NK 9: The structures and process(es) by which nurses are involved with the evaluation and allocation of technology and information systems to support practice or nurses’ participations in architecture and space design to support practice.

Similar to other large academic healthcare institutions, MGH is constantly changing to meet the needs of its patient population. This includes changes to physical space and enhancements to technological and information systems. Nursing has always had a strong voice and active participation in technology, information systems, and architecture and space design decisions. Three departments that support this involvement are the MGH Real Estate and Planning Department, PCS Clinical Support Services, and the PCS Informatics Department. The following examples illustrate the processes they use to ensure strong nursing participation in a diverse group of projects.

Architecture and Space Design

The Massachusetts General Hospital Real Estate and Planning Department provides comprehensive real estate services to meet the needs of the hospital. The office is comprised of directors, a clinical project manager, architects, project managers, planners and support staff. The team facilitates capital construction projects from the planning/programming, schematic and design development until final construction completion.

One key element that makes the MGH Real Estate and Planning Office unique is the role of the Clinical Project Manager (CPM). This position has been held by a senior nurse clinician since 1991. The CPM provides the clinical expertise to assure projects are built in the best interest of our patients, families and staff. During the programming stage, the CPM is able to summarize the clinical and support spaces and square footage required to meet outpatient and inpatient projects. This is the test fit phase of a project, that is, the hypothetical space layout of all or part of an organization drawn to show how the projected space requirements might be accommodated. The schematic and design phases are the detailed documentation efforts coordinating infra-structure, clinical and operational equipment as well as low voltage requirements. During these phases, mock ups of typical rooms are built to test and modify the design. Usually the focus is to evaluate the operational efficiency; test products and layout; and coordinate equipment, headwalls, work stations and other key features of the design. Multiple users are brought in for feedback and the CPM is the key contact between the hospital and any outside consultants. The CPM also works with the state regulatory departments as well as internal clinical, Infection Control, Environment of Care, and Quality and Safety Departments. Having a clinician at the forefront of projects with an awareness of current standards and future trends/best practices contributes to the success of MGH construction projects. Attachment NK 9.a and Attachment NK 9.b describes the job responsibilities and the organizational chart for the department, respectively.

The Real Estate and Planning Office team is interdisciplinary. The CPM is the liaison/interpreter between the hospital team and the consultants. The CPM’s primary focus is to ensure that the clinicians’ voices are heard during the design process, and to facilitate communication of time sensitive information/decision making between the hospital, project managers and the architectural and construction teams. The project requires substantial coordination efforts and awareness of new technologies and/or practice changes which might impact the design and, thus, the ultimate use of the space. The CPM is able to use clinical expertise and project knowledge to facilitate decisions that support and enhance the patient environment and their clinical practice.
Lunder Building

An example of a successful project is the recently constructed Lunder Building. This building, occupied in 2011, is a 14 floor addition with 10 floors above ground and 4 below. The building project provides 128 inpatient private beds, 22 ICU beds, 28 operating rooms, central sterile processing, radiation oncology exam and treatment, expansion of the emergency department, loading dock and materials management (Attachment NK 9.c).

The MGH Patient Care Delivery Model is interdisciplinary and patient and family-centered. It articulates a care-delivery model system that is supported by a philosophy of care and an environment that enhances patient outcomes. The MGH Lunder project is a perfect example of collaborative teams inclusive of nurses, physicians, administrators, therapists, pharmacists, biomedical engineers, telecommunications, materials management, environmental, architects, engineers, project managers, and support staff that were involved throughout the entire project. Attachment NK 9.d is an example of the Neuroscience Acute Workgroup.

User groups were formed during the planning process and remained through schematic, design development, construction, fit out and occupancy phases. The project team developed Guiding Principles that were critical to the success of the project. They were:

- Enhance the patient and clinician experience
- Be fiscally responsible
- Provide a modern, technological environment centered on the human element
- Add value and increased performance in clinical and building environments
- Provide maximum flexibility for the future allowable by the budget
- Embrace appropriate sustainable design parameters
- Provide a sense of welcome and community within MGH and beyond
- Represent MGH brand within MGH, Partners HealthCare, Boston and beyond
- Meet the requirements set by the IMP/BRA process
- Deliver success by maintaining scope, schedule and budget

During the design process, four mock-up rooms (ICU, OR, inpatient room, PACU) were built to test the layout and products proposed for the building. The rooms were completely fit out including headwalls, booms, equipment, furniture and finishes. Hundreds of clinicians and ancillary staff visited the space and provided feedback that was incorporated into the final design (Attachment NK 9.e).

During the construction design phase, a fast-track ICU and inpatient room were built to test constructability as well as final confirmation from the multidisciplinary team that all elements were captured before proceeding with the remaining 148 rooms (Attachment NK 9.f).

The new patient units provide state-of-the-art facilities in appropriately sized, flexible spaces that allow for modern technology and infrastructure. Such increased and flexible spaces allow the hospital to respond quickly to the demands of rapidly changing technologies, clinical practices, and clinical research. The team of nurses involved provided clinical expertise and worked closely with the design team to assure the units would meet the needs of patients, families and staff. The final design of the inpatient units was derived from their input.

Patient rooms are designed for patient safety, staff observation, and family and patient comfort. All are private rooms with ceiling lifts extending into the toilet room, personal protective equipment (PPE) cabinet upon entry, a clinical workstation inside the room, decentralized workstations that have views into the room, white boards for transmitting information to the patient and family, wide door entrance for easy equipment access, headwall with medical gases, monitoring,
sufficient power and data, flexible lighting as well as a night light that illuminates the room and
bathroom, and a family zone with pull out couch for overnight stays (Attachment NK 9.g).

The configuration includes nursing staff support areas (medication rooms, clean supply, etc)
that are conveniently located near the patient rooms, but also cross connect allowing access from
both corridors, therefore decreasing noise near the patient rooms. Consult/respite rooms are
located at the corners of the unit to allow private areas for the family close to the patients. Main
reception desks are located upon entry into the unit allowing families to be greeted immediately. A
blue desk located throughout the building provides a way finding theme for information.

Information Systems

Acute Care Documentation (ACD) Project

Patient Care Services Informatics (PCSI) department is responsible for developing,
implementing and evaluating clinical and administrative information tools and applications. The
department serves as a liaison between Patient Care Services and Partners Information Systems.
Patient Care Services Informatics (PCSI) integrates clinical science, computer science, and
information science to manage and communicate data, information, knowledge, and wisdom in
nursing and health professions practice. Informatics activities include the design and use of
informatics solutions and/or technology to support all areas of nursing and the health professions.
This includes but is not limited to the direct provision of care, establishing effective administrative
systems, managing and delivering educational experiences, supporting life-long learning, and
supporting nursing research.

Primary responsibility of Patient Care Services Informatics staff is to lead or participate in a
variety of projects related to the design, development, and evaluation of information systems, and
state-of-the art, easy-to-use information tools, as a means of supporting clinical practice, research,
and education at the MGH and Partners. Its leadership consists of all nurse project managers who
work with individuals or teams that include clinical staff, Partners information staff, application
development staff, and analysts. In addition, PCSI staff manages aspects of projects that relate to
business and clinical functional requirements, detailed software requirements, clinical knowledge
integration, and consultation for application development.

PCSI is involved in a variety of Patient Care Services and hospital-wide projects such as:

- Acute Care Documentation
- QuadraMed patient classification application
- OneStaff, staff scheduling application
- HealthStream on-line education
- RL Solutions Patient Advocacy application
- Co-chair for the Clinical Policy & Records
- Ordering and management of technical equipment
- Patient Care Services web site
- eMAR application
- Discharge Documentation module of Provider Order Entry

The ACD project is an example of a recent, complex, and extensive clinical informatics
endeavor directed by PCSI. This project was a multi-million dollar joint Massachusetts General
Hospital and Brigham and Women’s Hospital (BWH) initiative to automate the inpatient medical
record. Software developed by iMDsoft called MetaVision was built to meet the needs of all
inpatient clinicians and personnel who would document in a patient’s record.
Project governance included all levels of clinicians with a strong presence from nursing. One of the Executive Sponsors was the Chief Nurse and the three business owners were the director of Informatics (a nurse), a cardiologist and the director of Health Information Services. The Clinical Project Managers were nurses as well as several members of the Information Services (IS) leadership team. All levels of nurses were instrumental in developing the primary guiding principle of the project:

- Decisions shall be driven first by the needs of our patients, our focus on their safety and our commitment to quality. Established patient safety, regulatory, quality and professional practice standards will not be compromised.

The ACD project was discontinued before the house wide use of MetaVision due to a changed Partners Health System strategic direction. However, the principles, content, and methodology developed are viewed as the foundation for the future Partners Health System enterprise electronic health record (EHR).

Nurses were well represented within each committee/working group and they were directly responsible or contributed to the following:

- Inpatient documentation application selection
- Content development
- Screen layout and design
- Interfaces with legacy systems
- Report development
- Unit and integrated testing
- Hardware, fixed and mobile

Attachment NK 9.h displays the complex organization that was created to represent the needs of all clinicians. Nurses held key roles and shouldered many of the project responsibilities.

The Joint (MGH/BWH) Working Group performed all aspects of a documentation product selection including the development of the proposal, vendor demonstrations and site visits. This group continued to meet throughout the project providing guidance and clinical feedback on the project development.

A series of nine all-day design sessions were held during which clinicians from multiple disciplines met to discuss, develop, and decide on clinical content. Nurses comprised the majority of clinicians, and used expert knowledge and best practice to inform decisions. This content became the basis for the structured data fields in the electronic forms and notes in the documentation application. Nurses led content authoring groups and worked with nursing subject-matter experts (SMEs) to further refine content to meet quality and practice requirements. This process was managed by the Clinical Content Manager, also a nurse, who facilitated a multi-disciplinary joint content committee.

Nurses led authoring/build teams who worked with Information Systems (IS) analysts to develop clear and intuitive screens that reflected clinician workflow and followed consistent design principles. Nurses conducted Usability testing with groups of multi-disciplinary clinicians to assess the design and flow, and feedback was used to inform the iterative design process. Nurse leaders from the three pilot units met twice a month with the build teams to ensure that the application was being designed to support their unit practice and workflow. Ad hoc sessions with Staff Nurses on
these units were conducted to demonstrate application functionality and collect feedback, which was incorporated into the design process.

The ACD project also included integration between the new documentation application and the existing electronic medication administration record (eMAR). Nursing clinical leads from the ACD project, along with eMAR nurses, pharmacists and developers, met weekly for over two years to determine what information needed to flow between the two applications. The group decided how the users would navigate each application to create a seamless record with avoidance of double documentation. Key characteristics of medication administration and fluid maintenance were transferred to the electronic flowchart to provide a current and accurate recording of patient physiologic and hemodynamic values. Staff Nurses were instrumental in identifying the many and varied use cases that depicted medication administration scenarios. They worked closely with the developers to ensure accuracy and simplification of workflow.

Nurses worked with data warehouse developers to determine what information could be extracted into reports that would help with nursing workflow and patient outcomes. After meeting with nurse leaders from our Office of Quality and Safety, Infection Control departments and the pilot units, the nursing project team members worked with the developers to identify specific data elements and tables to be queried. The reports summarized key clinical information for nursing unit populations.

Testing was led by nursing clinical leads in conjunction with nursing unit staff. They wrote scenarios based on actual clinical situations, and used them to test the functionality of the application’s content, design, and interfaces. The PCS Collaborative Governance Informatics Committee was instrumental in ensuring that unit-based variations were addressed in these scenarios, and that documentation requirements for our diverse patient population were met. Staff nurses as well as nurse informaticists tested the software and device integration using monitor simulators, and applied their knowledge of clinical workflow to assess the adequacy of the build within the software.

Project team members understood that clinician acceptance of any software application was based partially on having adequate computers that are fast and accessible. Based on patient privacy, infection control concerns, and accessibility to clinicians, Staff Nurses and inpatient unit nursing leadership helped determine criteria for hallway computer cabinetry and distribution and storage of mobile devices. Nurses were among the clinicians involved in evaluating mobile devices for documentation during patient transport.

Hardware

With the advent of eMAR, additional unique hardware configurations were required. Staff Nurses needed to administer medications utilizing eMAR with barcode technology in real time at the bedside. Several vendors were selected and demonstrated their hardware configurations to the nursing staff. While ease of use was most important, regulatory, safety and structural limitations also had to be considered in the selection. Staff Nurses from all specialties and different kinds of structural environments (ICU, psychiatry) participated in the hardware selection. Due to space constraints and infectious control concerns, fixed bedside devices were selected with a computer and scanner permanently installed at every inpatient bed with a few exceptions. PCSI was instrumental in the successful selection and placement of these new workstations throughout the hospital.

Each component of the computer set up was evaluated individually by nursing staff including keyboards, mouse, scanner, display monitor and the ergonomic implications of the proposed selections. Attachment NK 9.i depicts the most common design that was selected for the majority of patient rooms. It was recognized early on that given some of the unique patient and structural requirements, that each nursing unit could require some specific modifications.
Hardware Distribution

A planning team was assembled that met weekly to coordinate bed closures, staffing assignments and resolve any outstanding issues. The ACD Clinical Manager was part of this team and provided clinical input and direction to the team. The hardware installation covered a 10-month period of time and involved the placement of over 1000 computer and scanner workstations. The team’s most important objective was to perform the work as efficiently as possible with minimal disruption to patient care.

Several weeks before the hardware installation, the placement team (including the ACD Clinical Project Manager) conducted a walkthrough on the nursing unit to determine the placement at each bed. This team was accompanied by the Nursing Director, Clinical Nurse Specialist and any available Staff Nurses to review potential placements and to discuss any unique workflows that would impact hardware placement. Their guidance and expertise was invaluable and all final decisions were approved by the unit’s Nursing Director before work could be started.

Several nursing units required unique configurations due to nursing workflow or safety concerns for either staff or patients. One example of this was the unique requirements of the inpatient Psychiatric Unit (Blake 11), where it was determined that the hardware could not safely be placed within a patient’s room. The placement team met with the Nurse Director, Clinical Nurse Specialist to review the medication administration process which involved encouragement of patients to come to the nurses’ station to receive their medications. To accommodate this workflow, a portion of the nurses’ station desktop was removed and two workstations were installed that would support this unique workflow (Attachment NK 9.j and Attachment NK 9.k).

Even after the hardware was installed and used frequently throughout the hospital, the team continued to meet with nurses to determine if any changes needed to be made to the configuration. This resulted in multiple installation changes such as:

- Extension arm removal. In order to be able to move the units out of the way, extension arms had been added. After further use, we determined that if not completely put away, they could pose a barrier in some of the smaller rooms. Each nursing unit was evaluated by the unit leadership resulting in removal of most of the extensions.
- Scanner bracket replacement/repositioning. With input from nursing, the brackets were redesigned and replaced to provide easier access.
- Arm stopping mechanism installation. For the computer workstations near a window, the range of movement allowed some of the units to come in contact with the window. Each of these units was fitted with a stopper that limited its range in order to prevent any damage.
- Cable management improvements. Nursing leadership identified some safety concerns around the numerous cables that were used. A solution was developed to mitigate any exposure to staff or patients from the numerous cables used as part of the workstation.

Due to the complexity of these workstations, a new ongoing maintenance plan was created to assure that the workstations are at their optimal performance. This is coordinated through nursing leadership on each unit to minimize unit disruption.

As MGH readies for a new electronic medical record with more online documentation requirements, additional hardware will be needed. MGH nurses will be well represented in the selection of hallway workstations and their placement, portable devices and evaluation of the ever changing technical advancements being made for documentation.
Technology
Voalté Selection

The PCS Clinical Support Services Department identifies, budgets, evaluates and procures new technology to support patient care. New technologies are identified in a number of ways including:

- Clinical staff bringing forth the need based on their experience with new technology at other institutions, conferences etc.
- Clinical staff bringing forth issues with existing technology that drive the need to explore alternatives
- Strategic planning process identifying new initiatives requiring enabling technology
- Clinical support departments such as Biomedical, Materials Management, IS, and Pharmacy identifying new options to explore
- Obsolescence of exiting technology

With a staff of over 500 personnel (e.g., Operations Managers, Operations Associates, Unit-Service Associates, Project Specialists), the department manages programs and/or projects to enhance department/service operations. Members of the department plan, implement, and evaluate specific projects designed to enhance department/service effectiveness. The department identifies and recommends fiscal, material and human resource requirements for specific project/programs. Additionally, it implements changes related to programs/projects working collaboratively with department staff and staff outside of the department. Some of its largest endeavors are in the following:

- Clinical & Professional Development
- Committee Structures
- Health-care policy
- Quality initiatives
- Scheduling and staffing
- Standards of practice
- Information systems development
- Coordination of Capital Budget Expense

Once a technology need is identified capital funding is requested through the MGH annual capital request process (TL 2). Nursing requests are brought forth by the CNO. Once funding is in place for an initiative, a specific team is formed whose size and composition is dictated by the technology under consideration. The key decision making component is the product evaluation by the clinical and support staff. Typically technology is trialed in a minimum of two clinical areas. Feedback is gathered based on staff using trial-specific evaluation forms as well as through group discussions with clinical users. In addition to the user feedback the evaluation can include reference calls and/or site visits, financial review and a technical review. The evaluation team then makes a recommendation to our CNO. Examples of technology decisions that have been managed using this process in recent years include patient beds, infusion pumps, and communication technology.

The selection of the Voalté staff communication system is illustrative of this process. Driven by staff and patient feedback MGH Department of Nursing partnered with IS to provide a better tool to support improving communication between unit-based staff, our patients and visitors, with a focus on improving our responsiveness to patient requests.
A formal, four-day process improvement Kaizen workshop was conducted to elicit the insight of unit-based staff (Staff Nurses, Patient Care Associates and Unit Secretaries) from two inpatient units. After reviewing their current state process related to receiving and responding to patient requests, the PCS staff generated ideas for improvements, which were then implemented on their unit over the course of the four days. The primary work included having Staff Nurses educate and remind patients about the roles of the various staff members on the unit; to explain the importance of giving specifics about the details of their request so the team can work collaboratively to meet that request as quickly as possible; to use technology to send specific messages about the details of patient requests; and to record certain static information to avoid unnecessary communication between the administrative and clinical staff.

Six-week trials of two communication devices, Voalté and Vocera, were conducted on Hematology Oncology Unit (Lunder 9- formally Phillips House 21) and General Medical Unit (White 11). Feedback on the two devices was solicited via staff evaluations, focus groups, and discussions with patients and families involved in the Cancer Center Patient Family Advisory Committee. The Nursing Executive Operations Committee used this information to select Voalté as the tool best suited for MGH Staff Nurses (EP 12).

The Voalté Smartphone and web application for voice and text communication was deployed in December 2011 to the six inpatient units in the Lunder building, followed by eight more Innovation units in the spring of 2012. Once a central IS infrastructure has been updated the implementation will resume in the fall of 2012 with the plan to complete the roll out to all inpatient units by the end of the first quarter of 2013.
JOB DESCRIPTION

JOB TITLE: Project Manager – Clinical Programs
FLSA STATUS: Exempt (Grade 650)
UNIT OR SECTION: Planning and Construction at MGH
REPORTS TO: Director
DATE: 1/12/09

GENERAL SUMMARY:

The Planning and Construction Office at MGH seeks a clinician with administrative experience to play a lead role in master planning, design and construction of clinical facilities, including inpatient and outpatient care units, diagnostic and treatment facilities, clinical research sites, labs and other clinical support areas. Incumbent serves as an advocate for quality clinical environments, and helps ensure integration of strategic and facility planning. For both MGH and Partners real estate staff, functions as liaison to clinical departments and as a resource on clinical standards, regulatory compliance, best practices, and emerging technologies and innovations. Project involvement varies as appropriate from a brief consultation to full project management, and from commenting on a discreet project phase to in-depth contributions across many aspects of a program. Works directly with staff at all levels, as well as a broad range of consultants and contractors. As a member of the Planning Office senior staff, aids in oversight and continuous improvement of the entire office.

PRINCIPAL DUTIES AND RESPONSIBILITIES:

1. Master Planning: Participates in mid-range and long-term facility master planning initiatives, serving as in-house consultant to interpret institutional and clinical program goals, and to help integrate strategic priorities with facility planning. Project scope ranges from campus-wide planning to studies for a single building, floor, facility prototype, or clinical program. Identifies opportunities and challenges, helps create and evaluate options, prepares or contributes to presentations and planning documents. Conducts tours for national and international visitors involved in planning new clinical facilities.

2. Project development: Establishes project purpose, urgency and contribution to institutional goals; directs feasibility studies, encompassing: data analysis to set performance criteria and benchmarks, cost estimates and revenue impacts, description of patient flows and operational challenges; documentation of space program and recommendations for space allocation; outlining of project scope, budget, and schedule; and identification of potential challenges re: infrastructure, regulatory approvals, construction conditions in clinical area, etc.

3. Project programming and design: Provides operations and logistics analysis, design reviews, equipment and furnishings specifications and recommendations. Facilitates communication with clients, interpreting how clinical operations relate to project design. Recommends options and alternative operational models, as project circumstances dictate. Advises on regulatory and code compliance. Recommends staff/consultant resources, reviews work of same. Assesses performance of project team members for senior staff.

4. Project construction, occupancy: Helps resolve challenges as they arise during construction and move-in re: infection control, phasing, changeovers to new systems or equipment, etc. Visits site to resolve problems.

5. Regulatory compliance: Interprets requirements for project team; reviews design documents for compliance; serves as liaison to corporate compliance unit, consultants and regulatory agencies; oversees and tracks submittals to DPH, JCAHO, and secures approvals; maintains expertise and knowledge base on current compliance standards, procedures, on behalf of office.

6. Hospital standards and systems: Advises department and project teams re: standards, policies and programs to maintain quality environment of care; maintains relationships with key clinical practice and operations staff (e.g., Biomed Engineering, Respiratory Services, Materials Mgt) to support role of internal consultant, key contact for clinicians. Researches web-based and other sources for benchmark information and other required project information. Office liaison for Surveillance Rounds, EOC committee, employee safety and occupational health work
groups, etc. Issues technical guidelines and instructions, participates in updating of policies, procedures for quality control of clinical facility construction, maintenance and operations.

7. **Clinical administration:** Advises on organizational structure of academic and clinical departments and their decision-making processes, to support project progress. Maintains relationships with key administrators, tracks organizational and institutional changes that may impact departmental operations and processes.

**SKILLS AND ABILITIES:**

1. Interpersonal and communications skills to deal effectively with individuals at all levels of the organization as well as consultants and contractors. Must be able to balance and effectively resolve conflict among those with competing facility, administrative and clinical perspectives.

2. Written and oral presentation skills to prepare and review documents, communicate effectively to a wide variety of audiences. Experience and natural affinity for teaching and learning, collaborative work style.

3. Administrative and organizational skills to manage simultaneous contributions to multiple projects of varied scope and size. Self-motivation and discipline to continuously re-balance priorities and effectively move projects forward within complex reporting and project structures.

4. Analytical and problem solving skills to anticipate and resolve issues that may affect project progress and successful completion. Must use sound judgment and professional skills to bring about workable solutions.

5. Affinity for facility planning and design, including ability to read two-dimensional plans and think in three dimensions; ability to interpret and effectively summarize/communicate technical and clinical information to administrators and project design team members.

**QUALIFICATIONS:**

1. College degree in nursing or other relevant health care profession; graduate degree or other training in project and team management.

2. Minimum of five years of experience in clinical care, with exposure to broad range of health care programs; five years of increasingly responsible administrative responsibilities in clinical operations / program management.

3. Several years of experience with staff and consultant supervision, project and contract management.

4. Facility with Microsoft Office applications, PeopleSoft financial applications, project management databases a plus; training can be provided.

5. Familiarity with MGH clinical programs preferred.

**SUPERVISORY RESPONSIBILITY:**

This position does not have supervisory responsibility. However, incumbent will often direct the work of and assess performance of project staff and consultants.

**WORKING CONDITIONS:**

Position will require frequent site visits to clinical areas, traveling from free-standing office building to campus complex, as well as occasional travel to other MGH and partners facilities. Construction site visits require hard hat and other standard precautions.

*The statement above describes the general nature and level of work performed by employees assigned to this classification. Employees are responsible for carrying out assignments in the method and manner prescribed by supervisors and acting in accordance with all Partners and Hospital policies.*

Fmpo/share/gen-off/PHSjob descriptions/MGHclinical pm
Lunder Building

**Inpatient Pavilion**
5 floors dedicated to cancer and neurology patients

**Surgical Center**
3 floors include 28 surgical suites, interventional radiology, perioperative and public space

**Emergency Department**
Includes covered ambulance area, trauma rooms and waiting areas

**Radiation Oncology Center**
Expanded on 2 floors, adjacent to collaborative departments

**Receiving Dock**

**Sterile Processing**
## Neuro Acute Workgroup

<table>
<thead>
<tr>
<th>Members</th>
<th>Department</th>
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<tbody>
<tr>
<td>Emad Eskander, MD</td>
<td>Physician team leader</td>
</tr>
<tr>
<td>Aneesh Singhal, MD</td>
<td>Physician team leader</td>
</tr>
<tr>
<td>Ann Kennedy, RN</td>
<td>Nursing Director team leader</td>
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### Core Group:

<table>
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<tr>
<th>Members</th>
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<tbody>
<tr>
<td>Audrey Cohen</td>
<td>Speech-Language Pathology</td>
</tr>
<tr>
<td>Andrew Cole, MD</td>
<td>Director MGH Epilepsy Service</td>
</tr>
<tr>
<td>Jean Fahey, RN</td>
<td>Clinical Nurse Specialist, EL 12</td>
</tr>
<tr>
<td>Shawn Farrell</td>
<td>Adm Director - Neurology</td>
</tr>
<tr>
<td>Patricia Galvin</td>
<td>Operations Coordinator WH 12/EL 12</td>
</tr>
<tr>
<td>Kara Houghton</td>
<td>Chief Technologist Epilepsy Monitoring Unit</td>
</tr>
<tr>
<td>Elizabeth Kafka</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Kathleen Lomuscio, RN</td>
<td>Case Management</td>
</tr>
<tr>
<td>Catherine Mackinaw, RN</td>
<td>Staff Nurse</td>
</tr>
<tr>
<td>Robert Martuza, MD</td>
<td>Dept of Neurosurgery</td>
</tr>
<tr>
<td>Cristina Matthews, RN</td>
<td>Staff Nurse - White 12</td>
</tr>
<tr>
<td>Mary Mott, RN</td>
<td>Nurse Practitioner - Neurology</td>
</tr>
<tr>
<td>Christopher Ogilvy, MD</td>
<td>Dept of Neurosurgery</td>
</tr>
<tr>
<td>Kristin Parlman</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Marion Phipps, RN</td>
<td>Clinical Nurse Specialist, WH 12</td>
</tr>
<tr>
<td>Brooke Swearingen, MD</td>
<td>Dept of Neurosurgery</td>
</tr>
<tr>
<td>Jennifer Totten, RN</td>
<td>Staff Nurse - ELL 12</td>
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### Ancillary Support:

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<thead>
<tr>
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<tbody>
<tr>
<td>Bill Banchiere</td>
<td>Environmental Services</td>
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<tr>
<td>Michael Bodock</td>
<td>Pharmacy</td>
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<tr>
<td>Meg Clapp</td>
<td>Pharmacy</td>
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<tr>
<td>Jeff Cooper</td>
<td>Biomedical Engineering</td>
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<tr>
<td>Ann Daniels</td>
<td>Social Services</td>
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<tr>
<td>Shawn Donahue</td>
<td>Telecommunications</td>
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<tr>
<td>Kathleen Kelly</td>
<td>Materials Management</td>
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<tr>
<td>Dan Kerls</td>
<td>Systems Improvement (Furniture &amp; Equipment)</td>
</tr>
<tr>
<td>Ray Mitrano</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Ed Raeke</td>
<td>Materials Management</td>
</tr>
<tr>
<td>Richard Turgeon</td>
<td>Environmental Services</td>
</tr>
<tr>
<td>Trish Volpe</td>
<td>Biomedical Engineering</td>
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** CHARGE: **

- Ultimate Problem Solving & Decision Making Authority relative to MGH Electronic Clinical Documentation
- Approve and prioritize projects, direction setting and resolve decisions that cannot be resolved by BO Group
- Oversight of progress and issues generated from within Work Groups

** CHARGE: **

- Decision Making Authority
- Implementation Planning Group
- Defines/sets guiding principles for how individual groups will work and the expectations of the work product
- Assures inclusion of all professional disciplines and health professionals
- Defines configuration work plan
- Defines structure of work groups

** CHARGE: **

- Manage issues and conflicts
- Assess hardware requirements and bring forward recommendations to BO Group
- Provide weekly updates of current work efforts
- Provide structure and direction to the UAT Leadership Committee
- Participates in all mini projects and all aspects of building, training and implementation
- Facilitates discussions with all clinicians

** CHARGE: **

- Decision Making Authority
- Provide oversight of work groups
- Approve and coordinate design and content recommendations
- Manage issues and conflicts
- Assess hardware requirements & bring forward recommendations to BO Group

** MEMBERSHIP INDEX:**

** ACD Steering Committee **

- **Physician Committee**
  - MD's: J. McFarland, M.D.
  - RN's: S. Millar, R.N., A. McDermott, R.N.
  - HIS: D. Adair, K. Wolf
  - IS: C. Schifiliti, R.N., T. Miller, M. Cullen, R.N.

- **Nursing Committee**
  - MD's: G. Lambert, M.D.
  - RN's: A. McDermott, L. Belsanti, S. Joyce, B. Delaney, S. Stuler, P. Grella
  - RT: D. Chipman, K. Strong
  - HIS: K. Wolf
  - IS: T. Miller, M. Cullen, J. Lynds, J. Mulholland, L'M'Sadoques, C. Glynn, L. Hannenberg
  - Biomed: L. Melendez, M. Yeung

- **ADT Multidisciplinary Working Group**
  - MD's, RN's, HIS, PT/OT, ST, RT, Pharm, SS, CM, IS, BioMed

- **ACD Business Owner Group**
  - Business Sponsors: J. Ives Erickson, R.N. & B. Nicholson, M.D.
  - IS Directors: J. Noga, C. Spurr
  - IS Managers: J. McFarland, M.D., S. Millar, R.N.

- **ACD Project Team Committee**
  - IS: C. Schifiliti, R.N., T. Miller, M. Cullen, R.N.

- **MGH Business Owner Group**
  - **Physician Nursing**
  - MD's, RN's, HIS, PT/OT, ST, RT, Pharm, SS, CM, IS, BioMed

- **Physician Committee**
  - MD's: G. Lambert, M.D.
  - RN's: S. Millar, R.N., A. McDermott, R.N.
  - HIS: D. Adair, K. Wolf
  - IS: C. Schifiliti, R.N., T. Miller, M. Cullen, R.N.

- **Nursing Committee**
  - MD's: G. Lambert, M.D.
  - RN's: S. Millar, R.N., A. McDermott, R.N.
  - HIS: D. Adair, K. Wolf
  - IS: C. Schifiliti, R.N., T. Miller, M. Cullen, R.N.

- **Health Professions Committee**
  - PT: N. Goode
  - OT: J. Evans
  - SS: A. Sobran and K. Tanklow
  - RT: D. Chipman, K. Strong
  - CM: E. Hughes
  - ST: A. Cohen
  - F & N: M. Lynch, C. Breen
  - HIS: S. Brown, K. Wolf
  - Pharm: P. Khoury
  - Bio Med: L. Melendez

- **MGH Physician Committee**
  - IS: C. Schifiliti, R.N., T. Miller, M. Cullen, R.N.

- **MGH Nursing Committee**
  - IS: C. Schifiliti, R.N., M. Cullen, R.N.

- **MGH Health Professions Committee**
  - PT: N. Goode
  - OT: J. Evans
  - SS: A. Sobran and K. Tanklow
  - RT: D. Chipman, K. Strong
  - CM: E. Hughes
  - ST: A. Cohen
  - F & N: M. Lynch, C. Breen
  - HIS: S. Brown, K. Wolf
  - Pharm: P. Khoury
  - Bio Med: L. Melendez

** CHARGE: **

- Assure proper allocation of resources
- Address barriers to implementation and resolve enterprise problems and issues with ACD project
- Meeting Frequency: Once a Month – plus email discussion on an as needed basis