.

---

**Results to Date - Early Signals**

A Dashboard of metrics has been developed, against which we will measure the impact of the interventions. Having just launched the Innovation Units initiative, hard data regarding the impact of our interventions will not be available for some time. However, early anecdotes and testimonials have been informative and encouraging.

**Patient/Family Notebook and Discharge Envelope**

- A child re-admitted after failure to thrive at home returned to MGH with his Patient/Family Notebook from the previous admission. The parents had continued to record symptoms, feeding, etc. in it while at home. When re-admitted the physicians found these data enormously helpful in diagnosing the patient.
Attending Nurse (ARN) Role

- On a surgical floor, patients admitted late afternoon usually miss the ARN. In response, the ARNs are connecting with patients in the Pre-Admission Testing Area (PATA) and with family via phone. Patients and staff are finding this very helpful.

- Feedback from a planned re-admission was that having the ARN business card/contact information was very helpful when he had a question. Other units have also reported hearing back from patients post-discharge when they have questions.

Handover Communication Format/SBAR

- Staff are finding creative ways to use the Situation/Background/Assessment/Recommendations (SBAR) format. Adapted from the US military and intended for situations where patients are being handed over from one situation to another (e.g. change of shift, change of patient location, etc.), other communications such as staff emails and temporary notes are being crafted in this fashion. Even change-of-shift handoffs between Unit Service Associates (USAs) are being conducted in this format!

On the Horizon – Preliminary Process Improvement Efforts

- Patients and staff and will be surveyed about the Patient/Family Notebook & Discharge Envelope starting late April. Results will help determine any revisions in content and layout, as well as use.

- A survey to capture the number and type of Post-Discharge Phonecalls conducted by MGH programs is underway. The results will be evaluated to determine the best way to coordinate contacts with patients after they leave the hospital.

- The portable laptop known as a Toughbook for use by the Attending Nurses is also being evaluated. Initial difficulties and corresponding solutions are being identified, as well as capturing new and creative uses of the devices.

- Weekly meetings of Unit staff as well project support managers continue to capture initial issues, questions, and feedback – and identify solutions.

Contact Us

We welcome questions, feedback and ideas! Contact us below, or through the Excellence Every Day web portal mailbox (PCSEED@partners.org).

Gayle Fishman, RN, BSN, MBA
Staff Specialist
Email: GFishman@partners.org
Tel:

Linda Lacke, MPH
Senior Project Manager
Email: LLacke@partners.org
Tel: 617-643-5840
Throughout May and June, the Innovation Units continued to be a-buzz with the roll-out of additional interventions and activities!

♦ **C-BEDS Electronic Whiteboards Installed on All Innovation Units**

![C-BEDS Electronic Whiteboards](image)

All Innovation Units are now using the electronic whiteboards. These unit census boards help track patient flow, patient characteristics and care teams. Requests for whiteboard feature edits are being addressed on an individual unit basis. Workflow has migrated from writing on the laminated white boards to using the electronic whiteboards.

♦ **Hand-held Electronic Communication Devices (Voalte phones) Now Live on 10 Innovation Units**

Handheld communication devices have been a huge hit! They have made staff communication faster and easier, greatly reducing overhead paging. This has resulted in a noticeable drop in unit noise.

White 6 Orthopaedics & White 7 General Surgery are in the process of completing their wiring and should be live in early July!
♦ **Patient In-Room Whiteboards**  All of the Innovation Units are using in-room whiteboards to facilitate communication between patients, families and care teams. Feedback from the units and patients has been very positive, with usage starting right from the moment of install. Audits uncovered some minor issues with keeping the data current on the whiteboards. This is being addressed with additional training and awareness efforts. Staff have commented that the whiteboard on the wall and the Patient & Family Notebook are tools that work well together to help articulate, direct, and answer questions, as well as identify goals for the patient.

♦ **Clinical Support Services Uniforms**  To help patients, families and visitors easily identify staff for assistance, uniforms for Clinical Support Services staff have been implemented. In response to staff feedback, different styles and materials were evaluated to enhance fit and comfort.

♦ **Staff and Leadership Idea Books**

   The Innovation Units Initiative will use multiple tools to evaluate the impact of the various interventions, as well as identify process characteristics. One such tool is the Idea Book. It is a composition book on all the Innovation Units used to capture narratives and observations from all MGHers involved in the initiative. Staff wishing to submit comments electronically can do so by emailing InnovationIdeas@partners.org. Everyone’s input is important so please submit your ideas and observations! All information collected is confidential. For more information please contact Jeff Adams, PhD, RN - Nurse Scientist at 617-643-7092 or JAdams9@partners.org.

---

### In the Spotlight

**Oncology/Lunder 9’s “Warm Handoff”**

Some of the MGH Innovation Units have implemented their own unit-based initiatives, in addition to the 12 interventions that all Innovation Units have taken on. Many patients from the Lunder 9 Oncology Unit transfer to Spaulding Cambridge to continue therapy and rehabilitation. In another great example of embodying Relationship-Based Care, Lunder 9 has been taking active steps to build a collaborative relationship with the Oncology Unit at Spaulding Cambridge. The staff from Lunder 9 and Spaulding Cambridge have visited each other’s site and have weekly meetings to review current and potential patients. As a result of this networking, a “warm handoff” has been established to facilitate communication from the acute care setting to long term care. “The Lunder 9 team and Spaulding Cambridge team collaboration is invaluable,” states Lunder 9 Nurse Director, Barbara Cashavelly. “Patients and family find comfort in the fact that their primary caregivers have a close working relationship with the Spaulding team. The patient is not only "known" to the Lunder 9 staff, the patient is also known to the Spaulding Cambridge Care team.”
## Results to Date - Early Signals

### Welcome Packet (Patient/Family Notebook and Discharge Envelope) Survey

In May Innovation Unit staff and patients were surveyed for feedback on the Welcome Packet. A broad representation on all 12 Innovation Units was achieved with 47 patients/families and 140 staff responding (39 in-person staff interviews, 71 weekend/night staff electronic surveys, and 30 electronic surveys from the disciplines). Findings include:

- Overall the Welcome Packet is being very well-received. It is introduced to the patient/family shortly after admission, usually by the Attending RN.
- The format of blank note pages with discussion prompts is especially appreciated along with the descriptions of the care team members.
- Response from all groups is that, when used, the Welcome Packet helps with communication between staff and patients/families, especially with discharge planning and teaching.
- Challenges with the Notebook include little opportunity to use by patients with short stays, limited space to put the Notebook near the bedside, and remembering to encourage use throughout the stay. The Discharge Envelope is used less on units with long-term patients and/or few discharges to home.
- Open comments on the surveys are being evaluated to provide additional training modalities and revisions to the Welcome Packet material.

### Average Length of Stay (ALOS)

In aggregate for the Innovation Units (excluding the ICUs), **ALOS is down 3.31%!** While it’s still too early to tell for sure, this is significant and is presumably being driven by a number of Innovation interventions. One element that many sense is key to this outcome is the role of the Attending RN in coordinating the patient’s stay and discharge. On Blake 11 Psychiatry), the number of discharges has increased considerably, which helps relieve the back-log of patients waiting to get onto the unit.
Patient Experience Surveys - Innovation Unit Scores

Patients are surveyed about their hospital experience approximately 2 weeks after discharge to home. Comparing 2011 to year-to-date 2012, MGH as a whole is showing a positive trend in Patient Experience scores, and the Innovation Units are showing an even greater improvement, improving at almost double the rate of the rest of the hospital in many instances! While still early in the process, it appears that the Innovation Interventions are making a difference to patients. Staff have also provided positive feedback about improved care coordination and care team members knowing their patients, thanks to the interventions and great teamwork. Bravo, Innovation Units!

Fun Facts!

Voalte – Currently 14 inpatient units at the MGH are using Voalte communication hand-helds. Eight of the 12 Innovation Units went live during May, joining Lunder 9 Oncology and Blake 12 ICU which had Voalte before becoming Innovation Units (and White 6 Orthopaedics & White 7 General Surgery will be coming online this summer). During the month of May, the 14 MGH units sent 211,424 text messages and completed 10,146 calls.

Welcome Packets – now in its second printing, approximately 6,500 Welcome Packets (Patient & Family Notebook, Discharge Envelope) have been distributed to the 12 Innovation Units to-date.

Discharge Phonecalls – from April 2012-June 25, 2012, four Innovation Units made 810 phone calls to patients discharged to home. The connect rate to patients who gave permission to be called was 69%. Those units participating in the trial during this time period are Blake 13 Family/Newborn, Bigelow 14 Vascular Surgery, White 6 Orthopaedics and White 7 General Surgery. The average phone call length was 3.4 minutes, and basic medical advice (e.g. discharge instruction clarification, medication questions, wound management) was given 23% of the time. Only 1% of the calls required Interpreter Services, but bi-lingual staff are also utilized to make calls.

Web Hits – In its first 3 months of activity, the Innovation Unit website (www.mghpcs.org/innovation_units) received 1,582 unique page views from 1,939 website visitors. Outside of the US, visitors were from Lebanon, South Africa, Switzerland, Singapore, United Arab Emirates, Canada, Brazil, China, Japan and Germany!

On the Horizon

Discharge Phone Calls – The Next Chapter

To help our patients navigate the first few days home from the hospital and to promote higher levels of patient satisfaction, the Innovation Units Initiative has as one of its interventions a follow-up phone call to the patient’s home after discharge. The initial pilot of this has been going well (see “Fun Facts” above). It is planned that eventually most, if not all, of the IUs will have a discharge call program in place by the end of the summer.

In the course of this pilot it was learned that many patients discharged from MGH were already receiving follow-up phone calls from a number of outpatient areas. There were even reports of some patients receiving multiple phone calls post-discharge. To help catalog calls from MGH, Rick Evans, Senior Director of Service, sent out a survey to the MGH community. The response revealed that there are at least 50 programs making calls to patients at home after discharge.
To better understand and coordinate this contact, a working group was convened with Evans as the chair. The group consists of representatives from programs across MGH. The purpose of the working group is to identify and propose ways to better coordinate post-discharge phone call contacts. Not only will this help lay the ground work for the launch of a phone call software program later this year, but it will also help advance some of the Partners Healthcare System Internal Performance Framework (IPF) initiatives. Most importantly, it will help care teams better communicate about patients and reduce redundancy, as well as make a patient’s transition from hospital to home more seamless. Stay tuned!

Contact Us

We welcome questions, feedback and ideas! Contact us below, or through the Excellence Every Day web portal mailbox (PCSEED@partners.org).

Gayle Fishman, RN, BSN, MBA          Linda Lacke, MPH
Staff Specialist               Senior  Project Manager
Email: GFishman@partners.org      Email: LLacke@partners.org
Tel: 617-724-8030          Tel: 617-643-5840

INNOVATION UNIT
Innovation Unit Retreat

Draft Agenda: September 13, 2012

I. Welcome and overview of the day: J. Ives Erickson

II. The Journey

1) Goals: J. Ives Erickson
2) Preparing for implementation
   ➢ Education plan: G. Chisari
   ➢ Communication plan: M. Ditomassi
   ➢ Lessons learned: ALL

III. Evaluation

1) Are Innovation Units effective in improving outcomes for:
   J. Adams & D. Jones
   ➢ Patient?
   ➢ Staff?
   ➢ Organization?
2) What is the general experience of working/ receiving care on an Innovation Unit?
   J. Adams & D. Jones
3) Specifically, does the role of the Attending Nurse impact care and how so?
   J. Adams & D. Jones
4) A deep dive into the Patient Experience: R. Evans
5) Cost of Care Delivery: M.A. Thadeu
6) Project Management Support: M. Ditomassi
7) Ongoing Communication: M. Ditomassi
8) Ongoing Education: G. Chisari

IV. Comparing our work to other Innovation Units across Partners: J. Ives Erickson

V. Reaction, questions, input: All

VI. New Challenges

1) Discharge Bundles: J. Ives Erickson
2) Partners eCare: J. Ives Erickson
3) Meaningful Use: S. Millar
4) Responsiveness: R. Evans
5) Noise: R. Evans

VII. Sustainability and Continuous Improvement: All

VIII. Summary: J. Ives Erickson
HCAHPS Results
MGH-wide YTD vs. Innovation Units YTD

<table>
<thead>
<tr>
<th>Measure</th>
<th>MGH 2011</th>
<th>MGH 2012 YTD</th>
<th>Change</th>
<th>Innovation Units 2011 Score*</th>
<th>Innovation Units 2012 YTD Score*</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Communication Composite</td>
<td>79.4</td>
<td>81.0</td>
<td>+1.6</td>
<td>76.3</td>
<td>80.6</td>
<td>+4.3</td>
</tr>
<tr>
<td>Doctor Communication Composite</td>
<td>81.9</td>
<td>81.8</td>
<td>- .1</td>
<td>81.5</td>
<td>82.2</td>
<td>+.7</td>
</tr>
<tr>
<td>Room Clean</td>
<td>69.8</td>
<td>72.7</td>
<td>+2.9</td>
<td>66.4</td>
<td>68.0</td>
<td>+1.6</td>
</tr>
<tr>
<td>Quiet at Night</td>
<td>45.2</td>
<td>48.0</td>
<td>+2.8</td>
<td>43.6</td>
<td>50.0</td>
<td>+6.4</td>
</tr>
<tr>
<td>Cleanliness/Quiet Composite</td>
<td>57.5</td>
<td>60.3</td>
<td>+2.8</td>
<td>55.0</td>
<td>59.0</td>
<td>+4.0</td>
</tr>
<tr>
<td>Staff Responsiveness Composite</td>
<td>63.6</td>
<td>63.7</td>
<td>+.1</td>
<td>62.3</td>
<td>62.1</td>
<td>-.2</td>
</tr>
<tr>
<td>Pain Management Composite</td>
<td>71.5</td>
<td>71.8</td>
<td>+.3</td>
<td>69.6</td>
<td>73.1</td>
<td>+3.5</td>
</tr>
<tr>
<td>Communication About Meds Composite</td>
<td>62.7</td>
<td>62.7</td>
<td>FLAT</td>
<td>58.9</td>
<td>65.5</td>
<td>+6.6</td>
</tr>
<tr>
<td>Discharge Information Composite</td>
<td>89.8</td>
<td>92.0</td>
<td>+2.2</td>
<td>89.6</td>
<td>92.5</td>
<td>+2.9</td>
</tr>
<tr>
<td>Overall Rating</td>
<td>79.1</td>
<td>80.5</td>
<td>+1.4</td>
<td>76.1</td>
<td>78.1</td>
<td>+2.0</td>
</tr>
<tr>
<td>Likelihood to Recommend</td>
<td>89.4</td>
<td>91.2</td>
<td>+1.8</td>
<td>87.9</td>
<td>90.3</td>
<td>+2.4</td>
</tr>
</tbody>
</table>

* Data for Innovation Units includes 7 units for which data is available – Bigelow 14, Blake 13, Ellison 16, Ellison 18, Lunder 9, White 6 and White 7. Data not available for ICU’s and Psych.

MGH/MGPO Practice Improvement
Service Excellence