OOO 3: Annual reports, strategic and quality plans.

The following documents are utilized to formally inform the staff of activities related to the strategic plans at the departmental (Patient Care Services [PCS]), organizational (Massachusetts General Hospital [MGH] and Massachusetts General Physician’s Organization [MGPO]), and corporate (Partners HealthCare System) levels.

**Annual Reports**
- Partners HealthCare System – 2011 Exhibit 3.a
- MGH – 2009 Exhibit 3.b
- MGH – 2010* Exhibit 3.c
- MGH – 2011* Exhibit 3.d
- PCS – 2011 Exhibit 3.e

**Strategic Goals and Plans**
- MGH Strategic Goals – FY12 Exhibit 3.f
- MGH Strategic Planning Update – July 2012 Exhibit 3.g
- PCS Strategic Plan – 2010-2011 Exhibit 3.h
- PCS Strategic Plan – 2012-2013 Exhibit 3.i

**Quality Goals Related to Strategic Plans**
- MGH-MGPO Quality and Safety Mid-Year Summary 2012 Exhibit 3.j
- PCS Office of Quality and Safety Strategic Plan and Tactics 2012 Exhibit 3.k

*Note: MGH made a strategic decision to suspend producing formal annual reports in 2010. In lieu of annual reports, annual financial and operating statistics are reported on the hospital website. MGH is featured as an integral part of the Partners HealthCare System annual report.*
WE’RE TAKING ON HEALTH CARE’S TOUGHEST CHALLENGES.
The year 2012 will be one of transition in the leadership of Partners HealthCare. Jack Connors, our Chairman of the Board, announced in 2011 that he would step down in July of this year. Jack has been our presiding officer since 1996, the overwhelming majority of the 18-year history of Partners. During that time our organization has been the beneficiary of his generosity, wisdom, and personal commitment to our mission.

We are very pleased that Edward Lawrence, the current Vice-Chair of the Partners Board and past Chair of the Massachusetts General Hospital, will assume the role and responsibilities of Chairman.

At Partners, we are blessed with leaders at every level of our extraordinary organization, from the dedicated members of our support teams to the devoted nurses caring for our patients, to the gifted surgeons who are saving lives. Leadership takes many forms. Jack, as a volunteer, has been and always will be one of our most passionate leaders. We are delighted that he has agreed to continue with us in the role of Chairman Emeritus.

Jack is and forever will be a mentor. He has been instrumental in guiding us on our journey. Partners’ first President and CEO Dr. H. Richard Nesson was the one who encouraged Jack to join the Board at Brigham and Women’s Hospital in 1992. Dr. Nesson knew Jack’s expertise could build bridges with the community. And Jack did just that; he learned from listening how important access to good care was for our communities. Thanks to Jack’s leadership and his collaborative skills with business and political leaders in our state, Massachusetts is leading the nation in transforming health care for all. And now Jack is helping us explore the next chapter as we focus on improving the care we provide and making it affordable for our patients and society.

Jack is making a difference in the lives of others every day. The evidence of his success is all around us, but perhaps nowhere more visible than Camp Harbor View, a nurturing place of hope on Long Island in Boston Harbor for hundreds of young people who spend a few weeks in the summer away from the streets. His contributions to our community and to Partners are endless and never ending.

Jack’s leadership has helped us to forge a path to strengthen our mission and maintain our standard of excellence that is recognized and respected not only at home, but around the world.

Thank you, Jack, from all of us at Partners HealthCare.

Gary Gottlieb, MD
President and CEO
Partners HealthCare

"The overarching challenge before us is to reduce costs while we improve care."

The story of Partners HealthCare is truly appreciated through the voices of our patients and their families. When we hear about their experiences, we continually marvel at the dedication, talents, and ingenuity of our doctors and nurses – all of the care providers and support teams across our organization who do everything they possibly can to help a neighbor in a time of need.

This is the mission of Partners HealthCare.

We embrace our responsibility to deliver the highest quality of care, while we challenge ourselves to explore innovative ways to make that care affordable to society. We lead in groundbreaking research that links discovery directly to the lives of our patients. We teach the next generation who will carry forward the important lessons of leadership. We commit to these tenets with a promise to improve the health of all the communities we touch every day whether they are local or around the world.

In this year’s annual report, we offer a sample of the inspiring ideas that the talented and dedicated men and women of the Partners HealthCare community have advanced over the last year that speak directly to the key concerns facing health care today. You will read how our teams, guided by a strategic vision, have explored inventive ways to improve the delivery of care that are coordinated, accessible, and cost efficient.

The depth and breadth of our extraordinary community of health care professionals, standing together, can provide the leadership to define a direction for our future that will benefit our patients, their families, and all the communities we serve.

Jack Connors, Jr.
Chairman
Partners HealthCare

Gary Gottlieb, MD
President and CEO
Partners HealthCare

Edward Lawrence
Vice Chairman
Partners HealthCare
“Partners has done amazing things to lower costs.”

— Stuart Altman, Brandeis University professor and nationally known health care authority

Voluntarily reduced by $345 million what we charge health insurers.

Partners has taken an extraordinary step to deal with rising health care costs. We tossed out and renegotiated contracts with Blue Cross Blue Shield and Tufts Health Plan to help reduce the growth in health care premiums by $345 million over the next four years. It is our expectation that patients and businesses across the state will benefit, as insurance companies pass along the savings.

We felt we needed to take concrete steps to lower health care costs without compromising our delivery of the highest quality of care for our patients. The savings were not easy to achieve, but we felt that we should be as creative in saving money as we have been in saving lives.

Our care redesign efforts have relied upon our doctors, nurses, technicians, specialists, and other medical leaders. We have developed new models of care, which we believe are better for patients and their families.

Diabetes care redesign: Potential to save $3 – 10 million.

Diabetes is a near-epidemic in this country and can often lead to kidney, liver, eye, and heart problems. It is just one of the conditions we have targeted for special attention; others include stroke, coronary disease, and colon cancer.

Sometimes you can make progress by wisely taking a step back. Alan Reiss, a type 2 diabetic, was not responding to expensive pills to manage his condition. “I kept telling my friends that I was going to die,” said Reiss. His doctor, Alan Cole, MD (pictured, foreground), tried a more traditional, albeit proven, treatment: insulin shots.

It worked.

At Partners, we estimate savings of $3 million to $10 million a year by moving from expensive brand-name pills to effective generics, or from pills to insulin injections.

Saving significant dollars in perioperative materials, the “stuff” of surgeries.

In an average week, more than 2,100 surgical procedures are performed at the hospitals in the Partners system. Because so many supplies and instruments are high cost, we have been able to achieve significant savings from manufacturers without compromising on what physicians need for the best possible patient care.

Lawrence Cohn, MD, of Brigham and Women’s Hospital, chairs a panel of expert physicians, nurses, and administrators from across the system; the panel reviews the “stuff” of operations, called perioperative supplies. These include sophisticated implantable medical devices such as heart valves and artificial knees, as well as more common sutures and sterile pads. Working with data drawn from our hospitals, Dr. Cohn’s panel has been able to identify opportunities for savings throughout our system.

The commitment to smarter use of supplies has many dividends, Dr. Cohn said: “If we improve efficiency and lower expenses in surgery, we can reduce the overall cost of care for our patients. At the heart of this goal is always to do what is best for our patients.”

Boston is a pioneer again, in Medicare savings.

A longtime national leader in health care, Partners was selected by the federal government to pursue a new method of affordable care for Medicare patients called an Accountable Care Organization (ACO). An ACO is a payment and care reform model that brings together a group of carefully chosen health care professionals to provide care to a group of patients.

The Pioneer ACO at Partners is in line with a highly successful trial launched by Massachusetts General Hospital in 2006, under Timothy Ferris, MD, Gregory Meyer, MD, and Eric Weil, MD (left). The trial showed savings of $2.65 for every $1.00 spent; its success led to an expansion to Brigham and Women’s Hospital, Faulkner Hospital, and North Shore Medical Center.

As a Pioneer ACO, Partners is one of only 32 health care organizations in the country to receive federal financial incentives to transform how it cares for Medicare patients. Providers who band together will be required to meet quality standards while slowing cost growth through better care coordination.

www.partners.org
How Partners is achieving cost savings and improving care.

Patient-centered medical homes: innovation at Brigham and Women’s.

Patient-centered care is much discussed these days. BWH’s Advanced Primary Care Associates on South Huntington Avenue in Jamaica Plain is putting it into practice. This new primary care practice connects each patient with a team that maps out a care plan that includes primary care, prevention, and wellness. Physician-led, patient-focused teams work with each patient and family, each patient is encouraged to take an active role in devising a self-care plan and sticking to it. Continuity of care is ensured by communication before, during, and after office visits to assess a patient’s progress and well-being.

Bicentennial Scholars: investing in the promise of the future.

At an event celebrating the hospital’s 200 years of commitment to the community, MGH introduced 26 local high school students selected as Bicentennial Scholars. The program honors students from Boston, Chelsea, and Revere in gaining admission to, succeeding at, and graduating from college.

While 70 percent of Boston high school graduates are admitted to two- or four-year colleges, many have a difficult time graduating, noted the hospital’s head of Community Health Improvement, Joan Quinlan. “MGH designed it to be more than a scholarship program,” she said. “In addition to an annual $5,000 scholarship, the students will receive intense college coaching and SAT preparation, as well as continued support after they transition to postsecondary education.”

Teaming up to redesign care for chronically ill patients after surgery.

A cardiac surgery innovation project at BWH is addressing the needs of post-cardiac surgical patients who are identified as “chronically critically ill.” These complex patients require enhanced nursing, nutritional, respiratory, and rehabilitative support.

All relevant team members meet weekly to improve communication, determine if medical issues have been addressed, and decide when the patient is ready to leave the hospital. This translates into improved patient outcomes, cost savings, and better transitions to rehabilitation or a home setting.

McLean strengthens its women’s mental health commitment.

Thanks to a generous donation from an anonymous donor, McLean Hospital is expanding its commitment to the mental health needs of women and girls by establishing the Women’s Mental Health Initiative. Research has shown that gender is often a significant factor in the risk, prevalence, presentation, course, and treatment of mental disorders.

Likewise, at a time when public resources for mental health are being reduced, McLean is stepping up its help for adolescents with substance abuse problems and is reaching out to college students.

Honoring a great doctor with a great new center of care.

“When Jerry Austen is the most important physician – really the most important person – to work at the MGH in the last 50 years and, in fact, one of the most important physicians in the 200-year history of this institution,” said Roman DeSanctis, MD, director emeritus of clinical cardiology. Surgeon-in-chief emeritus and chair of the MGH Chiefs’ Council, Dr. Austen has been a beloved and active leader in the MGH community for 57 years.

With 150 large private rooms for neuroscience and medical oncology patients, the Austen Inpatient Care Pavilion, located on the top five floors of the new Lunder Building, offers cutting-edge, patient- and family-centered care in a fitting tribute to its namesake.

Coordinating care for patients at highest risk.

Newton-Wellesley Hospital is focused on the relatively small number of patients who account for a very large portion of total medical expenses. A care coordinator works with the primary care physician and the patient to develop a plan that guides the course of care. The coordinator gets to know the patient and family and works to become a trusted member of the care team, helping the patient effectively navigate the health care system and guiding the patient to take steps that limit the need for emergency care or hospitalization. About 1,600 high-risk patients with complex medical conditions and chronic illnesses have been identified as candidates for this new care model.

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NSMC changes ER culture for the better.

With 92,000 visits a year, North Shore Medical Center operates one of the busiest emergency departments in the state. To more efficiently provide safe, consistent care, the Integrated Care and Rapid Evaluation (ICARE) team (left) at NSMC’s Salem Hospital has created a new, team-based approach to treating emergency patients that has decreased significantly their length of stay.

The team consists of a physician, nurse, physician’s assistant, unit secretary, nursing technician, and registration representative. “We documented every aspect of emergency care from our patients’ and caregivers’ perspective in extraordinary detail,” said ER physician and team member Steven Browell, MD. The team then made changes to improve patient flow and the overall patient experience, while still providing the highest quality care.
How Partners is achieving cost savings and improving care.

The year of the transplant at the Brigham.
A Brigham and Women’s surgical team, led by Bohdan Pomahac, MD, performed the nation’s first full face transplant in March, 2011; it was one of three such operations at the hospital this year. More than 30 physicians, nurses, and other clinicians worked for 15 hours to replace the face of Dallas Wiens, a 25-year-old man from Texas who lost his face in a devastating accident. The procedure involved the lips, nose, facial skin, muscles of the face, and the nerves that power them and provide sensation.

BWH teams also performed their first bilateral hand transplant in 2011. In October, Richard Mangino, a quadruple amputee from Revere, received a new pair of hands in a 12-hour surgery. A team of 40 conducted the delicate surgery, transplanting multiple tissues including skin, tendons, muscles, ligaments, bones, and blood vessels on both the left and right forearms and hands. Simon Talbot, MD, of Plastic and Reconstructive Surgery, led the hand transplantation team.

“I’m amazed to be given a life that you weren’t sure for quite a while that you were ever going to have again,” said Dallas Wiens.

National recognition for using technology to control costs.
Partners caregivers have used a sophisticated health IT system to determine which patients should have diagnostic imaging tests such as MRIs and CT scans. While nationally the cost to Medicare for imaging roughly doubled from 2001 to 2009, Partners’ imaging costs were flat from 2006 to 2009, and in some specialties even fell. Images per patient at Partners dropped 25 percent in that period.

In a Bloomberg News column Peter Orszag, former budget chief for the Obama administration, singled out Partners for its early adoption of electronic medical records (EMRs). EMR, he said, is an effective tool to limit unnecessary imaging tests and curb runaway health care costs. In 2003, when the late Partners CEO James Mongan initiated “High Performance Medicine,” only 10 percent of our physicians used EMR to improve quality and patient safety, and track a patient’s history. Today that number is 100 percent.

The Framingham Heart Study transformed cardiac care with far-reaching results. Researchers at BWH and Dana-Farber hope to do the same for cancer treatment through Profile, a study to create a database of genetic variations in cancer tumors. By understanding the genetic makeup of a tumor, doctors believe they can eventually tailor treatments to each patient’s form of cancer. Patients must consent to their tissue to being tested and used in the study. By linking the data with the patient’s electronic medical record, researchers can study which therapies are most effective against particular tumor types, and also design better clinical trials.

“For the first time, we have the opportunity to build a critical mass of genomic data that can be used to bring better treatments to patients,” says Neil Lindeman, MD, director, Center for Advanced Molecular Diagnostics at BWH.

Profiling cancer to improve treatment.

Getting wise about aging patients.
In response to the shortage of nurses and the anticipated population explosion as baby boomers age, Jeannette Ives Erickson, RN, DNP, and Ed Coakley, RN, MSN, MA, MEd, and numerous colleagues throughout nursing, launched a new program called MGH AgeWISE.

Dr. Erickson (left), senior vice president for Patient Care and chief nurse at MGH, explained that older nurses were given special training in the unique care needs of older patients in the final years of life. “We were able to retain nurses who might have retired, and those who completed the training feel a new sense of purpose.”

Creating change in real time: Innovation Units at MGH.
Twelve inpatient units at MGH are not only delivering quality care but are being used as testing grounds for new care-delivery models. These Innovation Units can assess new ideas as care is being delivered, meaning that positive changes can be adopted and spread quickly.

One of the new ideas is the creation of the job attending nurse, who will work along with the attending physician to ensure the timely delivery of admission to discharge. Other innovations include interdisciplinary team rounds to ensure that all caregivers can meet daily to address concerns and tackle obstacles, and a new discharge follow-up call program. “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 readmissions,” said Karen Rosenblum, RN, an attending nurse at MGH. “So many of these interventions are going to have a positive impact on patients and families.”

www.partners.org
How Partners is achieving cost savings and improving care.

**Making strides on total joint replacements, a $2.7 million savings plan.**
A special MGH team looked at the current process for patients undergoing total hip or knee replacement, from initial visit in the surgeon’s office to discharge, and identified areas where changes might reduce costs and improve efficiency. Team members estimated that their redesign proposals could lead to $2.7 million in annual savings. One proposal involved accelerated rehabilitation, providing physical therapy immediately following the procedure for certain patients to reduce their length of stay.

**Martha’s Vineyard Hospital brings new level of care to the island.**
Patients at Martha’s Vineyard Hospital have access to the island’s first fixed MRI machine, new and private rooms, a spacious ER, and operating rooms with advanced technologies. MVH doctors affiliated with MGH can prescribe digitally, use the electronic medical record, and participate in quality initiatives for patients with diabetes and hypertension.

**Nantucket to expand urgent care and streamline primary care.**
Nantucket Cottage Hospital will expand its outpatient urgent care services and improve its primary care scheduling system to better serve patients during its busy summer season. An administrator will schedule interim physicians from MGH and other short-term staff, opening more appointment times, especially for urgent care patients who might otherwise go to the ER.

**Going the extra miles to improve care and reduce waste.**
A team of clinicians from Newton-Wellesley Hospital is using state-of-the-art techniques for improving patient flow, standardizing medical tasks, decreasing waste, and increasing efficiency. Team members worked with leaders of the Virginia Mason Institute in Seattle to study how patients move through the system, and developed streamlined workflows. Physicians who are using the new “flow stations” have reported increased efficiency for patient and caregiver alike. Upcoming projects include the development of standardized work for medical assistants and better retrieval of patient data prior to visits.

**Keeping high-risk patients healthy, and lowering costs.**
Partners in Health might be best known for its vital work in Haiti, but its dedicated caregivers are also tackling important health issues at home. The PACT Project, a partnership between Partners in Health and BWH, is addressing health disparities in Boston neighborhoods.

Initially, PACT (Prevention and Access to Care and Treatment) provided community health workers to meet with high-risk HIV/AIDS patients in their homes, helping keep them on their medication and accompanying them to doctors’ appointments. Now it has expanded to include patients in underserved areas who suffer from other chronic illnesses such as diabetes. PACT has demonstrated strong success since its HIV/AIDS program began: 70 percent of patients have shown significant clinical improvement. By keeping patients healthier, PACT also lowers costs, with a 35 percent decrease in length of hospital stays, and a 60 percent drop in inpatient costs.

**Shared appointments: NSMC patients get better together.**
Terence Doorly, MD, a neurosurgeon and spine specialist at North Shore Medical Center is now seeing patients with similar neck and back injuries in small groups. He is the first Partners physician to offer “shared appointments.”

“Patients like the shared appointments because not only can they get in to see me a lot sooner, they also get a full hour and a half of education,” says Dr. Doorly, (right) who has been offering shared appointments at North Shore Physicians Group in Danvers. “They get the same level of personal attention that they would during an individual appointment, plus the added benefit of learning from the experiences of other patients.”

During the appointment, the six patients’ x-rays are displayed on a large-screen television as Dr. Doorly discusses possible causes and treatment options. By the time the session is over, each patient leaves having all of his or her questions answered – plus a few they might never have thought to ask. Building on its success, NSMC has begun offering shared medical appointments for primary care and diabetes patients as well.

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Patient portals: Gateway to better coordination of care.

Partners patients are continuing to flock to Patient Gateway, an online portal which helps patients better and more efficiently interact with their caregivers. In addition to the more traditional means of communication – face-to-face visits and phone calls – patients can go online to book appointments, get lab results, access their online medical records, and ask questions. By using Patient Gateway to address routine matters of patient care, caregivers can focus instead on more complex issues. The days of playing “phone tag” with busy clinicians may soon be over as Partners is committed to bringing this efficient communications tool to an increasing number of physician practices. At the end of 2010, 25 percent of Partners network physicians were offering Patient Gateway, and by the end of 2011 it was 60 percent, with more coming online all the time.

Kraft tackles shortage of community caregivers.
The Kraft Center for Leadership and Training in Community Health, established by a gift from the Kraft family to Partners, is responding to the increasing demand for community-based care by addressing the challenging shortage of caregivers in communities of need. The $20 million gift will support recruitment, retention, and public health skills enhancement of doctors and nurses to community health centers and similar care delivery settings, enabling these caregivers to make career-long commitments to improving the overall health of our communities. At the MGH-Chelsea Health Center, social worker Tania Soares (left) tends to refugee families.

The healing power of a job.
The Partners in Career and Workforce Development program is a rigorous six-week job training and internship program that enables Boston-area residents to take up careers in health care. “Partners has opened doors that some of us never even knew existed, and it has started a new chapter in each and every one of our life stories,” said Jessica Devance, a job-training graduate and class speaker, as she shared her thoughts with her classmates at graduation. Since it began in 2003, the program has graduated 355 young people and 85 percent have found full-time employment within our hospital network.

Patient navigators help patients keep appointments, saving lives and money.

Patient navigators help our patients in a variety of ways. For example, programs introduced by BWH and MGH encourage patients to keep appointments and prepare for colonoscopies. Over a nine-month period, 400 MGH-Chelsea patients who were assisted by a navigator were more than twice as likely to have colonoscopies as scheduled. Colonoscopies save lives by detecting and removing precancerous polyps throughout the colon before they can become malignant.

Since 2005, the Partners Primary Care Access Program has connected more than 9,000 patients who entered our hospitals through the ER and other departments to community-based primary care. With help from bilingual access coordinators, Partners is working to reduce use of costly hospital emergency departments.

Text messaging for pregnant women spreads to Jamaica Plain.

A pilot program at Lynn Community Health Center that uses text messaging to encourage pregnant women to receive the recommended level of prenatal care is now being offered to patients at BWH’s Brookside Community Health Center in Jamaica Plain. The program will run for one year and is open to all pregnant patients at the health center who are followed by a BWH midwife – at least 100 patients. In Lynn, the messages were found to give the moms-to-be a feeling of being closely connected to their care team.

Spaulding chosen to heal wounds from war in Libya.

Twenty-two wounded Libyan fighters were treated at Spaulding Rehabilitation Hospital North Shore. Spaulding, which specializes in long-term care and rehabilitation, was selected by the U.S. State Department for its ability to deal with a variety of serious injuries, including trauma to the brain. The soldiers, ages 16 to 40, were suffering from multiple traumas, gunshot wounds, and nerve damage sustained while fighting against the Gaddafi dictatorship. Surgical procedures were performed at North Shore Medical Center’s Salem Hospital as well as at BWH and MGH, particularly for hand and arm injuries.

www.partners.org
Two Partners hospitals ranked in top ten in nation by USNews & World Report.

Our two founding hospitals were again ranked among the top ten hospitals in the nation on the annual “honor roll” of America’s hospitals compiled by USNews & World Report. Both hospitals made significant leaps on the list, with MGH rising to the number two spot and BWH rising to number eight. McLean Hospital ranked third nationally in psychiatric care and remains the highest freestanding psychiatric hospital honored, while Spaulding Rehabilitation was rated fifth among all rehabilitation hospitals in the country.

Giving Adele her voice back.

MGH surgeon Steven Zeitels, MD, was thanked from the stage by Adele Atkins when she accepted the first of her six Grammy Awards for 2011. That evening marked the first time Adele had sung publicly since successful surgery at MGH. Dr. Zeitels is Director of the MGH Voice Center, which provides thousands of patients annually with the same state-of-the-art care that brings famous voices like Adele, Steven Tyler, and Julie Andrews to MGH.

BWH earns nursing honor.

In recognition of the exceptional care that its nurses provide to patients and families, the BWH Cardiac Surgery ICU was honored with the American Association of Critical Care Nurses’ Beacon Award for Excellence – Gold status. For patients and their families, the Beacon Award signifies excellence in patient care through improved outcomes and greater overall satisfaction.

Partners green saves green.

Since the Partners Sustainability Initiative began in 2008, energy use has dropped 9 percent across the system, amounting to $6 million in cost savings. And since operating in an environmentally responsible manner opens up new opportunities in delivering safe and cost-efficient care, Partners aims to reduce energy consumption by more than 25 percent by 2014.

The last four major buildings built by Partners, including the Lunder Building at MGH (right) and the Shapiro Cardiovascular Center at BWH (left), are LEED certified or on track to be, with energy consumption as much as 40 percent below energy code standards. “Green Teams” across Partners are working to reduce medical waste and increase recycling, with a positive result for the environment as well as a potential 50 percent drop in disposal costs.

Tradition of excellence.

18 Nobel laureates have trained or practiced at Partners-affiliated institutions.

2011: Ralph M. Steinman, MGH
2009: Jack Szostak, MGH
1998: Ferid Murad, MGH
1990: Joseph E. Murray, BWH
1990: E. Donnell Thomas, BWH
1989: J. Michael Bishop, MGH
1985: Herbert L. Abrams, BWH
1985: Michael S. Brown, MGH
1985: Eric Chivian, MGH
1985: Joseph L. Goldstein, MGH
1985: Bernard Lown, BWH
1985: James Muller, MGH
1980: Baruj Benacerraf, DFCI
1972: Gerald M. Edelman, MGH
1966: Charles B. Huggins, MGH
1953: Fritz Lipmann, MGH
1934: George R. Minot, MGH
1934: William P. Murphy, MGH

www.partners.org
Partners HealthCare is an integrated health system founded in 1994 by Brigham and Women’s Hospital and Massachusetts General Hospital. In addition to its two academic medical centers, the Partners system also includes community and specialty hospitals, community health centers, a physician network, home health and long-term care services, and other health-related entities. Partners is one of the nation’s leading biomedical research organizations and a principal teaching affiliate of Harvard Medical School. Partners HealthCare is a non-profit organization.

FOUNDING MEMBERS:
- Brigham and Women’s Hospital
- Massachusetts General Hospital

MEMBERS:
- Brigham and Women’s Physicians Organization
- Faulkner Hospital
- Martha’s Vineyard Hospital
- Massachusetts General Physicians Organization
- McLean Hospital
- MGH Institute of Health Professions
- Nunnally Cottage Hospital
- Newton-Wellesley Hospital
- North Shore Health System
- North Shore Medical Center:
  - Salem Hospital
  - Union Hospital
- MassGeneral for Children at North Shore Medical Center
- North Shore Physicians Group
- Partners Community HealthCare, Inc.
- Partners Community Health Centers:
  - BWH Health Centers:
    - Brookside Community Health Center
    - Southern Jamaica Plain Health Center
  - MGH Health Centers:
    - Charlestown HealthCare Center
    - Chelsea HealthCare Center
    - Revere HealthCare Center
- Independently Licensed Health Center (relationship with MGH)*
- Partners Continuing Care:
- Spaulding Rehabilitation Network
  - Spaulding Rehabilitation Hospital
  - Spaulding Hospital Cambridge
  - Spaulding Hospital North Shore
  - Spaulding Rehabilitation Hospital Cape Cod
  - Spaulding Nursing & Therapy Center North End
  - Spaulding Nursing & Therapy Center West Roxbury
  - Clark House
- Partners HealthCare at Home

MAJOR TEACHING AFFILIATE OF:
- Harvard Medical School

*The NECHC has a unique governance structure and affiliation arrangement with MGH that is not currently reflected in this chart reflecting the health center’s historic independence.

Partners HealthCare Leadership

Partners Trustees
- Jack Connors, Jr., Chair
- Edward P. Lawrence, Esq., Vice Chair
  - (from July, 2011)
- Anne M. Fimscane
- Charles K. Gifford
- Gary L. Gottlieb, M.D.
- Richard E. Holbrook
  - (from July, 2011)
- Albert A. Holman, III
- Professor Jay O. Light
- Stanley J. Lukowski
  - (from July, 2011)
- Maury E. McGough, M.D.
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#### Chiefs of Service

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<tr>
<th>Community Hospitals (continued)</th>
<th>Faulkner Hospitals</th>
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<tr>
<td>North Shore Medical Center</td>
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<tr>
<td>Prodyut Poddar, M.D. Chief of Thoracic Surgery NSMC Union Hospital</td>
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<tr>
<td>Allison L. Preston, M.D. Chair of Obstetrics and Gynecology North Shore Medical Center</td>
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<tr>
<td>Keith W. Rae, D.M.D., M.D. Chief of Plastic Surgery North Shore Medical Center</td>
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<td>Coleen Reid, M.D. Chief of Palliative Care North Shore Medical Center</td>
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<tr>
<td>David J. Roberts, M.D. Chair of Medicine (from April, 2011) Chief of Cardiology North Shore Medical Center</td>
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<td>Marc S. Rubin, M.D. Chair of Surgery North Shore Medical Center</td>
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<td>Mark A. Schechter, M.D. Chair of Psychiatry and Mental Health North Shore Medical Center</td>
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<td>Joel H. Schwartz, M.D. Chief of Hematology/Oncology North Shore Medical Center</td>
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<td>M. Christian Semne, M.D. Chair of Radiology North Shore Medical Center</td>
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<td>Neil S. Shore, M.D. Director of Pulmonary/Intensive Care NSMC Salem Hospital</td>
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<td>Glynn D. Stanley, M.D. Chief of Anesthesia North Shore Medical Center</td>
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<td>Khalid Syed, M.D. Chief of Rheumatology North Shore Medical Center</td>
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<td>O’Neil A. Britton, M.D. Intern Chief of Medicine Faulkner Hospital (from July, 2011)</td>
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<td>James Grosser, M.D. Chief of Anesthesiology Faulkner Hospital</td>
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<td>Pardon R. Kenney, M.D. Chief of Surgery Faulkner Hospital</td>
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<td>Richard E. Larson, M.D. Chief of Emergency Medicine Faulkner Hospital</td>
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<td>Stephen Pearson, M.D. Chief of Pathology Faulkner Hospital</td>
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<td>Stephen Ledbetter, M.D. Chief of Radiology Faulkner Hospital (from June, 2011)</td>
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<td>Martin A. Samuel, M.D. Chief of Neurology Brigham and Women’s Faulkner Hospitals</td>
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<td>Michael Wilson, M.D. Chief of Orthopedics Faulkner Hospital</td>
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<td>Stephen C. Wright, M.D. Chief of Medicine Faulkner Hospital (through July, 2011)</td>
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<td>Avraham Almozlino, M.D. Chief of Neurology Newton-Wellesley Hospital</td>
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<td>Mary Chris Bailey, M.D. Chief, Pediatric Emergency Medicine Newton-Wellesley Hospital</td>
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<td>Joel Bax, M.D. Chair of Pediatrics Newton-Wellesley Hospital</td>
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<td>Thomas L. Beatty, M.D. Chair of Obstetrics and Gynecology Newton-Wellesley Hospital</td>
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<td>Dennis J. Beer, M.D. Chief of Pulmonary Medicine Newton-Wellesley Hospital</td>
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<td>Mark R. Belasky, M.D. Acting Chair, Department of Orthopaedics Newton-Wellesley Hospital</td>
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<td>Joanne Borg-Stein, M.D. Chief of Physical Medicine &amp; Rehabilitation Newton-Wellesley Hospital</td>
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<td>John A. Burbler, D.M.D. Chief of Oral Surgery Newton-Wellesley Hospital</td>
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<td>Herbert Cares, M.D. Acting Chief of Neurosurgery Newton-Wellesley Hospital</td>
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<td>Thomas Cunningham, M.D. Chief of General Internal Medicine Newton-Wellesley Hospital</td>
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<td>Richard L. Curtis, M.D. Chief of Gastroenterology Newton-Wellesley Hospital</td>
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<td>Henry D’Angelo, M.D. Chair of Family Medicine Newton-Wellesley Hospital</td>
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<td>Sandra M. Fitzgerald, M.D. Chief of Psychiatry Newton-Wellesley Hospital</td>
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<td>Lawrence S. Friedman, M.D. Chair of Medicine Newton-Wellesley Hospital</td>
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<td>Henning Gausser, M.D. Chief of Thoracic Surgery Newton-Wellesley Hospital</td>
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<td>Don L. Goldberg, M.D. Chief of Rheumatology Newton-Wellesley Hospital</td>
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<td>Anthony J. Guidi, M.D. Chair of Pathology Newton-Wellesley Hospital</td>
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<td>Eric Hazen, M.D. Chief of Child and Adolescent Psychiatry Newton-Wellesley Hospital (from February, 2011)</td>
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<td>Esther J. Isselb, M.D. Chief of Pediatric Gastroenterology Newton-Wellesley Hospital</td>
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<td>Jacob Joffe, M.D. Chair of Anesthesiology Newton-Wellesley Hospital</td>
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<td>Jeffrey Lamont, M.D. Chief of Urology Newton-Wellesley Hospital</td>
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<td>William LoVerme, M.D. Chief of Plastic Surgery Newton-Wellesley Hospital</td>
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<td>Steven Miller, M.D. Chief of Pediatric Surgery Newton-Wellesley Hospital</td>
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<td>Christopher Mays, M.D. Acting Chief of Primary Care Newton-Wellesley Hospital</td>
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<td>Scott L. Rauch, M.D. Psychiatrist in Chief McLean Hospital</td>
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<td>Richard L. Zaniewski, D.O. Chief of Rehabilitation Medicine Spaulding Hospital North Shore</td>
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Our vision

To dedicate ourselves to the delivery of superior care that is patient- and family- centered, accessible, and equitable.

To provide a coordinated, cost-efficient, and transparent care model that will benefit patients across the continuum from prevention to long-term.

To touch the communities we serve, local or global, with sustainable improvements in the care we provide, with a keen focus on underserved populations.

To lead in research that fosters collaboration, bringing discovery to the patient’s bedside, and sharing those successes with the world so future generations may benefit.

To invest in education and training to nurture the next generation of leaders who can carry forward the lessons learned.

To seek ways to deliver the highest quality health care to all.

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SIR,

It has appeared very desirable to a number of respectable gentlemen, that a hospital for the reception of lunatics and other sick persons should be established in this town. By the appointment of a number of these gentlemen, we are directed to adopt such methods, as shall appear best calculated to promote such an establishment. We therefore beg leave to submit for your consideration proposals for the institution of a hospital, and to state to you some of the reasons in favour of such an establishment.

It is unnecessary to urge the propriety and even obligation of succouring the poor in sickness. The wealthy inhabitants of the town of Boston have always evinced that they consider themselves as "treasures of God's bounty," and in Christian countries, in countries where Christianity is practised, it must always be considered the first of duties to visit and to heal the sick. When in distress every man becomes our neighbour; not only if he be of the household of faith, but even though his misfortunes have been induced by transgressing the rules both of reason and religion. It is unnecessary to urge the truth and importance of these sentiments to those who are already in the habit of cherishing them; to those, who indulge in the true luxury of wealth, the pleasures of charity. The questions, which first suggest themselves on this subject, are whether the relief afforded by hospitals is better than can be given in any other way; and whether there are in fact so many poor among us, as to require an establishment of this sort.

True relief to be afforded to the poor, in a country so rich as ours, should perhaps be measured only by their necessities. We have then to inquire into the situation of the poor in sickness, and to learn what are their wants. In this inquiry we shall be led to answer both the questions above stated.

There are some, who are able to acquire a competence in health, and to provide so far against any ordinary sickness, as that they shall not then be deprived of a comfortable habitation, nor of food for themselves and their families; while they are not able to defray the expenses of medicine and medical assistance. Persons of this description never suffer among us. The Dispensary gives relief to hundreds every year, and the individuals who practice medicine gratuitously attend many more of this description. But there are many others among the poor, who have, if we may so express it, the form of the necessities of life, without the substance. A man may have a lodging, but it is deficient in all those advantages, which are requisite to the sick. It is a garret, or a cellar, without light and due ventilation, or open to the storms of an inclement winter. In this miserable habitation he may obtain liberty to remain during an illness, but, if honest, he is harassed with the idea of his accumulating rent, which must be paid out of his future labours. In this wretched situation the sick man is destitute of all those common conveniences, without which most of us would consider it impossible to live, even in health. Wholesome food, and sufficient fuel are wanting, and his own sufferings are aggravated by the cries of hungry children. Above all, he suffers from the want of that first requisite in sickness, a kind and skilful nurse.

But it may be said that instances are rare among us, where a man, who labours with even moderate industry, when in health, endures such privations in sickness as are here described. They are not however rare among those, who are not industrious, and who, nevertheless, when labouring under sickness, must be considered as having claims to assistance. In cases of long protracted disease, instances of such a description do occur amongst those of the most industrious class. Such instances are still less rare among those women, who are either widowed, or worse than widowed. It happens too frequently that modest and worthy women are united to men, who are prodigal and intemperate, by whom they are left to endure disease and poverty under the most aggravated forms. Among the children of such families instances are not rare of real suffering in sickness. To all such as have been described, a hospital would supply every thing which is necessary, if not all they could wish. In a well regulated hospital they would find a comfortable lodging in a duly attempted atmosphere; would receive the food best suited to their various conditions; and would be attended by kind and discreet nurses, under the directions of a physician. In such a situation the poor man's chance for relief would be equal perhaps to that of the most affluent, when affected with the same disease.

There are other persons also, who are of great importance in society, to whom the relief afforded by a hospital is exceedingly appropriate. Such are generally those of good and industrious habits, who are affected with sickness, just as they are entering into active life, and who have not had time to provide for this calamity. Cases of this sort are frequently occurring. Disease is often produced by the very anxiety and exertions, which belong to this period of life; and the best are the most liable to suffer. Of such a description, cases are often seen among journeymen mechanics, and among servants.

Journeymen mechanics commonly live in small boarding houses, where they have accommodations which are sufficient, but nothing more than sufficient, in health. —When sick, they are necessarily placed in small, confined apartments, or in rooms crowded with their fellow-workmen. They are sheltered from the weather, and have food of some sort, and these must in many cases be the extent of their accommodations. Persons of this description would do well to enter a hospital, even if they had to pay the expense of their own maintenance: In most cases they would suffer less, and recover sooner by so doing. When, as sometimes happens, they have not the means of payment, they become objects of charity, and the welfare of such persons should be considered among the strong motives in favour of establishing a hospital.

Servants generally undergo great inconveniences at least, when afflicted with sickness; and oftentimes much more than inconveniences. With so much difficulty is the care of them attended in private families, that many gentlemen would pay the board of their servants at a hospital, in preference to having them sick in their own houses. In some cases however, neither the master nor servant can afford the expense of proper care in sickness. Not uncommonly a young girl is taken sick in a large family, where she is the only servant. She lodges in the most remote corner of the house, in a room without a fire-place. The mistress is sufficiently occupied with the unusual labours, which are thrown on her, at a time, perhaps, when she is least fitted to perform them. Under such circumstances how can the servant receive those attentions, which are due to the sick. Of what use is it that the physician leaves a prescription to be put up, if honest, he is harassed with the idea of his accumulating rent, which must be paid out of his future labours. In this wretched situation the sick man is destitute of all those common conveniences, without which most of us would consider it impossible to live, even in health. Wholesome food and sufficient fuel are wanting, and his own sufferings are aggravated by the cries of hungry children. Above all, he suffers from the want of that first requisite in sickness, a kind and skilful nurse.

There is one class of sufferers, who peculiarly claim all that benevolence can bestow, and for whom a hospital is most especially required. The virtuous and industrious are liable to become objects of public charity, in consequence of diseases of the mind. When those, who are unfortunate in this respect, are left without proper care, a calamity which might have been transient, is prolonged through life. The number of such persons, who are rendered unable...
As we approach our bicentennial year, it is natural to look behind us and think about where we have been. We look back with special pride to August 1810 when this hospital was just a dream our founders argued for in a fundraising letter, the text of which is printed on the inside covers of this report. Known as the “circular letter,” this document still rings true in many ways today. Excerpts from the letter serve as inspiration for the stories found in this report. Those days were the crucible of our mission, and while we have expanded and enlarged our vision, we have not changed our purpose. Nor will we.

Standing at this moment, we appreciate the achievements of our forerunners, but from personal experience, I know that MGHers are forward thinkers. As the stories in this year’s Journeys reflect, this institution is defined by individuals who are constantly looking ahead and working toward a goal, whether they are clinicians like Susan Briggs and Nora Sheehan struggling to bring hope to patients in the face of implacable disaster, researchers like Jack Szostak and Bruce Walker searching for clues to the mysteries of biology, or nurses like Karen Clark and Beth West, ever vigilant in their efforts to bring a difficult pregnancy to term. I am constantly grateful that such persistent efforts to make this world a better place are common at Mass General – a goal that has motivated this hospital for 200 years.

The future of Mass General Hospital is as solid as the Building for the Third Century, now standing at the center of our campus. I can think of no better symbol of all our hopes and dreams than this – a grand and shining example of the support of our employees, trustees, donors and friends who collectively have guided us in the past and are now showing us the way to the future.

And so we look forward, both to a momentous bicentennial year and to the next two centuries, with confidence, pride and gratitude – and more than a little wonder.

Peter L. Slavin, MD
President
Massachusetts General Hospital
In June 2009, David Bangsberg, MD, MPH, was appointed director of the MGH Center for Global Health. Launched in 2006, the center seeks to build on the MGH’s long tradition of global health outreach and serves as a hub for the MGH’s activities around the globe, whether disaster response, research or patient care.

Kristian Olson, MD, MPH, of the Center for the Integration of Medicine and Innovative Technology Global Health Initiative, was named to the 2009 Scientific American Top 10 Honor Roll, which recognizes individuals who have demonstrated leadership in applying new technologies and biomedical discoveries for the benefit of humanity. Olson was honored for his work training midwives in developing countries to help newborns breathe by using a simple, inexpensive “Tekno-Tube.” Olson also has developed a neonatal incubator from car parts, which could make this life-saving equipment more accessible in rural hospitals.

MGHers Paritosh Prasad, MD; Chad T. Wilson, MD; Kerry Dierberg, MD; and Joy Williams, RN, were awarded the 2009 Thomas S. Durant Fellowship in Refugee Medicine. Created in 2003, the fellowship honors the life and work of the late Thomas S. Durant, MD, who had dedicated his career to helping victims of international crises, famine, war and disaster. Prasad served in Ethiopia and Cambodia, focusing on HIV care, while Wilson served as a surgical mentor in Kenya. Dierberg ran an HIV clinic and medical and pediatric wards in Liberia, and Williams served aboard the USNS Comfort in Haiti and helped start a rehabilitation clinic in that country.

On Jan. 12, 2010, the world watched in horror as the tiny island nation of Haiti suffered a 7.0-magnitude earthquake that sent the country reeling into disaster. As buildings cracked and crumbled in the capital of Port-au-Prince and surrounding areas, many victims, injured and trapped, could only wait for rescue teams to mobilize and begin searching for survivors. Hours after the initial quake, volunteers from the MGH prepared to join relief efforts.

Serving with two federal organizations – the Boston-area MA-1 Disaster Medical Assistance Team and the International Medical Surgical Response Team (IMSuRT) East – MGH volunteers arrived in the country just days after the disaster. Along with these federal agencies, the MGH supported two relief organizations: Project HOPE, which provides care aboard U.S. Navy ships, and Partners in Health, an international health and social justice organization based at Brigham and Women’s Hospital.

“When conditions on the ground were as bad as they could be,” says Susan Briggs, MD, MPH, MGH trauma surgeon, director of the MGH International Trauma and Disaster Institute, and founder of IMSuRT. “We knew, even after the initial phase of caring for traumatic injuries, that the Haitian people would be affected for years to come.”

As weeks turned into months, MGH doctors, nurses and support staff continuously deployed to Haiti. Working alongside the Haitian people, volunteers shared heartache and hope, laughter and tears. Back in Boston, the MGH community organized supply shipments and a relief fund to support Haitian employees whose families had suffered losses most individuals will not experience in a lifetime.

Since the earthquake, more than 90 volunteers from the MGH have deployed to Haiti – motivated in part by the hospital’s longtime practice of reaching out, in the spirit of human dignity, to serve the most vulnerable with compassionate care wherever they may be.

Nora Sheehan, RN, of General Medicine, cares for a Haitian patient while serving with Project HOPE aboard the USNS Comfort.

Inset: In 1917, the MGH sent medical personnel to Halifax, Nova Scotia, to aid victims of a munitions ship explosion that devastated the city. To this day, Nova Scotia sends Boston a large tree each Christmas as a special thank you.
The Survivorship Program at the MGH Cancer Center began accepting patients for care as of June 2010. The program provides treatment, counseling and support for patients and their loved ones facing the challenges of living with and beyond cancer.

MGH investigators reported in August 2010 that integrating palliative care early on in the treatment of patients with advanced lung cancer not only improved their mood and quality of life, but also extended their lives.

The beneficial effects of antiangiogenesis drugs in the treatment of the deadly brain tumors called glioblastomas appear to result primarily from reduction of edema – the swelling of brain tissue – and not from any direct antitumor effect, according to a study from MGH researchers. Their findings, published in 2009, suggest that antiangiogenesis therapy can increase patient survival even in the face of persistent tumor growth.

In 2009, a combination Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) prototype machine was tested at the MGH Cancer Center, the only place in the world this machine was being used in clinical trials. In addition to saving patients time and anxiety by combining tests, researchers are optimistic that the combination MRI/PET imaging technology will soon translate into vast improvements in patient care.

ENEE WEAVER, a lifelong nonsmoker, was devastated when at age 39, she was diagnosed with metastatic stage IV lung cancer. Luckily for Weaver, the MGH had opened the Translational Research Laboratory in March 2009. The new lab has been pivotal for some cancer patients who simply have nowhere else to go.

A distinctive joint venture of the MGH Cancer Center and the Department of Pathology, the laboratory’s mission is to uncover genetic codes and gene mutations in patients’ tumors and match them to available targeted therapies. Many of the Translational Research Laboratory patients are among the first recipients of what is known as personalized cancer care.

“There is a palpable feeling of energy that we are turning a corner in how we diagnose and treat cancers,” says Leif Ellisen, MD, PhD, who is co-executive director of the lab with A. John Iafrate, MD, PhD. “We believe that the profiling of tumors – molecular fingerprinting – will become more and more integrated with clinical practice in the very near future.”

Weaver’s tumor was analyzed and found to have a mutation that was causing her cancer to grow uncontrollably. Based on this information, she was placed on a new, targeted drug, which immediately began to shrink her tumors.

“This is an exciting time to be a scientist studying cancer,” notes Ellisen. “It used to take 10 years or more for cancer research results to be translated from bench to bedside. Now it takes just months to bring therapies to patients. It’s a whole new era.”

“I’m taking it a day at a time,” Weaver says. “Whether the results will be this great next time, who knows? But I’m feeling good. I’m trying to get back to a normal life. Thank God for the researchers and doctors who have made this happen. I don’t want to think about where I’d be without them.”

“... the sick man is destitute of all those common conveniences, without which most of us would consider it impossible to live ...”

Darrell Borger, PhD, co-director of the Translational Research Laboratory, examines a specimen from a lung cancer patient.

Inset: The MGH Mallinckrodt Laboratory, circa 1935
Two of the six Nursing Spectrum 2009 National Nurses of the Year were Grace Good, APRN, BC, leader of Team 5 of the Hospitalist Medical Service, and Adele L. Keeley, RN, BSN, MA, nursing director of the Medical Intensive Care Unit.

Susan Lee, RN, PhD, of the Yvonne L. Munn Center for Nursing Research, received a $900,000 grant from the Health Resources and Services Administration. The grant will fund a project focusing on the expansion of nursing knowledge, skills and competencies related to evidence-based practice (EBP) through continuing education programs; opportunities for nurses to participate in mentored, unit-based EBP projects; and the creation of an organizational infrastructure essential to supporting and sustaining EBP at the MGH.

The Gil Minor Nursing and Health Professions Scholarship was established as part of an effort to increase the number of MGH Patient Care Services (PCS) employees from diverse backgrounds. Five scholarships were given in 2009.

The Dedicated Education Unit (DEU) opened on the Ellison 7 Surgical/Trauma Unit in 2009. The DEU is an innovative model of clinical nursing education in which the entire unit serves as a teaching environment.

In 2009, Deborah Washington, RN, PhD(c), director of the PCS Diversity Program, became the inaugural recipient of the Arnold Z. Rosoff Agent of Change Award and was named a Champion in Health Care by Boston Business Journal.

HEY SAY it takes a village to raise a child – but for expectant mothers who require dialysis, it can also take a village to have one.

Five years ago, 36-year-old Noemy Rivera, originally from El Salvador, was diagnosed with Wegener’s granulomatosis. This rare disorder causes inflammation of the blood vessels, which in turn limits blood flow to various organs. To manage the disease, Rivera requires daily medication and lifelong dialysis.

When Rivera discovered she was pregnant in January 2008, she was excited, but also scared. Receiving dialysis while pregnant presents problems for both the mother and baby; reaching the normal 40 weeks of gestation would be a battle against time.

After her 24th week of pregnancy, Rivera came to the MGH, where one of her caregivers set a goal: for Rivera’s pregnancy to reach its 30th week. The challenge would require the teamwork of many – physicians, nurses, social workers and interpreters. Karen Clark, RN, of the Hemodialysis Unit, and Beth West, MSN, RN, of the Labor and Delivery Unit, were among those who rose to the challenge.

“Being pregnant while on dialysis carries many risks,” says West. “The normal medications and dialysis Noemy received had to be carefully adjusted now that there were two patients instead of one.”

“Arrangements were made for Noemy to receive her dialysis treatments in the Labor and Delivery Unit,” adds Clark. “We needed to be able to monitor both her and her baby’s health.”

Fluid volume, blood chemistry and blood pressure were only some of the factors the nurses had to closely track and react to in a moment’s time. After weeks of vigilant care, Rivera was transferred to the Surgical Intensive Care Unit because of hypertension and an unrelenting cough. But she had made it to 32 weeks, a full two weeks beyond the original goal – and the baby, Anthony, who was delivered through Caesarean section, was healthy. He turned two in July 2010.

“Seeing my son for the first time was indescribable,” says Rivera. “I am thankful to everyone at the MGH, especially the nurses, who cared for me with skill and kindness.”

Teamwork among nurses in the Hemodialysis and Labor and Delivery units, including Karen Clark, RN, left, and Beth West, MSN, RN, center, enabled Noemy Rivera to give birth to her son, Anthony.

Inset: MGH nurses, circa 1860

“Above all, he suffers from the want of that first requisite in sickness, a kind and skilful nurse.”
ELLY HOLMES is amazed by the care her daughter Kassie received at MassGeneral Hospital for Children (MGHfC). A premature birth had left Kassie with developmental delays and severely damaged kidneys, ultimately requiring a kidney transplant.

“First we were told she had 48 hours to live, then one week, and now here she is, 14 years later,” says Holmes.

Holmes remembers when her newborn daughter was in the Neonatal Intensive Care Unit, and the infant’s blood pressure was difficult to regulate. Kassie was placed on peritoneal dialysis and a variety of medications. She eventually came off dialysis, but she was left with chronic kidney disease.

“They didn’t think she would ever walk, maybe not even talk,” says Holmes. “They didn’t think she’d get very far at all.”

Kassie’s kidney function deteriorated over the years to dangerous levels. Finally she was faced with going back on dialysis or receiving a transplant. Her parents felt a transplant was the best option. To their relief, both were matches for their daughter.

“Kassie was a candidate for a transplant regimen that did not include steroids,” explains Avi Traum, MD, MGHfC nephrologist. “We felt this would be important for her, given the side effects associated with steroids. We also were encouraged that her parents were both potential donors, so Kassie could receive a pre-emptive transplant without having to suffer on dialysis.”

On Aug. 18, 2009, Kassie and her mother had surgery at the MGH. Within three weeks, Kassie was “up and running.”

“We’ve experienced major changes since her transplant,” says Holmes. “Kassie has more energy, and she is much happier. Her teachers have noticed that her attention level is way up, as is her receptiveness to what she is learning.” Kassie’s appetite and strength also have improved dramatically.

“She now tells us she’s hungry,” says her mother, “And she has no restrictions – she can eat whatever everyone else eats. She has the energy to ride her bike again, and she can keep up with the kids on the playground. The level of care we received – from the physicians to the front desk staff – was incredible.”

Kassie Holmes, left, and MGHfC nephrologist Avi Traum, MD

Inset: MGH co-founder Dr. James Jackson with his granddaughter, circa 1850

MGHfC made international headlines in 2009 by introducing the world to the term “third-hand smoke,” defined by physician-researcher Jonathan Winickoff, MD, MPH, as “tobacco smoke contamination that remains after the cigarette has been extinguished.” This effort to protect children from toxic particles has led to increased smoking cessation programs across Massachusetts and other parts of the United States.

To raise awareness of pediatric cancer research and treatment, members of the Boston Bruins and MGHfC’s Howard Weinstein, MD, chief of Pediatric Hematology/Oncology, had their heads shaved in April 2009 for the second annual “Cuts for a Cause” event with WBCN radio to benefit the MGHfC Cancer Center and the Boston Bruins Foundation. The event raised $28,000.

In 2009, Red Sox slugger David Ortiz proved his work extends far beyond the baseball field by partnering his David Ortiz Children’s Fund (DOCF) with MGHfC. The DOCF is committed to providing pediatric critical care and was founded following Ortiz’s visits to acutely ill children in his home country of the Dominican Republic.

The Trauma Clinic at MGHfC was established in late 2008 to provide comprehensive evaluation and timely specialty referrals for children who have sustained a traumatic injury and previously undergone evaluation and treatment in a hospital or ambulatory setting.
“In such a situation the poor man’s chance for relief would be equal perhaps to that of the most affluent, when affected with the same disease.”

The DOZEN WOMEN gathered at the Revere HealthCare Center for a meeting of the HAPPY Hearts Program huddle over worksheets testing their knowledge of blood pressure medications. The topic of the evening is blood pressure control, and the program’s health coaches are arming the women with information they need to tackle hypertension.

The Heart Awareness and Primary Prevention in Your Neighborhood (HAPPY) Program offers personalized care for low-income English- and Spanish-speaking women in Chelsea and Revere. The program introduces participants to lifestyle enhancements – such as exercise, smoking cessation, stress reduction and diet changes – that can help them achieve better health.

Malissa Wood, MD, co-director of the Corrigan Women’s Heart Health Program at the MGH Heart Center, established HAPPY Hearts to evaluate which primary prevention methods are effective at reaching this population of women, who tend to have a higher prevalence of risk factors for cardiovascular disease.

“If preventive medicine is going to be the mandate and the goal, then we need to start doing it the right way,” says Wood. “HAPPY Hearts is providing the participants with the knowledge and tools to address their individual risk factors.”

HAPPY Hearts tackles economic barriers by pairing each woman with a health coach who addresses her individual needs and provides her with opportunities that encourage long-term lifestyle changes. For those who can't make the weekly meeting, there's a Saturday morning walking group and one-on-one coaching in person and by phone. Participants also have free access to classes and services offered by the MGH Community Health Associates Wellness Center.

HAPPY Hearts is in its second year, and participants are already healthier, more active and less stressed, says Wood. For participant Lennie Lyons, the program has been a learning experience, introducing her to many activities she now enjoys, like tai chi and yoga. “It has gotten me out, and I’m much more active than I was before the program,” she says.

Eliana Pinelo, clinical research coordinator for the HAPPY Hearts Program, leads a Zumba aerobic dance class for the program’s participants and staff at the MGH Chelsea HealthCare Center.

Inset: Famed MGH cardiologist Paul Dudley White, MD, left, is playfully “examined” by his patient, President Dwight D. Eisenhower, circa 1958.
“Disease is often produced by the very anxiety and exertions, which belong to this period of life; and the best are the most liable to suffer.”

TRISH, a young mother in western Massachusetts, became concerned when her son began struggling in the classroom. “Christian was falling behind academically, and the anxiety of not learning began affecting him socially,” she says. “School officials thought he might be autistic, and since the town had an autism program, they recommended he enter it.”

Uncomfortable with the recommendation, Trish contacted Ellen Braaten, PhD, director of the Learning and Emotional Assessment Program (LEAP) in the MGH Department of Psychiatry. LEAP’s experts work with parents and school administrators to negotiate the complexities of child development and school-based learning. The program offers neuropsychological assessment, evaluation and consultation services for children ages 2 to 22.

After careful analysis of Christian’s cognitive skills, academic achievement, memory, language functioning, and his organizational and planning skills, Braaten diagnosed him with attention-deficit/hyperactivity disorder. Armed with this knowledge, Braaten joined Trish at a meeting at the school to ensure Christian’s needs would be met.

Such innovative programs are a hallmark of the MGH Department of Psychiatry, which was established in 1934 with a $50,000 grant from the Rockefeller Foundation. That gift helped bring psychiatry from the asylum setting into mainstream medicine. Since that time, the department has led the way in helping to reduce the stigma of mental illness by fostering a better understanding of its biological nature.

The Department of Psychiatry remains on the leading edge of recognizing and treating patients at high risk of psychiatric illness, among them adolescents and young adults like Christian. New initiatives aimed at this group are helping patients before their illness progresses.

“Christian was going to be put into a classroom situation that we didn’t feel was the right fit,” explains Trish. “Before working with LEAP, we felt completely stuck. We are grateful to the MGH and Dr. Braaten for changing that.”

LEAP Program Director Ellen Braaten, PhD, counsels and conducts assessments of children, adolescents and young adults.

Inset: Stanley Cobb, MD, the first chief of MGH Psychiatry, from 1934 to 1954, has been called the father of biological psychiatry in the United States.
“...women, who are unable to provide for their own welfare and safety, in one of nature’s most trying hours.”

Of all the babies delivered each year at the MGH Vincent Department of Obstetrics and Gynecology, 30 percent are born to mothers who receive their obstetrical care at one of the hospital’s community health centers. Some of these women endure living situations filled with poverty and isolation. They have few places to turn to for advice and limited access to help.

This was the case for one patient, Chrissie. Pregnant with her second child, Chrissie returned home one day close to her due date to discover that her apartment in Chelsea had been robbed of everything – including all the baby items she had worked so hard to afford. When her midwife and other staff at the MGH Chelsea HealthCare Center heard about her situation, they gathered furniture, diapers and other items to give to Chrissie when the baby arrived. They also directed her to programs available through the obstetrics practice for women and their families.

“Women’s health is not just about physical well-being,” says Alessandra Peccei, MD, director of Obstetrics and Gynecology for the MGH Community Health Centers. “In addition to providing high-quality care to these women and their children, we also tend to their emotional health and the needs of their families. Often, that’s where we make a tangible difference.”

At the MGH Chelsea HealthCare Center, the Vincent Newborn Necessities Program offers assistance to patients with limited resources. Developed in 2009 by The Vincent Club, a group of women dedicated to fundraising for the MGH Vincent Department of Obstetrics and Gynecology, the program provides families with new and gently used items, such as baby and maternity clothes and blankets. The Vincent Newborn Necessities Program is part of the Chelsea Prenatal Outreach Program, which works closely with health center providers to improve birth outcomes among at-risk pregnant women in Chelsea.
In July 2009, investigators from the MGH Cardiovascular Research Center and Harvard Stem Cell Institute reported identifying a master cardiac stem cell that gives rise to cells forming essential portions of the human heart. In a subsequent study, they used the mouse version of the same cell to create a functioning strip of heart muscle cells.

In two 2009 studies, a team of MGH researchers reported how viewing videos that show the effects of advanced dementia or that clearly illustrate what is involved in specific levels of end-of-life care helps patients choose among future treatment options and increases the number who prefer receiving comfort measures only.

A May 2009 study found that both patients and physicians considered virtual visits delivered through teleconferencing to be as satisfactory as face-to-face visits for primary care. Virtual visits may be useful for routine monitoring of chronic conditions and evaluation of acute, nonurgent conditions, while reducing overhead costs and the need for patients to travel.

Using an antiangiogenesis drug to shrink benign tumors on the hearing and balance nerves of patients with neurofibromatosis 2, an MGH research protocol preserved or improved hearing in several participants, the first successful treatment for the condition that does not involve surgery or radiation.
Nursing students in the first Accelerated Bachelor of Science in Nursing class at the MGH Institute of Health Professions graduated in September 2009. The program was established in May 2008 to offer a fast-paced, yet in-depth nursing education to college graduates with a bachelor’s degree in another field.

The MGH Primary Care Residency program was the first such program in the country. Founded in 1974, the program trains specialists in internal medicine to become experts in the provision of primary care.

In 2009, The Norman Knight Nursing Center for Clinical and Professional Development at MGH launched a new method of delivering educational programs to more than 3,200 nurses across the MGH using HealthStream. The online learning management system provides staff nurses and other caregivers around-the-clock access to dozens of educational opportunities from any computer with internet access.

The Accreditation Council for Graduate Medical Education established the Parker J. Palmer awards to honor program directors and institutional officials nationally each year. Since its establishment in 2001, two MGH program directors have received the Parker J. Palmer Courage to Teach Award: Hasan Bazari, MD, of Internal Medicine, and Gene Beresin, MD, of Pediatric Psychiatry. Debra Weinstein, MD, director of Graduate Medical Education, received the Parker J. Palmer Courage to Lead Award in 2007.

THE MGH FOUNDING FATHERS promoted the establishment of a hospital not only to care for the sick, but also because they recognized that hospitals are essential for the education of health care providers. Today the MGH educates thousands of medical and other health professionals each year through its world-renowned graduate medical education programs, which include 20 residency and 86 fellowship programs. The MGH plays a critical role in the education of Harvard Medical School (HMS) students and serves as a training site for students in nursing and other health professions through the MGH Institute of Health Professions.

The hospital has long attracted a select group of talented and highly motivated young professionals who are given the opportunity to work with a faculty of expert clinicians and researchers. MGH trainees use the hospital’s state-of-the-art facilities to care for a diverse group of patients presenting the full spectrum of diagnostic and treatment challenges. Program graduates have had a significant impact as leaders in all areas of health care.

Trainees receive outstanding specialty-based clinical training, enriched by interdisciplinary retreats focusing on topics such as patient safety, end-of-life care or professionalism. Many residents and fellows also pursue interests in global health, quality and safety, academic health care administration, and health policy through the “Centers of Expertise.” This Partners graduate medical education initiative provides opportunities for in-depth experience and mentoring from world-renowned faculty members.

Residents and fellows alike value these opportunities. “Walking through the halls of the MGH, surrounded by rich history and some of the world’s finest physicians, poses a challenge to the new trainee to strive to be his or her very best,” says Brandon S. Beamer, MD, an Orthopaedic Surgery resident. “This creates an environment of lifelong learners who will continue to advance medicine. I’m proud to be a part of this group.”

Since 1811, the MGH has been a leader in the education of tomorrow’s caregivers. This remains a top priority and will continue as a vital element of the hospital’s mission for generations to come.

Second-year resident Jessica Ravikoff, MD, speaks with one of her patients at the Internal Medicine Associates at MGH.

Inset: Harvard Medical School and the MGH share a long history together. The medical school, building at right, was originally located adjacent to the MGH Bulfinch Building, circa 1855.
“... it is to erect a most honourable monument of the munificence of the present times, which will ensure to its founders the blessings of thousands …”

IN THE 30 YEARS SINCE HIV/AIDS emerged as a global health crisis, scientists like MGH infectious disease specialist Bruce D. Walker, MD, director of the Ragon Institute of MGH, MIT and Harvard, have made great strides in understanding the disease and treating its symptoms. In South Africa – the heart of the AIDS epidemic – Walker has developed HIV treatment centers, established a research institute and a program for training African scientists, organized an MGH medical residency program overseen by Krista Dong, MD, and launched community outreach programs. But despite the significant scientific and medical progress made in AIDS treatment, the world is still waiting for an effective HIV vaccine.

With the establishment of the Ragon Institute in February 2009, Walker is now focusing on the development of such a vaccine, the ultimate public health goal.

“AIDS is a global pandemic, but I believe it’s a solvable problem,” says Walker. “We need to infuse more creativity into the field by bringing people with incredible expertise to the same table.”

The Ragon Institute, founded through an unprecedented gift from Phillip (Terry) and Susan Ragon, is making it possible to do just that. Walker has already begun to assemble the research and clinical resources of the MGH and the science and engineering talent of Massachusetts Institute of Technology (MIT) and Harvard University to bring them to bear on the mission to stop the spread of AIDS.

The challenge ahead is daunting, because HIV infects the very cells that should defend against the virus, damaging the human immune system in the process. The virus also is characterized by extreme variability and is evolving at a rapid rate. But Walker and his colleagues – bolstered by the funding and support of generous donors such as the Ragons, Mark and Lisa Schwartz, and Bill and Melinda Gates – are optimistic that this is a fight they can win. In an effort to identify a gene or protein that is critical to controlling the disease, the team currently is studying a group of 1,300 patients called “elite controllers,” who are infected with HIV but have no symptoms and are incapable of infecting others.

In 2009, thanks to a generous gift from Nancy Lurie Marks and her family, the Lurie Family Autism Center at MGH was established. The center provides comprehensive diagnostic and clinical care for both children and adults, pioneering research, a distinctive policy and advocacy program; and training for clinicians and researchers.

The MGH Cancer Center was one of five multi-institutional “dream teams” to receive a grant from the newly formed organization Stand Up To Cancer. The center received $15 million to help accelerate and disseminate research on the circulating tumor cell (CTC)-chip, a microchip-based device for detecting and analyzing tumor cells in the bloodstream.

Supporting primary care is a growing interest of MGH donors. In 2009 nearly $1 million was raised to support initiatives to enhance patient care, create innovative medical technologies and establish methods for the delivery of care under the auspices of the John D. Stoeckle Center for Primary Care Innovation at MGH.

Many spaces within the Building for the Third Century (B3C) will include the names of generous donors who have supported the building’s construction. The B3C houses an expanded radiation oncology center, an enlarged emergency department, three floors of high-tech surgical suites and five inpatient floors.

Bruce D. Walker, MD, with students in the KwaZulu-Natal province of South Africa
Inset: The first demonstration of ether as a surgical anesthetic in 1846 is among the MGH’s renowned achievements in patient care, daguerreotype circa 1847.
HEN DR. JAMES JACKSON and John Collins Warren wrote the “circular letter” in 1810 appealing for funds to build what would become the MGH, they could not have envisioned the institution recently portrayed in the dramatic spotlight of nationwide television along with Brigham and Women’s and Children’s hospitals. The ABC News documentary “Boston Med” premiered in June 2010 to enthusiastic reviews, and the poignant reality of the patients who daily come to the MGH could be glimpsed with all its joys and sorrows, hopes and disappointments.

“I know I speak for all three of the hospitals in saying that we were truly honored to be approached by ABC to do this series with them,” says Peter L. Slavin, MD, president of the MGH. “We’re all very proud of the care that goes on within our institutions and the incredibly talented and dedicated staff who work so hard day and night to offer their best for our patients and their families.”

The hospital’s bicentennial year – 2011 – promises to bring many celebratory moments. It will also no doubt bring moments of crisis, uncertainty and heartbreak. But whatever milestones, challenges and adventures lie ahead, the MGH will remain committed to a future of striving to improve the health and well-being of all.

“We flatter ourselves that … Boston may ere long assert her claim to equal praise.”

Above: MGH nurse Mike O’Donnell, RN, in a still from the ABC News documentary “Boston Med”

Left: A portion of the 1810 charter of the MGH
FACTS AND FIGURES | 2009 STATISTICS

Available beds 907
Average occupancy rate 82.33%
Admissions 47,649
Average length of stay (in days) 5.72
Admissions to observe 8,308
Births 3,566
Surgical cases
Inpatient 19,206
Ambulatory 18,803
Total surgical cases 38,009
Ambulatory visits
MGPO visits 508,827
Clinic visits 476,289
Danvers visits 6,663
Health center visits
Charlestown 55,253
Chelsea 141,602
Revere 90,832
Back Bay 18,292
Emergency visits 88,393
Total ambulatory, health center and emergency visits 1,386,151

Staff
Clinical staff 1,937
Residents 827
Clinical fellows 353
Research fellows 932
Nonclinical staff 625
Registered nurses 3,731
Per diem registered nurses 302
Other per diem 1,185
Bulfinch temps 1,551
Other employees 10,904
Total employees 22,347
Research expenditures $619,247,000
Excerpts from internal financial statements (in thousands of dollars).
Years ending Sept. 30.

<table>
<thead>
<tr>
<th>Revenue</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net patient service revenue</td>
<td>1,751,607</td>
<td>1,857,914</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct research revenue</td>
<td>409,199</td>
<td>466,820</td>
</tr>
<tr>
<td>Indirect research revenue</td>
<td>140,462</td>
<td>152,427</td>
</tr>
<tr>
<td>Other</td>
<td>160,657</td>
<td>156,707</td>
</tr>
<tr>
<td>Total operating revenue</td>
<td>2,461,925</td>
<td>2,633,868</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee compensation and benefits</td>
<td>955,256</td>
<td>1,009,908</td>
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<tr>
<td>Supplies and other expenses</td>
<td>769,107</td>
<td>803,699</td>
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<tr>
<td>Direct research and academic expenses</td>
<td>475,842</td>
<td>532,157</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>107,745</td>
<td>113,720</td>
</tr>
<tr>
<td>Interest</td>
<td>17,331</td>
<td>12,933</td>
</tr>
<tr>
<td>Provision for bad debt</td>
<td>22,282</td>
<td>29,479</td>
</tr>
<tr>
<td>Total operating expenses</td>
<td>2,347,563</td>
<td>2,501,896</td>
</tr>
</tbody>
</table>

Income from operations: 114,362 in 2009, 131,972 in 2008
Nonoperating gains, net: (7,713) and (85) respectively
Excerpts from internal financial statements (in thousands of dollars).

Years ending Sept. 30.

<table>
<thead>
<tr>
<th>Revenue</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net patient service revenue</td>
<td>474,609</td>
<td>514,660</td>
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<tr>
<td>Other operating revenue</td>
<td>137,424</td>
<td>151,466</td>
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<tr>
<td><strong>Total operating revenue</strong></td>
<td><strong>612,033</strong></td>
<td><strong>666,126</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee compensation and benefits</td>
<td>485,403</td>
<td>534,301</td>
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<tr>
<td>Supplies and other expenses</td>
<td>83,997</td>
<td>95,797</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>1,504</td>
<td>2,137</td>
</tr>
<tr>
<td>Provision for bad debts</td>
<td>13,895</td>
<td>9,473</td>
</tr>
<tr>
<td>Interest</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td><strong>584,799</strong></td>
<td><strong>641,708</strong></td>
</tr>
</tbody>
</table>

| Income from operations       | 27,234      | 24,418      |
| Nonoperating gains (expenses)|             |             |
| Income from investments      | 9,343       | 1,283       |
| Change in net unrealized gains (losses) on equity method investments | (22,633) | 8,371 |
| Gifts and other              | (2,524)     | (727)       |
| **Total nonoperating gains (losses)** | **(15,814)** | **8,927** |
| Excess of revenue over expenses | 11,420      | 33,345      |
| Other changes in net assets  |             |             |
| Transfer from/(to) affiliates | 94          | (804)       |
| Other                        | 623         | (1,107)     |
| **Cumulative effect of accounting change** | **(1,061)** |             |
| **Increase in unrestricted net assets** | **12,137** | **30,373** |
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(As of October 2009)
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| MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION |

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Assistant Secretary

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Elizabeth A. Mort, MD
Vice President for Center for Quality and Safety and Associate Chief Medical Officer
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Director of Specially Care Development
David F. Torchiana, MD
Chairman and Chief Executive Officer
Jeffrey B. Weilburg, MD
Associate Medical Director, Specialty Care
Eric Weil, MD
Associate Medical Director, Primary Care
Partnering to make a difference

Massachusetts General Hospital is a legacy bequeathed by the first donors to the hospital, whose support made exceptional patient care available to the diverse community of 19th century Boston. As the hospital approaches its bicentennial year in 2011, we celebrate our February 1811 founding and the groundwork it laid for the successful medical institution that is the MGH of the 21st century. Today’s donors are creating their own legacy for the future, making it possible for the MGH to continue delivering the best patient care; conducting groundbreaking research; developing best practices that improve quality, safety and efficiency; training world leaders in tomorrow’s medicine; influencing public policy; and serving diverse and distressed communities at home and abroad. Throughout our 200-year history, donor support has been the backbone in our commitment to turn science into medicine and advance human health around the world.

Thanks to the remarkable generosity of hospital donors, MGH programs and services continue to flourish despite challenging times in health care. During the 2009 fiscal year, MGH friends and supporters provided the hospital with $236 million in gifts, exceeding our philanthropic goal of $185 million. The MGH is exceptionally grateful to its donors; they are, indeed, everyday heroes. Their contributions are essential to advance cutting-edge research and develop new therapies and treatments. Charitable support also provides the cornerstone for the building of new facilities, which are necessary in accommodating the latest technological advances in clinical care.

Valued donors already have stepped forward to support the MGH’s critically important clinical expansion program by naming services and spaces within the Building for the Third Century. This state-of-the-art facility is scheduled to open in 2011 – the hospital’s bicentennial year – and will allow for the expansion and renovation of vital inpatient and outpatient services. The project holds enormous promise for the future of medicine, and the MGH looks forward to forging new relationships with key friends and donors to expedite the completion of the project.

The MGH Development Office serves as a resource to offer donors gift options, assist donors in achieving their philanthropic objectives and identify donor recognition opportunities. Donors may wish to direct their gifts to a program or research initiative at the hospital that holds special meaning for them or choose to make an unrestricted gift to the MGH Fund, which provides support for the hospital’s most critical priorities.

The MGH counts on and appreciates the support from all of its donors. We invite you to join the MGH in its ongoing effort to deliver leadership and excellence in the treatment and care of patients locally and worldwide.

For more giving opportunities or information, contact the MGH Development Office:

Massachusetts General Hospital
Development Office
165 Cambridge Street, Suite 600
Boston, MA 02114
Phone: 617-726-2200
Toll-free: 877-644-7733
E-mail: mghdevelopment@partners.org
Website: www.massgeneral.org/give
to provide for themselves, is probably greater than the public imagine; and of these a large proportion claim the assistance of the affluent. The expense, which is attached to the care of the insane in private families, is extremely great; and such as to ruin a whole family, that is possessed of a competence under ordinary circumstances, when called upon to support one of its members in this situation. Even those, who can pay the necessary expenses, would perhaps find an Institution, such as is proposed, the best situation, in which they could place their unfortunate friends. It is worthy of the opulent men of this town, and consistent with their general character, to provide an asylum for the insane from every part of the commonwealth. But if funds are raised for the purpose proposed, it is probable that the Legislature will grant some assistance, with a view to such an extension of its benefits.

Or another class, whose necessities would be removed by the establishment of a hospital, are women, who are unable to provide for their own welfare and safety, in one of nature's most trying hours. Houses for lying-in women have been found extremely useful in the large cities of Europe; and although abuses may have arisen in consequence, these are such as are more easily prevented in a small, than in a large town.

Then are many others, who would find great relief in a hospital, and many times have life preserved, when otherwise it would be lost. Such especially are the subjects of accidental wounds and fractures, among the poorer classes of our citizens, and the subjects of extraordinary diseases in any part of the commonwealth, who may require the long and careful attention of either the physician or surgeon.

It is possible that we may be asked, whether the almshouse does not answer the purposes, for which a hospital is proposed. That it does not is very certain. The town is so much indebted to the liberality of those gentlemen, who, without compensation, superintend the care of the poor, that we ought not to make this reply without an explanation. The truth is that the almshouse could not serve the purpose of a hospital, without such an entire change in the arrangements of it, as the overseers do not feel themselves authorized, to make; and such as the town could not be easily induced to direct, or to support.

The almshouse receives all those, who do not take care of themselves, and who are destitute of property, whether they be old and infirm, and unable to provide means of subsistence; or are too vicious and debauched to employ themselves in honest labour; or are prevented from so employing themselves by occasional sickness. This Institution then is made to comprehend what is more properly meant by an almshouse, a bridewell or house of correction, and a hospital. Now the economy and mode of government cannot possibly be adapted at once to all these various purposes. It must necessarily happen that in many instances the worst members of the community, the debauched and profligate, obtain admission into this house. Hence it has become in some measure disreputable to live in it, and not unfrequently those, who are the most deserving objects of charity, cannot be induced to enter it. To some of them death appears less terrible, than a residence in the almshouse.

It is true, that the sick in that house are allowed some greater privileges and advantages, than are extended to those in health. Yet the general arrangements and regulations are, necessarily, so different from those required in a hospital, that the sick, far from having the advantages afforded by the medical art, have not the fair chance for recovery, which nature alone would give them. Most especially they suffer for the want of good nurses. In these officers must be placed trust and confidence of the highest nature. Their duties are laborious and painful. In the almshouse they are selected from among the more healthy inhabitants—but unfortunately those, who are most qualified, will always prefer more profitable and less laborious occupations elsewhere. It must then be obvious that the persons employed as nurses cannot be such, as will conscientiously perform the duties of this office.

In addition to what has already been stated, there are a number of collateral advantages, that would attend the establishment of a hospital in this place. These are the facilities for acquiring knowledge, which it would give to the students in the medical school established in this town. The means of medical education in New-England are at present very limited, and totally inadequate to so important a purpose. Students of medicine cannot qualify themselves properly for their profession, without incurring heavy expenses, such as very few of them are able to defray. The only medical school of eminence in this country is that at Philadelphia, nearly four hundred miles distant from Boston; and the expense of attending that is so great, that students from this quarter rarely remain at it longer than one year. Even this advantage is enjoyed by very few, compared with the whole number: Those who are educated in New-England have so few opportunities of attending to the practice of physic, that they find it impossible to learn some of the most important elements of the science of medicine, until after they have undertaken for themselves the care of the health and lives of their fellow citizens. This care they undertake with very little knowledge, except that which they have acquired from books;—a source whence it is highly useful and indispensable that they should obtain knowledge; but one, from which alone, they never can obtain all that is necessary to qualify them for their professional duties. With such deficiencies in medical education, it is needless to shew to what evils the community is exposed.

To remedy evils so important and so extensive, it is necessary to have a medical school in New-England. All the materials necessary to form this school exist among us. Wealth abundantly sufficient can be devoted to the purpose without any individual’s feeling the smallest privation of any, even of the luxuries of life. Every one is liable to suffer from the want of such a school; every one may derive directly or indirectly the greatest benefits from its establishment.

A hospital is an institution absolutely essential to a medical school, and one which would afford relief and comfort to thousands of the sick and miserable. On what other objects can the superfluities of the rich be so well bestowed?

The amount required for the institution proposed may, at first sight, appear large. But it will cease to appear so, when we consider that it is to afford relief, not only to those who may require assistance during the present year, or present age; but that it is to erect a most honourable monument of the munificence of the present times, which will ensure to its founders the blessings of thousands, in ages to come; and when we add that this amount may be raised at once, if a few opulent men will contribute only their superfluous income for one year. Compared with the benefits, which such an establishment would afford, of what value is the pleasure of accumulating riches in those stores, which are already groaning under their weight?

Hospitals and infirmaries are found in all the Christian cities of the old worlds, and our large cities in the middle states have Institutions of this sort, which do great honour to the liberality and benevolence of their founders. We flatter ourselves that in this respect, as in all others, Boston may ere long assert her claim to equal praise.
Massachusetts General Hospital: Statistics and Financials 2010

F A C T S A N D  F I G U R E S  |  2 0 1 0  S T A T I S T I C S

Admissions and Occupancy
Available beds 907
Average occupancy rate 83.35%
Admissions 47,243
Average length of stay (in days) 5.84
Admissions to observe 8,748

Births 3,481

Surgical cases
Inpatient 18,776
Ambulatory 21,844
Total surgical cases 40,620

Ambulatory visits
MGPO 517,142
Clinic 485,772
Danvers 20,544
Total ambulatory visits 1,023,458

Health center visits
Charlestown 57,065
Chelsea 141,402
Revere 89,597
Back Bay 18,993
Total health center visits 307,057

Emergency visits 90,413

Total ambulatory, health center and emergency visits 1,420,928

Staff
Clinical staff 2,002
Residents 839
Clinical fellows 356
Research fellows 977
Nonclinical staff 657
Registered nurses 3,783
Per diem registered nurses 307
Other per diem 1,312
Bulfinch temps 1,741
Other employees 11,138
Total employees 23,112

Research expenditures $696,000,000
**FINANCIALS | THE GENERAL HOSPITAL CORPORATION**

Excerpts from internal financial statements (in thousands of dollars).  
Years ending Sept. 30.

<table>
<thead>
<tr>
<th>Revenue</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net patient service revenue</td>
<td>1,857,914</td>
<td>2,006,631</td>
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<tr>
<td>Other operating revenue:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct research revenue</td>
<td>466,820</td>
<td>501,278</td>
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<tr>
<td>Indirect research revenue</td>
<td>152,427</td>
<td>171,808</td>
</tr>
<tr>
<td>Other</td>
<td>156,707</td>
<td>159,941</td>
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<tr>
<td>Total operating revenue</td>
<td>2,633,868</td>
<td>2,839,658</td>
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</table>

<table>
<thead>
<tr>
<th>Expenses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating expenses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee compensation and benefits</td>
<td>1,009,908</td>
<td>1,085,544</td>
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<tr>
<td>Supplies and other expenses</td>
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<td>Direct research and academic expenses</td>
<td>532,157</td>
<td>565,105</td>
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<tr>
<td>Depreciation and amortization</td>
<td>113,720</td>
<td>123,470</td>
</tr>
<tr>
<td>Interest</td>
<td>12,933</td>
<td>9,770</td>
</tr>
<tr>
<td>Provision for bad debt</td>
<td>29,479</td>
<td>30,093</td>
</tr>
<tr>
<td>Total operating expenses</td>
<td>2,501,896</td>
<td>2,663,992</td>
</tr>
<tr>
<td>Income from operations</td>
<td>131,972</td>
<td>175,666</td>
</tr>
<tr>
<td>Nonoperating gains, net</td>
<td>(85)</td>
<td>5,634</td>
</tr>
<tr>
<td>Excess of revenue over expenses</td>
<td>131,887</td>
<td>181,300</td>
</tr>
</tbody>
</table>
### Excerpts from internal financial statements (in thousands of dollars)

**Years ending Sept. 30.**

<table>
<thead>
<tr>
<th>Revenue</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net patient service revenue</td>
<td>514,660</td>
<td>543,470</td>
</tr>
<tr>
<td>Other revenue</td>
<td>151,466</td>
<td>168,896</td>
</tr>
<tr>
<td><strong>Total operating revenue</strong></td>
<td><strong>666,126</strong></td>
<td><strong>712,366</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee compensation and benefits</td>
<td>534,301</td>
<td>567,852</td>
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<tr>
<td>Supplies and other expenses</td>
<td>95,797</td>
<td>102,499</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>2,137</td>
<td>2,756</td>
</tr>
<tr>
<td>Provision for bad debts</td>
<td>9,473</td>
<td>15,675</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td><strong>641,708</strong></td>
<td><strong>688,782</strong></td>
</tr>
<tr>
<td>Income from operations</td>
<td>24,418</td>
<td>23,584</td>
</tr>
<tr>
<td>Nonoperating gains (expenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income from investments</td>
<td>9,654</td>
<td>20,409</td>
</tr>
<tr>
<td>Gifts and other</td>
<td>(727)</td>
<td>(598)</td>
</tr>
<tr>
<td><strong>Total nonoperating gains (losses)</strong></td>
<td><strong>8,927</strong></td>
<td><strong>19,811</strong></td>
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<tr>
<td><strong>Excess of revenue over expenses</strong></td>
<td><strong>33,345</strong></td>
<td><strong>43,395</strong></td>
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<tr>
<td>Other changes in net assets</td>
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<td></td>
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<tr>
<td>Transfer from/(to) affiliates</td>
<td>(804)</td>
<td>(1,730)</td>
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<tr>
<td>Other</td>
<td>(1,107)</td>
<td>(496)</td>
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<tr>
<td>Cumulative effect of accounting change</td>
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<tr>
<td><strong>Increase in unrestricted net assets</strong></td>
<td><strong>30,373</strong></td>
<td><strong>41,169</strong></td>
</tr>
</tbody>
</table>
Massachusetts General Hospital: Statistics and Financials 2011

**Facts and Figures | 2011 Statistics**

**Admissions and occupancy**
- Available beds: 927*  
- Average occupancy rate: 81.77%  
- Admissions: 47,000  
- Average length of stay (in days): 5.89  
- Admissions to observe: 9,140

**Births**: 3,657

**Surgical cases**
- Inpatient: 18,976  
- Ambulatory: 21,576  
- Total surgical cases: 40,552

- As of year end

**Ambulatory visits**
- MGPO: 740,726  
- Clinic: 483,543  
- Danvers: 22,153  
- Total ambulatory visits: 1,246,422

**Health center visits**
- Charlestown: 57,465  
- Chelsea: 145,789  
- Revere: 85,327  
- Back Bay: 18,926  
- Total health center visits: 307,507

**Emergency visits**: 89,476

**Total ambulatory, health center and emergency visits**: 1,643,405

**Staff**
- Clinical staff: 2,025  
- Residents: 850  
- Clinical fellows: 374  
- Research fellows: 998  
- Nonclinical staff: 670  
- Registered nurses: 3,965  
- Per diem registered nurses: 314  
- Other per diem: 1,268  
- Bulfinch temps: 1,384  
- Other employees: 11,325  
- Total employees: 23,173

**Research expenditures**: $764,000,000
Excerpts from internal financial statements (in thousands of dollars).
Years ending Sept. 30.

<table>
<thead>
<tr>
<th>Revenue</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net patient service revenue</td>
<td>1,976,538</td>
<td>2,071,361</td>
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<td>Other operating revenue</td>
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<tr>
<td>Direct research revenue</td>
<td>501,278</td>
<td>554,699</td>
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<td>Indirect research revenue</td>
<td>171,808</td>
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<tr>
<td>Other</td>
<td>159,941</td>
<td>168,326</td>
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<tr>
<td>Total operating revenue</td>
<td>2,809,565</td>
<td>2,979,520</td>
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<table>
<thead>
<tr>
<th>Expenses</th>
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<tr>
<td>Employee compensation and benefits</td>
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<td>Supplies and other expenses</td>
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<td>Direct research and academic expenses</td>
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<td>Interest</td>
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<tr>
<td>Total operating expenses</td>
<td>2,663,992</td>
<td>2,768,551</td>
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</table>

Income from operations | 175,666 | 210,969 |
Nonoperating gains, net | 5,634   | 12,945  |

Excess of revenue over expenses | 181,300 | 223,914 |
Excerpts from internal financial statements (in thousands of dollars).
Years ending Sept. 30.

<table>
<thead>
<tr>
<th>Revenue</th>
<th>2010</th>
<th>2011</th>
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</thead>
<tbody>
<tr>
<td>Net patient service revenue</td>
<td>527,795</td>
<td>575,945</td>
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<tr>
<td>Other revenue</td>
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<td>168,118</td>
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<tr>
<td><strong>Total operating revenue</strong></td>
<td>696,691</td>
<td>744,063</td>
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</table>

<table>
<thead>
<tr>
<th>Expenses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee compensation and benefits</td>
<td>567,852</td>
<td>609,287</td>
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<td>Supplies and other expenses</td>
<td>102,499</td>
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<td>Depreciation and amortization</td>
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<td>3,289</td>
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<td><strong>Total operating expenses</strong></td>
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<td>724,284</td>
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<tr>
<td>Income from operations</td>
<td>23,584</td>
<td>19,779</td>
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<tr>
<td>Nonoperating gains (expenses)</td>
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<tr>
<td>Income from investments</td>
<td>20,409</td>
<td>3,741</td>
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<tr>
<td>Gifts and other</td>
<td>(598)</td>
<td>(667)</td>
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<tr>
<td><strong>Total nonoperating gains (losses)</strong></td>
<td>19,811</td>
<td>3,074</td>
</tr>
<tr>
<td>Excess of revenue over expenses</td>
<td>43,395</td>
<td>22,853</td>
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<tr>
<td>Other changes in net assets</td>
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<tr>
<td>Transfer from/(to) affiliates</td>
<td>(1,730)</td>
<td>(1,013)</td>
</tr>
<tr>
<td>Other</td>
<td>(496)</td>
<td>60</td>
</tr>
<tr>
<td><strong>Increase in unrestricted net assets</strong></td>
<td>41,169</td>
<td>21,900</td>
</tr>
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</table>
A Legacy of Leadership

PATIENT CARE at TWO HUNDRED

A Legacy of Leadership
Disciplines

- Nursing
- Chaplaincy
- Child Life
- Medical Interpretation
- Occupational Therapy
- Physical Therapy
- Respiratory Care
- Social Work
- Speech-Language Pathology

Patient Care Services Programs

- Cancer Resource Room
- Caring Headlines
- Center for Global Health
- Child Protection
- Consultation Team
- Clinical Support Services
- HAVEN Program
  (Helping Abuse and Violence End Now)
- Information Ambassadors
- International Patient Center
- Ladies Visiting Committee
  Retail Shops
- MGH Quit Smoking Service
- Office of Patient Advocacy
- Orthotics and Prosthetics
- Patient and Family Lodging
- PCS Diversity Program
- PCS Financial Management Systems
- PCS Informatics
- PCS Office of Quality & Safety
- Volunteer Services

The Institute for Patient Care
- Center for Innovations in Care Delivery
- Maxwell & Eleanor Blum Patient and Family Learning Center
- Norman Knight Nursing Center for Clinical & Professional Development
- Yvonne L. Munn Center for Nursing Research
2011 Strategic Goals

- Meet or exceed the expectations of patients and families.
- Enhance care delivery by improving the efficiency and effectiveness of systems.
- Ensure that staff have a strong voice in the design of care and services.
The Mass General Mission

*Guided by the needs of our patients and their families, we aim to deliver the very best healthcare in a safe, compassionate environment; to advance that care through innovative research and education; and to improve the health and well-being of the diverse communities we serve.*
In 2011, Massachusetts General Hospital (MGH) celebrated a special milestone: the 200th anniversary of its founding. This provided us with a rare opportunity to celebrate a truly remarkable history.

As the third general hospital in the United States, MGH has been at the forefront of advances in healthcare delivery for the past 200 years—from establishing the earliest nursing education programs in America to offering computerized simulation training; from caring for the soldiers and sailors wounded in the Spanish-American War in tents on the Bulfinch Lawn to responding to disasters throughout the world, whether it be Indonesia in the aftermath of a horrific tsunami, the US Gulf Coast following hurricanes Katrina and Rita, or Haiti when devastated by a powerful earthquake. We established the first hospital-based social work program and helped shepherd the early development of whole new professions—speech-language pathology, occupational and physical therapy, child life, and respiratory therapy—that today comprise Patient Care Services.

As we explored this history, we recognized familiar themes that wove throughout the hospital’s 200 years: a relentless commitment to providing the best available care to those in need; advancing that care through lifelong learning; attaining and sharing knowledge broadly; contributing to our professions as a whole; and serving our country and our neighbors, near and far.

We were reminded, time and again and in no uncertain terms, that ours is a legacy of leadership and innovation. As you review a few of the highlights from our bicentennial year, it becomes clear that we are very privileged to witness the work of those who are writing the next chapter.

With admiration,

Jeanette Ives Erickson, RN, DNP, FAAN
Senior Vice President for Patient Care and Chief Nurse
In the early 1800s, there was no organized system of healthcare in America and no general hospital in New England. The wealthy were cared for in their homes and the poor in an almshouse. The few nurses who worked at the time were virtually untrained, and the many disciplines that today comprise Patient Care Services did not yet exist.

The very concept of establishing the Massachusetts General Hospital was a major innovation in its day, and the Bulfinch Building—with all of its modern conveniences and advanced architecture—symbolized a new era in caring for the sick.
Two centuries after its founding—and with the advent of sweeping healthcare reform—the Massachusetts General Hospital continues to lead the charge to advance healthcare delivery.

The goal: to ensure that every patient has access to the highest-quality, safest, most efficient and cost-effective care possible.
Wide-scale healthcare reform, rising costs and a volatile national economy are today challenging hospitals to run more efficiently while continuing to provide exceptional care and optimal patient outcomes. Creativity, innovation, and openness to new ideas are in high demand. As the Massachusetts General Hospital celebrated its 200-year legacy of leadership and innovation, Patient Care Services embarked on a massive and unprecedented effort to alter the future of care delivery, tapping into the wisdom and creativity of staff. Under the umbrella of the Partners Patient Affordability Direct Care initiative, MGH boldly faced the challenges of a rapidly changing healthcare landscape. Throughout 2011, interdisciplinary teams examined care delivery with an eye toward redesigning systems to make care more efficient and affordable. Within Patient Care Services, the conversation and strategic planning centered around establishing Innovation Units—safe testing grounds for new ideas. These Innovation Units would help PCS leadership and staff craft a care delivery model for the future and quickly determine which proposed changes worked and which didn’t.
Throughout the many months of planning, the Innovation Unit concept centered around research on relationship-based care, which states that chaos during hospitalization is minimized when healthcare workers are truly focused on the patient. With this in mind, the introduction of a new nursing role—attending nurse (ARN)—became a focal point of the Innovation Unit model. Following meetings with all of the clinical disciplines, a series of open forums, and three day-long Innovation Unit leadership and staff retreats, the ARN role was refined. The ARN was envisioned as a leader accountable for the continuity and progression of the care plan from admission to discharge, serving as the primary contact for physicians, the care team, patients, and families, and actively engaging them in the care plan as a cohesive team.

**The Innovation Units are designed to:**

- Focus on patient and family values
- Increase time spent with patients
- Increase continuity of care
- Increase caregiver productivity
- Increase inter-disciplinary teamwork
- Introduce new technology and improve existing technology
- Redesign the physical environment of care
- Focus on organizational goals and mission
At the heart of the Innovation Unit planning there emerged 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 represented “top priority” actions that would lead to the highest levels of consistency, continuity, and efficiency. In addition to the new ARN role, these included:

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

As of this writing, the 12 Innovation Units are up and running and providing valuable insights into care redesign efforts, even in their early stages. Their success over time will be measured by pre-determined metrics related to length of stay, patient satisfaction, staff satisfaction, quality and safety, and nursing-sensitive indicators. One thing we already know for certain: MGH continues to lead the nation in advancing care delivery redesign.
Dr. Richard Cabot, a senior physician at Mass General, hired the first social worker in 1905 to provide social work services in the hospital’s outpatient clinics. Shortly thereafter, Dr. Cabot met Ida Maude Cannon and hired her to jointly organize the nation’s first hospital-based social work program.

Hausman Young Scholars

With support from the Hausman Fund, PCS this year introduced the Hausman Young Scholars Program, an interactive learning experience for the children of MGH support staff from diverse backgrounds. The Hausman Young Scholars Program offers weekend classes in CPR, first aid, computer skills, web design, and exposure to hospital settings, such as the chemistry and simulation labs. As part of the program, MGH staff give their time to teach and mentor these middle school-aged children. And as a result of the program, students begin to see the influence they can have as a voice for good health within their families and peer groups. The program builds on the success of Patient Care Services’ Hausman Nursing Fellowship, Hausman Accent-Reduction Program, and Hausman Multi-Cultural Nursing Program.
Marie Elena Gioiella, MA, MSW, LICSW, was named the director of the MGH Social Service Department. She joined the staff at MGH in 1994 as a clinical social worker and has served as clinical director of the MGH Social Work Oncology Program since 2006. Gioiella earned a bachelor’s degree from the College of the Holy Cross and two master’s degrees in social work and pastoral ministry from Boston College. During her career at MGH, she has been an active member of the Clinical Recognition Program Review Board, the Disabilities Awareness Council and the Cancer Center Community Outreach Program. She has earned numerous honors throughout her MGH career, including the Domestic Violence Unsung Hero Award, the Arthur and Susan Durante Award for Exemplary Care and Service with Cancer Patients, and the Stephanie Macaluso Expertise in Clinical Practice Award, and has been named a Clinical Scholar by the MGH Clinical Recognition Review Board. Gioiella has published extensively and presented her work nationally.

Kevin Whitney, RN, MA, NEA-BC, joined the PCS executive team as an associate chief nurse. Whitney brings many years of clinical and administrative experience, most recently serving as a consultant for Applied Management Systems, Inc. Previously, he served as chief nurse at Emerson Hospital. In his new role, Whitney oversees the Neuroscience, Orthopaedic, and inpatient surgical services. He also serves as associate chief nurse for the Vascular Center, the Digestive Health Center, and the Transplant Center, and is participating in the development of a new institute linking the Heart and Vascular Centers. Whitney is the president of the Organization of Nurse Leaders of Massachusetts and Rhode Island.
Remembering Judy Newell, RN
MGH lost a veteran nurse leader in 2011 with the death of Judy Newell, RN. Newell’s career spanned more than 40 years at MGH; she joined the hospital ranks as a staff nurse in 1969 and ultimately served as the nursing director for OB/GYN and Pediatrics. Throughout the course of her distinguished career, Newell helped shape the culture, environment, and soul of MGH through her committee work, leadership of patient care units, and unflinching desire to do the right thing no matter how difficult or uncomfortable. Newell was respected for her clinical leadership and open mind and likewise admired for her warmth, generosity of spirit, and sense of humor. In the summer of 2011, she was in attendance when the Ellison 18 playroom was dedicated in her honor.

Clinical Ethics Residency for Nurses
Contemporary nursing often requires specialized knowledge and skills in ethical decision making. This year, 19 registered nurses graduated from the inaugural Clinical Ethics Residency for Nurses (CERN), an MGH-based program designed to increase the number of registered nurses who possess specialized knowledge, skill, and competency in clinical ethics. Graduates go on to assume consultative roles in ethics rounds and on hospital committees. Supported by a grant from the US Department of Health and Human Services, the seven-month program provided 98 hours of multimodal learning opportunities—on-line and didactic education, discussions, readings, role-playing, and clinical mentorships. A next round of CERN fellowships is currently under way.
China exchange

Since 2005, MGH and Huashan Hospital in Shanghai, China, have been affiliated as part of a formal effort to expand their relationship and create a platform to exchange knowledge, skills and opportunities. As an expression of their gratitude, the nursing leadership of Huashan Hospital presented a replica Da Ke Ding, or “Supreme Treasure Tripod Cauldron” (pictured), to the Department of Nursing during a 2011 visit to the hospital. The original artifact dates back thousands of years to the Zhou Dynasty, and was cast by a nobleman named Ke during the King Xiao Era. Today it is a symbol of honesty, credibility and prosperity for one’s nation; the inscription on the stand reads: “Walking into great splendor. Jointly creating prosperity.”

ECMO advances

MGH is one of a number of centers in the country that treats patients using extracorporeal membrane oxygenation (ECMO), in which an external device takes over the work of the heart and lungs. ECMO pumps the blood through an artificial lung, or membrane oxygenator, oxygenates and removes carbon dioxide from the patient’s blood and gives the heart and lungs a rest and time to strengthen.

The Department of Respiratory Care has provided ECMO for patients at the Massachusetts General Hospital since 1988. Over the years, the team has gone from primarily supporting neonatal patients with primary pulmonary hypertension of the newborn, meconium aspiration syndrome, congenital diaphragmatic hernia, and severe respiratory distress syndrome to supporting adult and pediatric patients with various diagnoses resulting in severe respiratory failure. In 2011, the team once again revised its major focus to care for adults in need of cardiac support and resuscitation. With this change, the team expects to care for 35 to 40 patients of all ages per year; since October, the ECMO team has provided support for 23 patients.
Blum programs introduced
This year, The Maxwell & Eleanor Blum Patient and Family Learning Center introduced several new programs designed to support patient education. The first was a series of Healthy Living lectures that promote healthy lifestyles through prevention and other wellness-oriented behaviors. The Blum Center is also hosting a National Health Observances discussion series that centers around the US Department of Health and Human Services’ Health Observances Calendar. Each month, a topic from the calendar is discussed in a free lecture by an expert on the topic. The Blum Center is also hosting an ongoing Book Talks Series in which MGH authors discuss their books on various health issues.

Job Shadow
MGH is the second-largest summer employer of Boston youth in the city. In February 2011, the hospital hosted Boston-area high school students for Job Shadow Day. Among those taking part were the Physical and Occupational Therapy departments, where students had a valuable opportunity to see firsthand how therapists and healthcare providers interact with many different patients, personalities, and pathologies. Students saw therapists thinking on their feet and modifying their treatment plans to create patient-centered plans of care. The experience is a valuable opportunity to learn firsthand about healthcare professions and the skills needed to work in a hospital setting. As one student observed, the same communication skills she uses every day at school and home would be very helpful in a hospital setting.
**A week in Burundi**
Kerry Quealy, RN, BSN, is an MGH nurse and 2011 Thomas S. Durant Fellow who was in Haiti as the country began its battle with a cholera outbreak in the wake of a devastating earthquake that hit the tiny nation in 2010. Thanks to Quealy and the rest of the MGH Global Health team that was there, daily cholera patient numbers of up to 200 per day soon began decreasing.

The team continued to work to address the resources, training and education needed to manage the disease. Quealy’s fellowship later took her to Burundi, a small country in East Africa, where she worked in a community health clinic.

More than half of the country’s physicians operate in the capital city—home to less than five percent of the population—leaving the majority of Burundians without basic health care.

**70th anniversary**
This year marked the 70th anniversary of the MGH Chapel, whose doors first opened on April 25, 1941. Patients, families, chaplains, Eucharistic ministers, staff, and leaders of the MGH community gathered to celebrate the milestone. Songs, speeches and prayers filled the room as speaker after speaker shared rich nuggets of the Chapel’s long history and affirmed its importance to the overall mission of the hospital.

Speech-Language Pathology traces its roots to the 19th century when a treatment for stammerers was first offered. In 1925, a small group of practitioners that had been doing research and teaching in the field of speech correction decided to establish a new and independent profession. At about this time, an informal language clinic was established at MGH as part of the outpatient Neurology Department. During World War II, the clinic became the primary training ground and treatment center in the eastern United States for patients with aphasia, an acquired language impairment.
Occupational Therapy at MGH dates back to 1822 when it was an integral part of moral treatment at McLean Asylum (later McLean Hospital), originally part of MGH. Rufus Wyman, MD, was the first physician to supervise a program in Occupational Therapy that used the novel concept of promoting wellness by engaging patients in crafts, gardening, and recreation.

Excellence Every Day portal launched

In an effort to make critical information readily available to staff and leadership, Patient Care Services launched a new Excellence Every Day Web portal at www.mghpcs.org/eed. The page serves as a central clearinghouse for information related to Collaborative Governance, Magnet recognition, regulatory readiness and innovation. These four areas are mainstays of the Excellence Every Day philosophy, with a substantial amount of interconnected information. The Excellence Every Day portal is easy to navigate, is updated monthly, and offers ‘one-stop-shopping’ for access to all things quality and safety. To date, the page has tallied nearly 27,000 page views.

Nurse Residency Program

MGH has a legacy of being at the forefront of nursing education models, and that continues with a new Nurse Residency Program, developed by The Norman Knight Nursing Center for Clinical & Professional Development. This faculty-guided 960-hour training model was established to help new graduate nurses make the transition from student to staff nurse. The program links recently licensed nurses to the knowledge and expertise of experienced nurse-residency faculty to provide a pathway for becoming a caring, thoughtful, competent nurse. This past year, MGH witnessed history as 49 nurse residents accepted certificates of completion, marking their graduation from the ground-breaking Nurse Residency Program.
Professional practice symposium

As healthcare organizations begin to reexamine and redesign healthcare delivery, nurses will play a critical role in shaping care delivery and achieving high-quality clinical outcomes in a variety of settings. Given the urgency and opportunity at hand, it was standing room only in the O’Keeffe Auditorium during “Strategies for Creating and Sustaining a Professional Practice Environment,” MGH Institute for Patient Care’s first International Nursing Symposium, which was held in 2011. Nurses in all role groups from the US, Singapore, China, Spain, Norway, and Bermuda were on hand. Weighing in at the national level, Karen Drenkard, RN, executive director of the American Nurses Credentialing Center, delivered the keynote address, focusing on the transformative power of nursing leadership and its importance in an institution seeking Magnet recognition. Morning sessions examined leadership, strategic planning and evaluation, including “Using a Professional Practice Model to Guide Strategic Planning,” presented by Jeanette Ives Erickson, RN, DNP, FAAN, senior vice president for Patient Care and chief nurse; and “Evaluation of the Professional Practice Environment,” co-presented by Dorothy A. Jones, EdD, RNC, FAAN, director of The Yvonne L. Munn Center for Nursing Research, and Marianne Ditomassi, RN, DNP, MBA, executive director of Patient Care Services Operations and Magnet Program director. Afternoon breakout sessions focused on specific scalable and translatable best practice programs, including fall prevention, patient- and family-centered care, diversity, nurse residency programs, research and evidence based practice, and interdisciplinary shared decision making.
Redesigning Collaborative Governance

Patient Care Services Executive Committee

Collaborative Governance Committee Leaders

- Diversity
- Ethics
- Informatics
- Practice & Quality
- Patient Education
- Inter-Disciplinary Research
- Staff Advisory Committees
- Tiger Teams

- Fall Prevention
- Pain Management
- Restraint Usage
- Policies, Products & Procedures
- Skin Care
For 14 years, Collaborative Governance has played an integral role in shaping and advancing the practice of the various disciplines that comprise MGH Patient Care Services. Its success rests on the ability to shift clinical decision making from administrators to clinicians at the bedside. By empowering staff in this way, clinicians are positioned to use their knowledge, experience and commitment to provide the best possible care to patients and families.

After a comprehensive review and much deliberation, the Collaborative Governance committee structure underwent a strategic redesign to ensure that the work being done was aligned with the strategic goals of Patient Care Services and the many changes in healthcare, technology, as well as the evolving needs of patients and staff.

The new structure in place throughout 2011 included a variety of key changes, including:

- The Nursing Practice and Quality committees merged into a Practice & Quality Committee with five subcommittees with specific areas of focus:
  - Fall Prevention
  - Pain Management
  - Policies, Products & Procedures
  - Restraint Usage
  - Skin Care
- A new interdisciplinary Informatics Committee
- The Nursing Research Committee became the Interdisciplinary Research & Evidence Based Practice Committee, charged with fostering a spirit of inquiry around clinical practice through the dissemination of evidence-based knowledge and research findings.
- Tiger Teams will be formed as needed to address and make recommendations on issues identified by the Patient Care Services Executive Committee.

In addition:

The Diversity Committee continues to support the PCS goal of creating an inclusive and welcoming environment for patients, families, and staff through professional development, student outreach, community outreach, and culturally competent care programs.

The Ethics Committee develops and implements programs to further clinicians’ understanding of ethical aspects of patient care and identifies strategies to integrate ethical judgment into professional practice.

The Patient Education Committee supports staff in developing their role in culturally appropriate patient-education activities. Champions facilitate and generate knowledge of patient-education materials to improve care and enhance the environment in which clinicians shape their practice.

Staff Advisory Committees—Staff Nurse, Physical and Occupational Therapy and Social Work—serve as forums for sharing information between clinicians and leadership.

A new Collaborative Governance website provides quick access to information about each committee’s goals and current work.
In 1955 and before the Salk vaccine was available, a polio epidemic spread throughout the Boston area. MGH was a regional referral center for treatment in iron lungs. This novel approach to the epidemic led to the opening of a respiratory unit at MGH, and later the formation of Respiratory Care Services.

Nursing Spectrum Excellence Awards

The 2011 Nursing Spectrum Excellence Awards proved an especially exciting time for MGH Nursing. Event organizers paid special tribute to MGH Nursing in honor of the hospital’s bicentennial anniversary and rich history of nursing leadership. Furthering this legacy of leadership, three MGH nurses were honored as New England Regional Finalists: Gino Chisari, RN, DNP, for “Advancing and Leading the Profession”; Natalie Harris, RN, for “Community Service”; and Lillian Ananian, RN, PhD(c), for “Clinical Care.” Chisari and Harris were named the overall winners in their respective categories.

Infection prevention

Infection prevention has always been a priority of the inpatient cleaning program. After receiving high marks on patient satisfaction surveys of patients reporting that their rooms and bathrooms were always kept clean, PCS Clinical Support Services continued to ramp up its focus on infection prevention. This year, the team introduced a new fluorescent marking system called iGLO (Innovative Germ Locating Opportunity) on several inpatient units. High-touch surfaces close to the patient are marked with “invisible” ink that is only visible under black light. After cleaning, operations managers review the marked surfaces with a beam of light. If the marks are gone, so too are the germs. In the end, successful infection prevention requires the involvement and cooperation of all members of the team.
Supporting practice
The systems that function behind the scenes to support care delivery are critical and large-scale enterprises. In today’s demanding healthcare environment and prevailing economic climate, for example, it is critical to be able to accurately quantify patients’ needs for nursing care and identify trends in order to make important staffing decisions and allot resources as safely and effectively as possible.

Since 1985, MGH has used the QuadraMed patient-classification system, participating in its revalidation every five to seven years. The MGH nursing staff has been instrumental in the evolution of the tool, providing input and feedback to ensure that issues related to the changing patient population were appropriately addressed. As a result, this year, an entirely new and more complex methodology was implemented that allows for an even more accurate picture of patients’ needs and the nursing care required to meet those needs. Of particular significance, nurses can now track several predefined events, activities or procedures throughout the day, providing the system with more robust data.

It was no small task to roll out the new system. The training of the hospital’s nursing staff—day, evening and night shifts—began on Jan. 3, 2011, the first unit went “live” with the system on January 18, and by March 1, the rollout was complete. Today, more than 2,000 staff nurses practicing on the inpatient units are actively classifying patients every day, ensuring safe staffing levels throughout the hospital.

Nursing at Two Hundred
In celebration of the MGH bicentennial, the Department of Nursing published a 256-page book titled MGH Nursing at Two Hundred. The publication provided a rare overview of 200 years of nursing at the country’s third-oldest general hospital. A lively combination of more than 170 historic images and written reflections spanned from the sparse beginnings of nursing in America in the early 1800s to present-day practice, touching upon highlights and major milestones—the people and events—that helped shape the profession. Special thanks to the Massachusetts General Hospital Nursing Alumni Association and STERIS Corporation for making this book possible.”
Opening the Lunder Building

The challenges involved in moving into multiple inpatient units, an entirely new, 28-OR suite and perioperative spaces—with entirely new configurations and systems—are many, complex and demanding of flawless execution. While the task was daunting, the results were spectacular. From the outset, the needs of patients and families guided the work, backed by exquisite planning, preparation, execution and the dedication of the many staff involved in making Lunder operational.

Planning formally began when an initial multidisciplinary team began to meet regularly some six years before construction was complete. This allowed staff and leadership to actively participate, visit other hospitals to learn from their experiences, and provide input to the building architect, keeping the project relatively “surprise free,” on time and on target. Eighteen months prior to the move, the work intensified as the team formed work groups on key areas of concern, including staff and patient and family communications, support services, staff education, and move day.

The actual moves took place over the course of several weeks, without incident or a break in service.
In Memoriam

The Mass General community was saddened by the sudden death of Keith Perleberg, RN, MDiv, director of the PCS Office of Quality & Safety, in May of 2012. He touched the lives of countless patients, families, friends and colleagues through his gentle, engaging and compassionate nature. Always generous with his time, knowledge, insight and spirit, he often shared experiences and learnings from his theological training, clinical practice as a staff nurse and years as a nursing director.

As he assumed leadership of the new PCS Office of Quality & Safety, he expanded the reach and impact of his focus on patient- and family-centered care, his devotion to systems improvement and the quality of work life for staff. He worked tirelessly to advance a vision in which, working together (as he once described) we would “transform the institution’s culture into one where quality and safety are the central passion of our entire community.” In just four and a half years, Keith made good on that promise … and did so with grace and gentility. He will be sorely missed.
2011 Professional Achievements
PROFESSIONAL ACHIEVEMENTS • awards

PATIENT CARE SERVICES
Catherine Benacchio, RN  
Medical Intensive Care Unit  
The Norman Knight Nursing Scholarship
Carrole Caillet  
Infectious Disease  
Norman Knight Clinical Support Excellence Award
Janet Callahan, PT, MS, NCS  
Physical Therapy Services  
Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award
Amy Christmas  
Neuroscience Intensive Care Unit  
Anthony Kirvilaitis Partnership in Caring Award
Mark Clarke  
Medical Intensive Care Unit  
Anthony Kirvilaitis Partnership in Caring Award
Tracey DiMaggio, RN  
Oncology  
Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy
Siobhan Durkin, RN  
General Medicine  
The Norman Knight Nursing Scholarship
Sacha Field, CCL  
Pediatrics  
Brian M. McEachern Extraordinary Care Award
Kenia Giron  
Anesthesia  
The Gil Minor Nursing and Health Professions Scholarship to Advance Workforce Diversity in Patient Care Services
Katie Guerino, RN  
Infusion  
Marie C. Petrilli Oncology Nursing Award
Nghi Huynh  
Patient Care Services  
The Gil Minor Nursing and Health Professions Scholarship to Advance Workforce Diversity in Patient Care Services
Tod Rinehart, LICSW  
Social Services  
Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award
Topaz Samuels-Sioley  
Post Anesthesia Care Unit  
The Gil Minor Nursing and Health Professions Scholarship to Advance Workforce Diversity in Patient Care Services
Jolene Marangi, RN  
Gynecology  
Marie C. Petrilli Oncology Nursing Award
Mary Ellen McNamara, RN  
Cardiac Intensive Care  
Jean M. Nardini, RN, Nurse Leader of Distinction Award
Julie Park, ORT/L, ED M  
Occupational Therapy Services  
Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award
Suja Philipose, RN  
Newborn Nursery  
The Gil Minor Nursing and Health Professions Scholarship to Advance Workforce Diversity in Patient Care Services
The MGH team deployed to Hôpital Albert Schweitzer, Deschapelles, Haiti:  
Marjorie Curran, MD  
Grace Deveny, RN, MPH  
Patent Care Services Operations  
Katherine Fillo, RN, MPH  
General Medicine, Bigelow 11  
April Kaufman, RN  
Thoracic Unit  
John Bresnahan, RN, BSN  
General Medicine, White 9  
Colleen Shea, RN  
Neuro ICU  
Susan Taricani, RN, BSN  
General Medicine, White 9  
Outstanding Volunteer Certificate from the US Army Boston Healthcare Team
Barbara Chase, APRN, BC, ANP  
Adult Medicine, MGH Chelsea  
Portraits in Primary Care Award, from the John D. Stockeble Center for Primary Care Innovation
Constance Dahlin, APRN, BC, FAAN  
Palliative Care Service  
“the one hundred” for 2011, MGH Cancer Center
Lisa Doyle, RN, BSN  
Gynecology/Oncology  
Oncology Nursing Career Development Award, MGH Cancer Center
Angela Ferrari, CNM  
Obstetrics and Gynecology Service  
Thomas S. Duran, MD, Fellowship in Refugee Medicine
STATE AND REGIONAL
Janet Callahan, PT, MS, NCS  
Physical and Occupational Therapy Services  
Outstanding Achievement in Clinical Practice Award, American Physical Therapy Association of Massachusetts
Gino Chisari, RN, DNP  
The Norman Knight Nursing Center for Clinical & Professional Development  
Nursing Spectrum Award for Advancing and Leading the Profession
Linda Connor Lacke, MPH  
Trauma  
Making a Difference Award, Massachusetts Interscholastic Athletic Association
Vivian Donahue, RN  
Cardiac ICU  
Medivance Arctic Circle Excellence Award, from Medivance
Mary Guanci, RN  
Neuroscience Unit  
Medivance Arctic Circle Excellence Award, from Medivance
Dean Hess, PhD, RRT, FAARC, FCCP, FCCM
Respiratory Care
Henry D. Chadwick Medal, American Lung Association, New England Medical and Scientific Branch

Todd Hultman, RN, NP
Palliative Care
Outstanding Preceptor Award for 2011, Massachusetts Coalition of Nurse Practitioners

Mary McCormick-Gendzel, RN, MS, CRNI, RN-BC
IV Therapy
Chapter President of the Year Award, New England Chapter, Infusion Nursing Society

Michelle McHugh, RN, MS, ANP-BC
Internal Medicine, MGH HealthCare Center, Revere
Exceptional Preceptor Award for 2011, Massachusetts Coalition of Nurse Practitioners

James Zachazewski, PT, DPT, ARC, SCS
Physical and Occupational Therapy
Cynthia Peterson, MBA
Brigham and Women’s/Mass General Health Center
Entire Staff from Mass General Rehabilitation Services
Good Neighbor 2010 Award for Community Service, Tri-Town Chamber of Commerce

NATIONAL
Jacqueline Arroyo, RN
Main Operating Room
2011 Clinical Excellence Award, 58th Congress, Association of periOperative Registered Nurses

Stephanie Ball, RN, DNS(c)
Emergency Department
Virginia Earles Research Award in Nursing, Sage College

Brian French, RN, PhD(c), BC
The Knight Simulation Program and The Maxwell & Eleanor Blum Patient and Family Learning Center
Jonas Scholar for 2011-2012, National League for Nursing

Jane Harker, RN, BSN, MS, CGRN
Gastrointestinal Unit
Gabriele Schindler Excellence in Clinical Practice Award, Society of Gastroenterology Nurses and Associates

Marian Jeffries, RN, MSN, ACNS-BC, FNP-C
Thoracic & Laryngeal Surgery Unit
Member, Clinical Nurse Specialist Content Expert Registry for 2011-2015, American Nurses Credentialing Center

Barbara Levin, RN, BSN, ONC, LNC
Orthopaedics
Stryker Scholarship Award, National Association of Orthopaedic Nurses

Angelika Zollfrank, MDiv, BCC, CPE
MGH Chaplaincy
2011 Emerging Leader Award, National Conference, Association for Clinical Pastoral Education
PROFESSIONAL ACHIEVEMENTS • presentations

STATE AND REGIONAL

Mary Amatangelo, RN, MS, ACNP-BC, CCRN
The Acute Stroke Consult
18th Annual Northeast Regional Nurse Practitioner Conference, Newton, MA
28th Annual NH Brain Injury and Stroke Conference, Manchester, NH

Transient Ischemic Attack (TIA): A Brief Overview
Sixth Annual Conference: Brain Matters 2011, American Association of Neuroscience Nurses, Waltham, MA

Carol Brown, RN, NP
ECG Interpretation, Part I
12-Lead ECG Interpretation – The Basics as Well as STEMI, LVH, Digoxin Effect, Takotsubo Syndrome and Pericarditis
Nurse Practitioner Meeting, Beth Israel Deaconess Medical Center, Boston, MA

12-Lead ECG Interpretation – STEMI, NSTEMI and Miscellaneous ECG Changes
18th Annual Conference, Northeast Regional Nurse Practitioners, Newton, MA

12-Lead ECG Interpretation and Cardiac Arrhythmias
21st Annual Main Geriatrics Conference, University of New England College of Osteopathic Medicine, Bar Harbor, ME

Janet Callahan, PT, MS, NCS
Vestibular Rehabilitation in Sports
Harvard/MBG Sports Medicine Conference, Boston, MA

Dysostonia and Exercise
Dysostonia Support Group, Providence, RI

Physical Therapy for Parkinson’s and Alzheimer’s Diseases for the Boston Asian Community
South Cove Community Health Center, Boston, MA

Concussion: Physical Therapy Assessment and Management
Annual Conference and Exposition, American Physical Therapy Association of Massachusetts, Norwood, MA

Virginia Capasso, PhD, ANP-BC, CWS
Advances in Wound Care
Teleconference, Saudi Aramco Medical Services

Prevention and Treatment of Pressure Ulcers
Surgical Grand Rounds, Eastern Maine Medical Center, Bangor, ME

Pressure Ulcers
School of Osteopathic Medicine, University of New England, Biddeford, ME

Policy to Practice of a Never Event: Pressure Ulcers
21st Annual Main Geriatrics Conference, University of New England College of Osteopathic Medicine, Bar Harbor, ME

Barbara Chace, APRN, BC, ANP
Facilitating Behavior Change
Simmons Graduate Nursing Alumni Association, Boston, MA

Gino Chisari, RN, MSN, DNP
Implications and Opportunities for Nursing Practice and Making the Voice of Nursing Heard
2011 Legislative Action Forum – Health Care Payment Reform: The Future Role for Nursing, Massachusetts Association of Registered Nurses, Massachusetts State House, Boston, MA

Suzanne Curley, MS, OTR/L, CHT
Professionalism
Tufts University, Medford, MA

Constance Dahlin, ANP, BC, FAAN
Caring, Collaborative Communication: Nursing in Palliative Care
AgeWISE: Improving Quality Geriatrics and Palliative Care at the Bedside
Palliative Care Conference, Maine Medical Center, Portland, ME

Constance Dahlin, ANP, BC, FAAN
Maureen Lynch, ANP, BC, ACON
Palliative Care Nursing: Art and Science of Palliative Nursing

Dana Farber Cancer Institute and Massachusetts General Hospital, Boston, MA
Constance Dahlin, ANP, BC, FAAN
Maureen Lynch, ANP, BC
Marie Bakitas, PhD, ANP, AOCN
Managing Symptoms at End of Life
Oncology Nursing Society, Boston, MA

Regina Doherty, OTR/L, OTD
Ethics and Occupational Therapy: A Survey of Practitioners
2011 Conference, Massachusetts Association for Occupational Therapy, Norwood, MA

Daniel Fisher, MS, RRT
Moderator: The Fourth Annual MSRC Research Forum
35th Conference, Massachusetts Society for Respiratory Care, Sturbridge, MA

Carol Harmon Mahony, MS, OTR/L, CHT
Fracture Management
Wrist Injuries
School of Occupational Therapy, Tufts University, Medford, MA

Joanna Hollywood, MS, OTR/L, CHT
Splinting the Hand and Upper Extremity
Dynamic Splinting of the Upper Extremity Lab
School of Occupational Therapy, Tufts University, Medford, MA

Jeanette Ives Erickson, RN, DNP, FAAN
Nurses for the Future: Translating the Institute of Medicine (IOM) Report Recommendations into Action
CRICO/RMF Patient Safety Summit for Nurses, Boston, MA

Vicki Jackson, MD, MPH
Todd Rinehart, LICSW, ACHP-SW
Personal Narratives
“I Hate Role Plays” and Breaking Bad News
Understanding Life-Threatening Illness Discussing DNR Orders Deepening the Interview Negotiating Treatment Goals Managing Family Conflict The Program for Palliative Care Education and Practice, Center for Palliative Care, Harvard Medical School, Cambridge, MA

Marian Jeffries, RN, MSN, ACNS BC, FNP-C
Predictors of Skin Breakdown and Pressure Injury in the Tracheostomized/Stoma Patient Professional Development Symposium, North Eastern Organization of Nurse Educators, Woburn, MA

Joanne Kaufman, RN, MPA
Improving Patient Care in a High-Risk Medicare Population: A Primary Care-Based Model for Transitions, Communication and Continuity Connecticut Chapter Meeting, American Case Management Association, Uncasville, CT

Aimee Klein, PT, DPT, DSc, OCS
What Do You Value White Coat Event, Physical Therapy Program, Northeastern University, Boston, MA

Evelyn Lauture, MSW, LICSW
Earthquake’s Impact on Mental Health and Family Life: Role of Social Workers 10th Annual Haitian Health Career Seminar, School of Medicine, Boston University, Boston, MA

Gerry Leone, Esq.
Elizabeth Speakman, LICSW
Erin Miller
Joanne Timmons
Responding to Domestic Violence in the Health Care Setting: Patient Care and Workplace Violence Domestic Violence Roundtable Program, Cambridge Police Department, Cambridge, MA

Barbara Levin, RN, BSN, ONC, CMSRN, LNC
Your Best Defense: Lowering Your Legal Risks Annual Conference, Massachusetts Nurses Association

Keys for Successful Documentation State Convention, Massachusetts Nurses Association, Canton, MA

Colleen Lowe, MPH, OTR/L, CHT
Sensation and Sensibility Tufts University, Medford, MA

Repetitive Stress Injuries School of Occupational Therapy, Tufts University, Medford, MA

Patricia Lowry, NP
Updates in Hypertrophic Cardiomyopathy and Sudden Cardiac Death National Primary Care Conference, Boston, MA

Barbara Luby, LICSW
Psychosocial Issues Facing Families of the Chronically Ill
New England Chapter, The NephCare Foundation, Wellesley, MA

Barbara Maxam, MSW
Caregiver Issues in Alzheimer’s Disease Parkinson’s Disease, Alzheimer’s Disease and Stroke: An Educational Program for Health Care Providers in the Boston Asian Community, Boston Chinatown Lecture Series, Boston, MA

Catherine Mannis, RN, MSN, OCN
Diane Doyle, MS, APRN-BC, AOCN
Elene Viscosi, APRN-BC
The Role of the Advanced Practice Nurse (APN) in a Radiation Oncology Setting 2011 Oncology Nursing Society Congress, Boston, MA

Kathleen Miller, RN, MA, PhD, AHN-BC
Body as a Prayer: Body Based Spiritual Practices
3rd Annual Spirituality and Nursing Conference, The Art of Healing Presence: The Essence of Nursing Practice, Boston, MA

Kathleen Miller, RN, MA, PhD, AHN-BC
Donna Pelletier-Saxe, RN, MSN, ACM
Holistic Nursing Interventions for Chronic Disease in a Community Health Setting First Annual Northeast AHNA Conference, American Holistic Nurses Association, Manchester, NH

Patient Care Services staff listed in bold.
<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Kathleen Miller, RN, MA, PhD, AHN-BC</td>
<td>The Art of Providing Complementary Therapies in Community Health Center Settings</td>
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<td>Joanne Rowley, RN, MS, CS, HNB-BC, TTS</td>
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<td>Donna Perry, RN, PhD</td>
<td>Making a Difference: Expanding Humanitarian Capacity for the Human Good</td>
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<td>International Humanitarian Studies Association, Tufts University, Medford, MA</td>
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<td>Todd Rinehart, LICSW, ACHP-SW</td>
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<td>Don’t Take It Personally: Responding to ‘Difficult’ Patients and Challenging Behaviors at the End of Life</td>
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<td>The Art &amp; Science of Palliative Nursing Conference, Boston, MA</td>
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<td>Boston Healthcare for the Homeless, Barbara Mcmhin House, Boston, MA</td>
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<td>Barbara Robarge, NP, PhD</td>
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<td>Characterizing Emergency Department Utilization Patterns from a Geriatric Primary Care Practice</td>
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<td>Annual Meeting, Gerontological Society of America, Boston, MA</td>
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<td>Constance Roche, ANP-BC, OCN, APNG</td>
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<td></td>
<td>10 Things You Should Know About Breast Cancer</td>
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<td>National Primary Care Conference, Nurse Practitioner Associates for Continuing Education, Boston, MA</td>
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<td>Summer Bioethics Program, Yale Interdisciplinary Center for Bioethics, New Haven, CT</td>
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<td>Panel Discussion: The Respiratory Therapist: 2015 and Beyond</td>
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<td>34th Annual Meeting Massachusetts Society for Respiratory Care, Shurbridge, MA</td>
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<td>Christine Gryglik, RN, ACNS-BC, PhD(c)</td>
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<tr>
<td>Daphne Noyes, MA</td>
<td>The Art of Healing Presence: The Essence of Nursing Practice</td>
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<td>Third Annual Spirituality and Nursing Conference, Boston, MA</td>
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<td>Lynn Oertel, ANP</td>
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<td>Update: Anticoagulation Provider Certification</td>
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<td>Difficult Cases Panel</td>
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<td>Gayle Olson, MS, ATC, PES</td>
<td>Body Composition Assessments and Sports Injury Consults Health Fair, Lutheran Church of Our Redeemer, Foxborough, MA</td>
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<td>Training and Conditioning to Prevent Injuries</td>
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<td>Spring Sports Medicine Symposium, Massachusetts Interscholastic Athletic Association, Franklin, MA</td>
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<td>Jennifer Orcutt, RN, MSN</td>
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<td>Erin Dalis, RN, MSN</td>
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<td>Mary Lynn Fahey, RN, MSN</td>
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<td>Julie Marden, RN, MSN</td>
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<td>Karen Pickell, RN, MSN</td>
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<td>Janet Rico, RN, MSN</td>
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<td>An Innovative Role for Nurse Practitioners to Facilitate Patient Throughput</td>
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<td>Jean O’Toole, PT, MPH, CLT-LANA</td>
<td>Breast Cancer Related Lymphedema: The Evidence Vermont Lymphedema Network, Burlington, VT</td>
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<td>The Natural History of Cording Following Treatment for Breast Cancer Research Day, Dana Farber Cancer Center, Boston, MA</td>
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Martha Brezina, RN, NP
Eileen Comeau, RN, NP
Elizabeth Delalis, RN, NP
Kellyann Jeffries, RN, NP
Jack Kane, RN, NP
Tracy Laferty, RN, NP
Michelle Letourneau, RN, NP
Jennifer Logan, RN, NP
Jeanne Vaughn, RN, NP

Acute Care of Oncology Patients in an Inpatient Oncology Nurse Practitioner Unit
36th Congress, Oncology Nursing Society, Boston, MA

Rosalie Tyrrell, RN, MS

Understanding and Leading a Multigenerational Workforce
Annual Leadership Conference: The Bridge to Nursing Leadership, Massachusetts Organization of Nurse Executives, Waltham, MA

Marjorie Voltero, RN, BSN, CGRN
Kimberly Foley, RN, BSN, CGRN
Jane Harker, RN, MS, BS, CGRN

Sedation vs. Anesthesia in the Care of the ERCP and EUS Patients in Endoscopy
Winter Meeting, New England Society of Gastroenterology Nurses and Associates, Burlington, MA

NATIONAL

Paul Armstein, PhD, RN-BC, ACNS-BC, FNP-C, FAAN

Trimorbidity: Assessing and Treating Patients with the Complex Care Issues of Pain, Addiction and Psychiatric Illness
International Nurses Society of Addictions, Tucson, AZ

Diane Doyle, RN, MS, APRN BC, AOCN
Elene Viscochi, RN, APRN, ANP BC

The Role of the Advanced Practice Nurse in a Radiation Oncology Setting
36th Congress, Oncology Nursing Society, Boston, MA

Christin Dryer, ATC
Amy Leonard, ATC, LMT
Jennifer Morin, PT, MSPT, ATC
Gayle Olson, MS, ATC, PES

Learning Lab - Injury Care at Your Fingertips: Manual Therapy Upper Extremity Techniques
National Convention, Athletic Trainers’ Association, New Orleans, LA

William Evans, MS, CF-SLP

Obligatory Deep Processing? Task Effects in Sentence Reading During Eye Tracking
2011 Conference, American Speech-Language-Hearing Association, San Diego, CA

Ellen Fern, RN
Janet King, RN, BSN, CGRN

Collaborating to Link the World of pH and Best Practice
38th Annual Course, Society of Gastroenterology Nurses and Associates, Indianapolis, IN

Marion Freehan, RN, MPA/HA, CNOR

Cost Cutting Strategies in Endoscopy Staffing
Fourth Annual Endoscopy Directors Meeting, Boston, MA

Catherine Griffith, RN

Advancing Professional Practice: Research Nurse Roundtable
3rd Annual Conference, International Association of Clinical Research Nurses, National Institute of Health, Bethesda, MD

Mary Guanci, RN

Brain Death: Myths and Methods
18th Annual Neuroscience Conference, Penn State, Hershey, PA

Carol Harmon Mahony, MS, OTR/L, CHT

Cheiroarthropathy, the Limited Joint Mobility Associates with Diabetes Type I
Study on the Epidemiology of Diabetes Interventions and Complications, National Institute of Health, Miami, FL

Cheiroarthropathy: Limited Joint Mobility Associated with Diabetes Type I
National Institute of Health Study on the Epidemiology of Diabetes Interventions and Complications, San Diego, CA

Functional Assessment of Movement
34th Annual Meeting, American Society of Hand Therapists, Nashville, TN

Dean Hess, PhD, RRT, FAARC, FCCP, FCCM

Patient-Ventilator Synchrony During Volume-Controlled Ventilation
Society of Critical Care Medicine Congress, San Diego, CA

New Modes of Mechanical Ventilation
Society of Thoracic Surgery Congress, San Diego, CA

Optimizing Noninvasive Ventilation: Are Spontaneous Breathing Trials Useful? Approaches to Prolonged Mechanical Ventilation
International Conference on Comprehensive Mechanical Ventilation, Orlando Regional Medical Center, Orlando, FL.
PROFESSIONAL ACHIEVEMENTS • presentations

Robert Kacmarek, PhD, RRT, FAARC, FCCP, CCMM
Proportional Assist Ventilation and Neurally Adjusted Ventilatory Support
NIV: New Technologies and Techniques
Annual Meeting, Society of Critical Care Medicine, San Diego, CA

The Mechanical Ventilator: Past, Present and Future
Patient-Ventilator Synchrony: PAV-NAVA
The 32nd Anniversary of the CSRC Tahoe Conference, Lake Tahoe, NV
Ventilator Management of Severe Hypercapnia
Proportional Assist Ventilation and Neurally Adjusted Ventilatory Assist
Respiratory Care 2015 and Beyond: Recommendations for Change
The 11th Annual Focus Conference, San Diego, CA

Karen Miguel, RN, MM-H
Enhancing Teamwork and Communication: The Art (and Challenge) of Changing Culture
13th Annual Congress, National Patient Safety Foundation, Washington, DC

Gayle Olson, MS, ATC, PES
Injury Care at Your Fingertips: Lower Extremity Techniques
Fourth Year Athletic Training Curriculum, Florida Southern College, Lakeland, FL

Mary Orencole, RN, MS, APRN, BC
Heart Failure Management in an Evolving Environment
11th Essentials of CRM Therapy and Patient Management Meeting, Heart Rhythm Society, San Francisco, CA

Jean O'Toole, PT, MPH, CLT-LANA
The Natural History of Cording Following Treatment for Breast Cancer
Annual Meeting, American Society of Shoulder and Elbow Therapists, White Sulphur Springs, WV

Donna Peltier-Saxe, RN, MSN
Laughing Yoga
31st Annual Conference, American Holistic Nurses Association, Louisville, KY

Katherine Phillips, PT, MS, CHT, CLT
Scapular Dyskinesis
23rd Annual Meeting, American Society of Hand Therapists, Nashville, TN

Christopher Robbins, RN, BSN, CGRN
Advanced ERC/ Hands-On
38th Annual Course, Society of Gastroenterology Nurses and Associates, Indianapolis, IN
Aerosol Delivery Techniques
Mechanical Ventilation of the Patient with ARDS
Noninvasive Ventilation for Acute Respiratory Failure
*Universidad del Desarrollo, Concepcion, Chile*

Noninvasive Ventilation. The Approach in the United States
*European Respiratory Society, Amsterdam, The Netherlands*

Epithelioid Hemangioendothelioma: Transplant—A Treatment Option in an Adult with a Pediatric Diagnosis
*20th Annual Symposium, International Transplant Nurses Society, Goteborg, Sweden*

Setting the Stage: The Importance of a Professional Practice Environment
Professional Practice Model: Shared Decision-Making
*Twinning Initiative, Huashan Hospital, Shanghai, China*

Epithelioid Hemangioendothelioma: Transplant—A Treatment Option in an Adult with a Pediatric Diagnosis
*20th Annual Symposium, International Transplant Nurses Society, Goteborg, Sweden*

Setting the Stage: The Importance of a Professional Practice Environment
professional Practice Model: Shared Decision-Making
*Twinning Initiative, Huashan Hospital, Shanghai, China*

Choosing the Correct Non-Invasive Ventilator
*31st International Symposium on Intensive Care and Emergency Medicine, Brussels, Belgium*

Mechanical Ventilation: Five Situations That Make the Intensivist Feel Uncomfortable
Effectiveness of Difference Modes of Ventilation
*International Conference on Critical Care and Respiratory Care, Buenos Aires, Argentina*

RCT Noninvasive NAVA vs. Noninvasive PSV
*ARDS Current Approach and Future Study Lines*  
*Spanish Pediatric Intensive Care Annual Meeting, Salamanca, Spain*

Transporting the Critically Ill Mechanically Ventilated Patient
The Roles and Impact of Respiratory Therapists in the US
*33rd Annual Meeting of the Japan Society of Respiratory Care Medicine, Yokohama, Japan*

New Modes of Mechanical Ventilation
The Mechanical Ventilator: Past, Present and Future
*2nd Annual Course of the Practical Application of Mechanical Ventilation, Madrid, Spain*

Choosing a Transport Ventilator
Adaptive Support Ventilation with Closed Loop CO2 Control
Translaryngeal Ventilation
*2013 International Symposium on Pediatric Nursing, Seoul, South Korea*

Has the Incidence of ARDS Decreased?
Bedside Evaluation of Patient-Ventilator Dysynchrony

*Danny Nunn, MS, CCC-SLP*
Swallowing Disorders on Neuromuscular Disease
Speech and Language Services Provided at Massachusetts General Hospital
Guidelines and Protocols for Speech, Language and Swallowing Evaluation and Treatment
Updates on SLP Therapy
Speech Language Pathologist in Hospital Setting
*First International Rehabilitation Symposium, Sao Paulo, Brazil*

*Jean O’Toole, PT, MPH, CLT-LANA*
The Natural History of Cording Following Treatment of Breast Cancer
Transient and Persistent Lymphedema Following Breast Cancer
*International Lymphedema Framework Conference, Toronto, Canada*

*Mary Ellin Smith, RN, MS*
Patient- and Family-Centered Care and Responsiveness
The Clinical Narrative: Using Stories to Understand Nursing Practice
*Twinning Initiative, Huashan Hospital, Shanghai, China*

*Danny Nunn, MS, CCC-SLP*
Swallowing Disorders on Neuromuscular Disease
Speech and Language Services Provided at Massachusetts General Hospital
Guidelines and Protocols for Speech, Language and Swallowing Evaluation and Treatment
Updates on SLP Therapy
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*First International Rehabilitation Symposium, Sao Paulo, Brazil*

*Jean O’Toole, PT, MPH, CLT-LANA*
The Natural History of Cording Following Treatment of Breast Cancer
Transient and Persistent Lymphedema Following Breast Cancer
*International Lymphedema Framework Conference, Toronto, Canada*

*Mary Ellin Smith, RN, MS*
Patient- and Family-Centered Care and Responsiveness
The Clinical Narrative: Using Stories to Understand Nursing Practice
*Twinning Initiative, Huashan Hospital, Shanghai, China*
PROFESSIONAL ACHIEVEMENTS • poster presentations

STATE AND REGIONAL

Lin-Ti Chang, RN-BC, MSN, ANP-BC, CCRN
Diane Connor, RN, MS, CDE
Theresa Gallivan, RN, MS
Barbara Moscowitz, LICSW

Closing the Gap of Health Disparity by Improving Access to Health Education and Wellness for Elder Chinese Residents Living in the Boston Community

200 Years of Commitment to the Community, Center for Community Health Improvement, Boston, MA

Patricia Grella, RN, MHA
Brenda Griffin, RN, MBA
Patricia Dykes, RN, DNSc, FAAN
Denise Goldsmith, RN, MS, MPH

Standardizing Initial Nursing Assessment Across Two Academic Medical Centers
9th Annual Symposium, New England Nursing Informatics Consortium, Waltham, MA

Marian Jeffries, RN, MSN, ACNS BC, FNP-C

Predictors of Skin Breakdown and Pressure Injury in the Tracheostomized/ Stoma Patient
Professional Development Symposium, Northeast Organization of Nurse Educators, Woburn, MA

Karen Parmenter, RN, MSN
Patricia McCarthy, PA, MHA
Beth Ellbeg, RN, MS
Sally Millar, RN, MBA

Use of Electronic Pre-Admission Medication List to Facilitate Medication Reconciliation for Patients Evaluated in a Pre-Admission Testing Telephone Program
9th Annual Symposium, New England Nursing Informatics Consortium, Waltham, MA

Colleen Snyderman, RN, MSN
State of the Science: Nurse Peer Reviews Impact on Patient Safety
Multidisciplinary PhD Research Development Day, Boston College, Boston, MA

Jean Stewart, RN, MSN
Diane Doberty, RN, BSN
Sherilyn GaulDET, RN, BSN
Kathleen Myers, RN, MSN, CNE
Joanne Hughes Empoliti, RN, MSN, G-CNS

1 Care Rounds: Implementing a Standardized Approach to Improve Patient Satisfaction and Nurse Presence
Academy of Medical-Surgical Nurses, Boston, MA

NATIONAL

Jacqueline Arroyo, RN
Transapical Aortic Valve Implantation
58th Congress, Association of periOperative Registered Nurses, Philadelphia, PA

Brian Beardslee, RN, MSN
Sarah Wojcik, RN
Development of a Nurse Education Module to Navigate Clinical Trial Protocols
11th National Conference on Cancer Nursing Research, Oncology Nursing Society, Los Angeles, CA

Rachel Bolton, RN, CPON
Show Me How: Peer Mentoring Among Children Receiving Radiation Therapy
35th Annual Conference, Association of Pediatric Hematology/Oncology Nurses, Anaheim, CA

Julie Cronin, RN, BSN, OCN
Family Member's Perceptions of Most Helpful Nursing Interventions During End-of-Life Care of a Loved One
36th Annual Congress, Oncology Nursing Society, Boston, MA

Daniel Fisher, MS, RRT
Grace thorner, MPH, RN
Mary-Liz Bilodeau, MS, RN, CCRN, ACNP-BC
Shawn Fagan, MD
Bronchoalveolar Lavage as a Screening Tool for Pulmonary Infections in an Adult Burn Unit
Society of Critical Care Medicine, 40th Congress, San Diego, CA

Marion Freehan, RN, MPA/HA, CNOR
Jamie Rossi, MS
Creating an Environment of Care for the GI Endoscopy Patient—The Role of the Child Life Specialist
38th Annual Course, Society of Gastroenterology Nurses and Associates, Indianapolis, IN

Sandra Hession, RN, BSN, CCRN
Scope Processing Can Be an Endoscopy Unit's Strongest or Weakest Link
38th Annual Course, Society of Gastroenterology Nurses and Associates, Indianapolis, IN

Yanhong Liu, PhD, MD
Ailiang Wang, MD
Andrew Marchese, BS
Ken Shelton, MD
Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM
Yandong Jiang, PhD, MD
Yandong Jiang, PhD, MD
Jet vs. ICU Ventilator During Simulated Transtracheal Ventilation: A Lung Model Study
Annual Meeting, American Society of Anesthesiologists, Chicago, IL

Elizabeth Johnson, RN, MSN, AOCNS, OCN
Jane D'Addario, RN, BSN
Elizabeth M. Johnson, RN, BSN
Paving the Way to Oncology Nursing Practice: A Summer Clinical Fellowship for Senior Nursing Students
36th Annual Congress, Oncology Nursing Society, Boston, MA

Patricia Lally, RN, BSN, CCRN
Development of a Prescreening Tool for Pediatric Patients In a Hospital Based GI Endoscopy Unit: Collaboration is the Key
38th Annual Course, Society of Gastroenterology Nurses and Associates, Indianapolis, IN

Qian Li, MD
Paul Alltine, MD
Hovig Chitilian, MD
YanHong Liu, PhD, MD
Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM
Yandong Jiang, PhD, MD
Arterial Oxygen Saturation May Be the Limiting Factor for O2 Delivery During Compression-Only CPR
Resuscitation Science Symposium, American Heart Association, Orlando, FL

YanHong Liu, PhD, MD
Ailiang Wang, MD
Andrew Marchese, BS
Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM
Yandong Jiang, PhD, MD
Jet vs. ICU Ventilator During Simulated Transtracheal Ventilation: A Lung Model Study
Annual Meeting, American Society of Anesthesiologists, Chicago, IL

Patience Care Services staff listed in bold.
Michele Lucas, MSW
Hyperarousal/Hypervigilance in Brain Cancer Patients Creates a Cycle of Sleep Disturbance and Daytime Sleepiness
16th Annual Scientific Meeting and Education Day, Society of Neuro-Oncology, Garden Grove, CA

Lea Ann Matura, PhD
Anne McDonough, PhD
Diane Carroll, RN, PhD, FAAN
Health Status, Health-Related Quality of Life, and Psychological State in Patients with Pulmonary Arterial Hypertension
7th Annual Conference, American Association of Heart Failure Nurses, Seattle, WA

Mary McAdams, RN-BC, MEd
Sheila Golden-Baker, MS, RN-BC, CRNN
Developing Subject Matter Experts to Design Online Learning Events
National Nursing Staff Development Organization, Chicago, IL

Kathleen Miller, RN, MA, PhD, AHN-BC
Dancing into Wholeness; Dance and Movement as Pathways for Health as Expanded Consciousness
Nourishing the “Sacred Flow” in a Community Health Center Setting
31st Annual Conference, American Holistic Nurses Association, Louisville, KY

Vita Norton, RN, BSN, OCN
Corrina Lee, RN, BSN, OCN
Caring for the Morbidly Obese Patient with a Gynecologic Malignancy
36th Annual Congress, Oncology Nursing Society, Boston, MA

Lynn Oertel, MS, ANP, CACP
Jennifer O’Neil, RN, BSN
Impact of Patient Self Testing on Time in Therapeutic Range
Anticoagulation Forum, 11th National Conference on Anticoagulation Therapy, Boston, MA

Constance Roche, MSN, ANP-BC, APRN, ONC
A Program to Increase Use of Chemoprevention for Women with High Risk Breast Lesions
21st Annual National Interdisciplinary Breast Center Conference, Las Vegas, NV

Sandra Silvestri, RN, MS, CNOR
Josie Ehrenfeld, MD, MPH
Maureen Hemingway, RN, BSN, MHA, CNOR
Laurie Lynch, RN, BSN, CNOR
Lisa Morrissey, RN, BSN, MBA, CNOR
Kathleen Myers, RN, MSN
Charlene O’Connor, RN, MSN, CNOR
Jill Pedro, RN, ACNS-BC, ONC
Multidisciplinary Approach to Decreasing OR Positioning Injuries
Annual Congress, Association of periOperative Registered Nurses, Philadelphia, PA

Sandra Silvestri, RN, MS, CNOR
Chalene O’Connor, RN, MS, CNOR
Laurie Lynch, RN, BSN, CNOR
Kathleen Myers, RN, MSN
Jill Pedro, RN, ACNS-BC, ONC
Maureen Hemingway, RN, BSN, MHA, CNOR
Lisa Morrissey, RN, BSN, MBA CNOR
Multidisciplinary Approach to Prevention of OR Positioning Injuries
Annual Congress, Association of periOperative Registered Nurses, Philadelphia, PA

Demet Sulemanji, PhD, MD
Fangping Bao, MD
Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM
Yandong Jiang, PhD, MD
Unidirectional Breathing Pattern Improves the Breathing Efficiency in COPD Patients. Society 40th Critical Care Congress, Society of Critical Care Medicine, San Diego, CA

INTERNATIONAL
Sheila Burke, RN, MSN
Susan Briggs, MD, MPH, FACS
The Role of Nurses in International Disasters
17th World Congress on Disaster and Emergency Medicine, Beijing, China

Diane Carroll, RN, PhD, FAAN
Needs of Older Patients and Their Spouses After a Cardiovascular Procedure
11th Annual Spring Meeting, Council of Cardiovascular Nursing and Allied Professionals, European Society of Cardiology, Brussels, Belgium
CLINICAL RECOGNITION PROGRAM

The Mass General Clinical Recognition Program serves as a formal way to recognize excellence in practice, encourage professional development, and build a diverse community of reflective practitioners within Patient Care Services. Applicants work with their directors and clinical specialists to analyze their practice relative to clinician-patient relationship, clinical knowledge and decision-making, teamwork and collaboration and movement (for Occupational Therapy and Physical Therapy professionals). Criteria within these themes define four levels of clinical practice: Entry, Clinician, Advanced Clinician and Clinical Scholar.

2011 ADVANCEMENTS

Advanced Clinician

Kate Adeletti, PT  
James Bradley, RN  
Heidi Cheerman, PT  
Angela Chyn, RN  
Chimwemwe Clarke, RN  
Julie Cronin, RN  
Nancy Davis, RRT  
Arthur R. Edmonds, RN  
Ellen Fern, RN  
Elisa Beth Gear, RN  
Shauna Harris, RN  
Joanna Hollywood, OTR/L  
Thomas Hunter, RN  
Colleen Kehoe, RN  
Jodi Kleim, PT  
Erin Lackay, SLP  
Amanda Laskey, RN  
Tara Logan, RN  
Kristin Moriarty-Paggi, RN  
Natacha Nortels, RN  
Jennifer Podesky, PT  
Karen Ratto, RN  
Paula Restrepo, RN  
Katharine Teele, PT  
Janice Tully, RN  
Laura White, RN  
Lin Wu, RN

Clinical Scholar

Robin Azevedo, RN  
Susan Barisano, RN  
Elizabeth Cole, PT  
Diane DeTour, RN  
Rosanne Karp, RN  
Karon Konner, LICSW  
Anne LaFleur, LICSW  
Brenda Pignone, RN
PROFESSIONAL ACHIEVEMENTS • appointments

STATE AND REGIONAL

Daniel Fisher, MS, RRT
Current Past President, Massachusetts Society for Respiratory Care

July Guarente, RN, MS, CCRN
Member, Board of Directors, New England Society of Gastroenterology Nurses and Associates

Jeanette Ives Erickson, RN, DNP, FAAN
Board Chair, Lander-Dineen Health Education Alliance of Maine
Instructor, Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School
Clinical Assistant Professor, Adjunct Faculty, MGH Institute for Health Professions
Clinical Professor of Nursing, Massachusetts College of Pharmacy and Health Sciences
School of Nursing
Visiting Scholar, Boston College School of Nursing
Member, National Advisory Council on Nurse Education and Practice, Health and Human Services Administration
Member, Board of Trustees, MGH Institute of Health Professions, Inc.
Member, Harvard Humanitarian Initiative Executive Committee, Harvard University
Member, Greater Boston Aligning Forces for Quality Initiative Planning Group
Member, National Advisory Council on Nurse Education and Practice, Health and Human Services Administration
Member, Board of Trustees, MGH Institute of Health Professions, Inc.
Member, Harvard Humanitarian Initiative Executive Committee, Harvard University
Member, Greater Boston Aligning Forces for Quality Initiative Planning Grant Community Council
Member, Greater Boston Aligning Forces for Quality Initiative Planning Grant Planning Group
Co-Chair, Host Committee, Celebration of Women in Healthcare, Kenneth B Schwartz Center
Member, Harvard Humanitarian Initiative Executive Committee, Harvard University
Member, Board of Directors, The Institute for Nursing Healthcare Leadership
Member, Board of Directors, The Benson-Henry Institute for Mind Body Medicine Chairperson, Chief Nurse Council, Partners Healthcare System, Inc.

Elise Townsend, PT, DPT, PhD, PCS
Associate Professor, Department of Physical Therapy, School of Health and Rehabilitation Sciences, MGH Institute of Health Professions

Laura Walsh, RN, BSN, ACRN
President-Elect, Boston Chapter, The Association of Nurses in AIDS Care

Kevin Whitney, RN, MA, NEA-BC
President, Organization of Nurse Leaders of Massachusetts and Rhode Island
Member, Standing Committee on Public Affairs, Massachusetts Hospital Association

NATIONAL

Lillian Ananian, RN, MSN, PhD(c)
Member, Research Committee, Society of Critical Care Medicine

Paul Arnstein, PhD, RN-BC, ACNS-BC, FNP-C, FAAN
Co-Chair, Pain Education Special Interest Group, American Pain Society
Member, Education Advisory Board, American Pain Society

Barbara Blakeney, RN, MS
Public Policy Fellow, National Academies of Practice
Secretary, Board of Directors, Health Care Without Harm
Secretary, Board of Directors, Practice Green Health

Ann Haywood-Baxter, MDiv, BCC
President-Elect, Advisory Council, Pediatric Chaplains Network

Patient Care Services staff listed in bold.
Todd Hultman, PhD, ACNP, ACHPN
Member, Board of Directors, Hospice and Palliative Nurses Association
Member, Primary Palliative Care Performance Improvement Module Committee, American Board of Internal Medicine
Member, Review Committee, American Board of Internal Medicine

Jeanette Ives Erickson, RN, DNP, FAAN
Member, Operational Review Team, National Institutes of Health
Member, National Advisory Council on Nurse Education and Practice, Health and Human Services Administration

Marian Jeffries, RN, MSN, ACNS BC, FNP-C
Member, Clinical Nurse Specialist Content Expert Registry for 2011-2015, American Nurses Credentialing Center

Aimee Klein, PT, DSc, OCS
Member, Credential Services Committee, American Physical Therapy Association, and American Board of PT Residency and Fellow Education

Gail Lenehan, RN, MSN, EdD, FAEN, FAAN
President, Emergency Nurses Association

Mary Pomerleau, DNP, RNC-OB
Member, Board of Directors, American Association of Women’s Health Obstetrics and Neonatal Nurses

Elyse Levin-Russman, LICSW
Member, Board of Directors, and Chairperson, Quality of Life Committee, The Association of Pediatric Oncology Social Workers

Lynn Oertel, MS, ANP, CACP
Member, Medical and Scientific Advisory Board, National Blood Clot Alliance

Amanda Stefańczyk, RN, MSN, MBA, CNML
Member, Health Care Reform Tax Force for 2011, American Organization of Nurse Executives

Deborah Washington, RN, PhD
Co-Chair, Diversity Workgroup, Future of Nursing, Campaign for Action Initiative, Institute of Medicine

INTERNATIONAL

Barbara Blakeney, RN, MS, FNAP
Member, Nominating Committee, The International Council of Nurses

Jeanette Ives Erickson, RN, DNP, FAAN
Visiting Professor, Huashan Hospital/Fudan University, Shanghai, China
Member, Kappa Zeta-at-Large Chapter, Sigma Theta Tau International
Board Member, Duranti Fellowship for Refugee Medicine, Massachusetts General Hospital

Mary McAdams, RN-BC, MEd
Vice President, Membership, Massachusetts Chapter, International Society of Performance Improvement
Richard Ahern, RN, DNP, ANP-BC, AACRN
Inge Corless, RN, PhD, FAAN
Sheila Davis, RN, DNP, ANP-BC, FAAN
Jeffrey Kwong, DNP, MPH, ANP-BC, AACRN

Infusing Swanson’s Theory of Caring into an Advanced Practice Nursing Model for an Infectious Diseases Anal Dysplasia Clinic
Journal of the Association of Nurses in AIDS Care

Paul Arnstein, PhD, RN-BC, ACNS-BC, FNP-C, FAAN
Multimodal Approaches to Pain Management

Is Palliative Sedation Right for Your Patient?
Nursing 2011

Paul Arnstein, PhD, RN-BC, ACNS-BC, FNP-C, FAAN
Kathleen Broglio, ANP-BC, ACHPN, CPE
Elsa Wuhrman, MS, FNP, BC
Mary Beth Kean, CNP, ACNS-BC
Use of Placebos in Pain Management
Pain Management Nursing

Paul Arnstein, PhD, RN-BC, ACNS-BC, FNP-C, FAAN
Kathleen Broglio, PhD, ANP
Elsa Wuhrman, RN, MS, ACNP, FNP, BC
Placebos: No Place in Pain Management
Nursing 2011

Thomas Barnes, EdD, RRT
Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM

Variability: The Spice of Life?
Critical Care Medicine

Cheryl Brunelle, PT, MS CCS, CLT
Jackie Mulgrew, PT, CCS
Exercise for Intermittent Claudication
Physical Therapy 2011

Elizabeth Correger, RN
Gergio Murias, RN
Eli Chacon, RN
Antonio Estruga, RN
Betty Sales, RN
Jesus Lopez-Aguilar, PhD, MD
Jamie Montanya, PhD
Oscar Garcia-Esquiro, MD
Ana Villagrazia, PhD, MD
Jesus Villar, PhD, MD
Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM
Mpfj Burgueno, PhD
Lluis Blanch, PhD, MD
Interpretation of Ventilator Curves in Patients with Acute Respiratory Failure
Medicina Intensiva

Constance Dahlin, ANP, BC, FAAN
Emily Gallagher, RN
Jennifer Terrel, MD
Early Intervention Palliative Care – Implications for Nursing
The Oncology Nurse

Deborah D’Avolio, APRN-BC, PhD
Mary Ellen Heike, RN, MMHS
Debra Burke, MBA, MSN
Theresa Gallivan, MSN
The Plus of 65+
Nursing Management

Melissa Duan, MD
Lorenzo Berra, MD, PhD
Asheesh Kumar, MD
Susan Wilcox, MD
Steve Safford, AS, RRT
Robert Goulet, MS, RRT
Michelle Landers, RN
Ulrich Schmidt, MD, PhD
Use of Hypothermia to Allow Low-Tidal-Volume Ventilation in a Patient With ARDS
Respiratory Care

Patricia Dykes, RN
Diane Carroll, RN, PhD, FAAN
Kerry McColgan, RN
Lisa Colombo, DNP, RN
Maureen Donahue, RN, DNSc, FAAN
Ann Hurley, RN
Angela Benoit
Development and Testing of the Nurse and Assistant Self-Efficacy for Preventing Falls Scales
Journal of Advanced Nursing

Juliana Ferreira, PhD, MD
Felix Bensenor, PhD
Michael Rocha, MD
Joseph Salgo, MD
Robert Harris, MD
Atul Malhotra, MD
Roberto Kairalla, MD
Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM
Carlos R Carvalho, PhD, MD
A Sigmoidal Fit for Pressure-Volume Curves of Idiopathic Pulmonary Fibrosis
Patients on Mechanical Ventilation: Clinical Implications
Clinics (Sao Paulo)

Daniel Fisher, MS, RRT
Novel Endotracheal Tube Cuffs: Improving the Seal as a Barrier to Leakage
Respiratory Care

Jaime Garzon-Serrano, MD
Cheryl Ryan, RN, MSN
Karne Waak, PT, DPT, CCS
Ronald Hirschberg, MD
Susan Tully, RN, BSN
Edward Bittner, MD
Daniel Chipman, BS, RRT
Ulrich Schmidt, PhD, MD
Georgios Kasotakis, MD
John Benjamin, MD
Ross Zafonte, DO
Matthias Eikermann, PhD, MD
Early Mobilization in Critically Ill Patients: Patients' Mobilization Level Depends on Health Care Provider’s Profession
Physical Medicine and Rehabilitation
PROFESSIONAL ACHIEVEMENTS • publications

Greer Glazer, RN, PhD, CNP, FAAN
Jeanette Ives Erickson, RN, DNP, FAAN
Laura Mykoff, RN, PhD
JoAnn Mulready-Stick, RN, EdD, CNE
Gaurdia Banister, RN, PhD
Partnering and Leadership: Core Requirements for Developing a Dedicated Education Unit
Journal of Nursing Administration

Dean Hess, PhD, RRT, FAARC, FCCP, FCCM
Patient-Ventilator Interaction During Noninvasive Ventilation
Respiratory Care

Dean Hess, PhD, RRT, FAARC, FCCP, FCCM
How Much PEEP? Do We Need Another Meta-Analysis?
Respiratory Care

Dean Hess, PhD, RRT, FAARC, FCCP, FCCM
Ventilator Discontinuation: Why are We Still Weaning?
American Journal of Respiratory and Critical Care Medicine

Gordon Hilsman, DMin
Angelika Zollfrank, BCC
In Search of Theory and Criteria for the Practice of Distance Supervision
Reflective Practice: Formation and Supervision in Ministry

Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM
Thomas Barnes, EdD, RRT
Charles Durbin, MD
Survey of Directors of Respiratory Therapy Departments Regarding the Future Education and Credentialing of Respiratory Care Students and Staff
Respiratory Care

Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM
Jesus Villar, PhD, MD
Lung Recruitment Maneuvers During Acute Respiratory Distress Syndrome: Is It Useful?
Minerva Anestesiologica

Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM
Proportional Assist Ventilation and Neuromodulated Ventilatory Assist
Respiratory Care

Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM
The Mechanical Ventilator: Past, Present, and Future
Respiratory Care

Mary Larkin, MS, RN, CDE
Paul McGaugian, BSN, RN, CDE
Denise Richards, MSN, FNP, CDE
Karen Blumenthal, BA
Kerry Milaszewski, BSN, RN, CDE
Laurie Higginbotham, MS, RD, LDN, CDE
Jill Schaniel, MD
Christen Long, BA
Collaborative Staffing Model: Reducing the Challenges of Study Coordination
Applied Clinical Trials

Susan Lee, RN, PhD
Edward Coakley, RN, MS, MA, MEd
Geropalliative Care: A Concept Synthesis
Journal of Hospice and Palliative Nursing

Michele Lucas, LICSW
A Private Caregiver Listserv: Maximum Benefit for Minimum Cost
Journal of Psychosocial Oncology

Maureen Lynch, ANP
Constance Dahlin, ANP, BC, FAAN
Todd Hultman, ANP
Edward Coakley, MSN
Palliative Care Nursing—Defining the Discipline?
Journal of Hospice and Palliative Nursing

Neil Maclntyre, MD
Stefano Nava, MD
Robert DiBlasi, RRT
Ruben Restrepo, MD, RRT
Dean Hess, PhD, RRT, FAARC, FCCP, FCCM
Respiratory Care Year in Review 2010: Part 2. Invasive Mechanical Ventilation, Noninvasive Ventilation, Pediatric Mechanical Ventilation, Aerosol Therapy
Respiratory Care

Rajeev Malhotra, MD
Dean Hess, PhD, RRT, FAARC, FCCP, FCCM
Gregory Lewis, MD
Kenneth Bloch, MD
Aaron Waxman, MD, PhD
Marc Semigran, MD
Vasoreactivity to Inhaled Nitric Oxide Predicts Long-Term Survival in Pulmonary Arterial Hypertension
Pulmonary Circulation

Andrew Marchese, BS
Demet Sulemanji, PhD, MD
Daniel Chipman, BS, RRT
Jesus Villar, PhD, MD
Robert Kacmarek, PhD, RRT, FAARC, FCCP, FCCM
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Respiratory Care

Annette McDonough, RN, PhD
Leanne Matura, RN, PhD
Diane Carroll, RN, PhD, FAAN
Symptom Experience of Pulmonary Artery Hypertension Patients
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Karen Miguel, RN, MM-H
Joshua Hirsch, MD
Robert Sheridan, RT(R)
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Beth-Ann Norton, RN, MS, ANP-BC
Stephen Hanauer, MD
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Donna Perry, RN, PhD
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Jean O’Toole, PT, MPS, CLT-LANA
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Breast Diseases: The Year Book Quarterly, 2011

Breast Cancer-Related Lymphedema: Modern Methodology of Assessment and Management
Breast Diseases: The Year Book Quarterly, 2011

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Kimberly Parks, MD
Mary Orencole, RN, MS, APRN
The MGH Heart Failure Device Monitoring Clinic
EP Lab Digest
Laurel Radwin, RN
Lillian Ananian, RN, MSN, PhD
Howard Cabral, PhD, MPH
Adele Keeley, RN
Paul Currier, MD
Effects of Patient/Family-Centered Practice Change on the Quality and Cost of Intensive Care
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Joan Rosenbaum, MD
Joan Renaud Smith, RN, MSN, NNP-BC
Angelika Zollfrank, BCC
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Bruce Rubin, MD
Rajeev Dhand, MD
Gregg Ruppel, RRT
Richard Branson, RRT
Dean Hess, PhD, RRT, FAARC, FCCP, FCCM
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Ulrich Schmidt, MD, PhD
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Edward Bittner, MD, PhD
To Decannulate or Not to Decannulate: A Combination of Readiness for the Floor and Floor Readiness?
Critical Care Medicine
Irina Selivestrov, MS, NP, CACP
Practical Management Approaches to Anticoagulation Non-Compliance
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Melissa Skolny, MSHA
Cynthia Miller, BS
Jean O’Toole, PT, MPS, CLT-LANA
Alphonse Taghian, MD, PhD
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Nursing Interventions for Family Members Waiting During Cardiac Procedures
Clinical Nursing Research
Jesus Villar, PhD, MD
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Wnt/β-catenin Signaling is Modulated by Mechanical Ventilation in an Experimental Model of Acute Lung Injury
Intensive Care Medicine
Jesus villar, PhD, MD
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Art Slutsky, PhD, MD
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Jesus Villar, PhD, MD
Jesus Blanco, PhD, MD
Lena Perez-Mendez, PhD, MD
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Gerardo Aguilar, MD
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Acute Respiratory Distress Syndrome Definition: Do We Need a Change?
Current Opinion in Critical Care
Saul Weingart, MD, PhD
Junya Zhu, RN, MS, MA
Laurel Chiapetta, MS
Sherri Stuver, ScD
Eric Schneider, MD, MSc
Arnold Epstein, MD, MA
Jo Ann David-Kasden, RN, MS, SM
Catherine Annas, JD
Floyd Fowler, Jr., PhD
Joel Weissman, PhD
Hospitalized Patients’ Participation and its Impact on Quality of Care and Patient Safety
International Journal for Quality in Health Care
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Anesthesiology
Mass General is fortunate to have more than 1,400 volunteers each year who provide countless and valuable services to patients and staff throughout the hospital. They can be found in a variety of settings, from greeting patients when they first arrive to escorting them to transportation after discharge. Although the volunteers come from all age groups, backgrounds and experiences, they share a commitment to making a difference at Mass General. In 2009, many volunteers reached significant milestones for the total number of hours they have served the hospital community.

100 +
Arthur Aaronson
Delphine Acha
Donna Marie Alvin
Douglas Arnold
Elizabeth Balacanis
Kevin Bardon
Marcia A. Barron
Ken Beardsley
Mary Benham
Sandra Brodowski
Thomas Burns
Adam Castiglioni
Corinne Cavolick
Amulkrumar Chaniara
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Camille Chow
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Mery Daniel
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Stephen Dipietro
Katelynn Donovan
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Senan Ebrahim
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Eugene Floreendo
Evita Floreendo
Jonathan Fox
Bobbie Gallarda
Aditya Gill
Renee Giorgia
Patricia Gold
Gayle Gordon
Avalin Green
Julio Guillen
Meynardo Gutierrez
Sarah Hadge
Samer Haidar
Jessica Harrop
Katie Hatfield
William Hendriksen
Haile Hernandez
Robert Hoffman
Edward Hong
Gilberte Jean-Mary
Lauren Kava
Karol Keating
Hattie Kessler
Hyon Suk Kim
Dhimane Kodili
Barry Kriegerman
Elizabeth Kross
Timothy Kyi
Paul Lacerda
Joel Lesser
Kimberly Levin
Kaitlin Lockhart
Katherine Luo
Christina Maheras
Sairah Mahmoud
Lauren Maiello
Olaseni Makinde
Diane Marie
Dawn McCauley
Debra McNeil
Sarah Meigs
Ross Merrin
Janice Mottolo
Maria Olivier
Richard Orluk
Bianca Ornellas
Page (Katherine)
Osborn
Pamela Oswald-Louis
Joo-Hye (Christine)
Park
Corey Pasakarnis
Payal Patel
Amy Patti
Ervin Pejo
Anirudh Penumaka
Gloria Platon
Stephanie Redfield
Raquel Rodriguez
Sandra Rolland
Stephanie Santos
Jack Schenele
Sippy Scipien
Royce Shou
Sean Siebert
Elizabeth Smith
Anne Sommer
Elizabeth Spelios
Louise Spracklin
Emily Staudenmaier
Diane Straus
Marion Tina
Ivyalo Tomov
Nicole Tonkonog
Nam Truong
Kelly Tsang
Alice Tse
Suan Tuang
Spencer Twyman
Greg Valentini
Anastasia Vedenko
Rebecca Wagner
Clive Wan
Becky Warsosky
Amy Wei
Eva Wendel
Shannon Wilton
Felix Ye
Heidi Yu
Melissa Yu
Anne Zepf
Kathleen Iannotti
Kathy Kenney
Richard Keyes
Isabel King
Derek London
Donna Marie Mason
Sarah Nduuga
Hope Nguyen
Sheila Njau
Brendan O’Brien
Carter Petty
Martha Pierce
Betty Raymond
Leslie Salzberg
Nora Tiffany
Betsy Westra
Peter Whistler
Rachel Wilson

500 +
Wendy Bazari
Stephen Currier
Charley Davidson
Lydia DeSanctis
Hinda Haims
Barbara Haley

3,000 +
Kevin Currie
Rose McCabe
Deborah Morrison
George L. O’Brien

4,000 +
Kay Bander
Anne Hill
Bill Lauch
Duncan MacDonald
Peggy Scott

5,000 +
Mimi McDougal

6,000 +
Patty Austen

8,000 +
Margaret Wilkie

10,000 +
James Gillespie

2,000 +
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David Moccia
David O’Brien
Janet Shipman
Louise Smith
“Guided by the needs of our patients and their families, we aim to deliver the very best healthcare in a safe, compassionate environment; to advance that care through innovative research and education; and to improve the health and well-being of the diverse communities we serve.”

—The MGH Mission
Executive Team

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Executive Director, The Institute for Patient Care

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Associate Chief Nurse

Leila Carbunari, RN, MEd
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Sally Millar, RN, MBA
Director, PCS Informatics; Interim Director, PCS Financial Management Systems

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Anabela Nunes, MBA
Director, Medical Interpreter Services

Rev. John Polk, DMin, BCC
Director, Chaplaincy

George Reardon, MBA
Director, Clinical Support Services

Susan Sabia
Executive Editor, Caring Headlines

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Director, Physical Therapy and Occupational Therapy

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Associate Chief Nurse

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Director, Speech, Language & Swallowing Disorders

Deborah Washington, RN, PhD
Director, PCS Diversity Program

Kevin Whitney, RN, MA, NEA-BC
Associate Chief Nurse; Interim Director, PCS Office of Quality & Safety
MASSACHUSETTS GENERAL HOSPITAL
FY 2012 Priorities
Strategic Goals

Make MGH Care Better and More Affordable
○ Effect measurable improvements in quality and safety of MGH care.

○ Co-lead (with Mass General Physicians Organization CEO) further development and implementation of Partners HealthCare Systems strategic plan at MGH/MGPO; develop 5-10 year strategic plan for MGH/MGPO that harmonizes with PHS plan and gives direction to programmatic and investment decisions at MGH, including next major MGH construction project.

○ Achieve FY12 operating budget margin target including developing and implementing a plan to improve operating performance by $33M/year by 4th quarter ($16M already achieved in FY10).

○ Expand population health management efforts at MGH/MGPO (and PHS).

Other Critical Goals
• Recognize final quarter of MGH’s 200th anniversary successfully – (1) Warren Triennial Prize and (2) Russell Museum opening.

• Achieve FY12 fundraising target ($170m) and continue successful implementation of capital campaign.

• Complete successful searches for new Chiefs of Urology, Neurology, Medicine and SVP for Research.

• Improve administrative support to MGH investigators.

• Integrate undergraduate medical education activities into Executive Committee on Teaching and Education.

• Ensure that all MGH Bicentennial Scholars graduate from high school and get accepted to college.

• Enhance diversity of medical staff and senior management.

• Keep MGH the employer of choice in health care.

• Advocate at state and federal level for reasoned policies to (1) enhance insurance coverage, (2) make health care more affordable, and (3) provide appropriate support for biomedical research.
MGH / MGPO Strategic Planning Next Steps

July 29, 2012
Goal

To review and revise the MGH/MGPO strategic plan and associated initiatives in the face of the evolving health care landscape. The focus of the work will be across all four missions of the organization: clinical care, education, research and service to communities both locally and across the globe.
## Where We Are In the Process: Workgroup Launch

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<tbody>
<tr>
<td>Develop structure and process</td>
<td>Synthesize internal/external environment and supporting analytics</td>
<td>Launch multidisciplinary workgroups</td>
<td>Report out of each workgroup’s recommendations</td>
<td>Development and approval of final strategic plans</td>
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<td>Launch analytics committee</td>
<td>Introduce concept of workgroups focusing on each mission</td>
<td>Workgroups: - Review/assess work to date - Conduct further analysis if necessary - Develop preliminary strategies and tactics</td>
<td>Group validation of preliminary strategies and tactics</td>
<td>Implementation planning begins</td>
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<td>Gather information for review of external and internal environments/current assessment</td>
<td>Hold 1st retreat</td>
<td>Hold 2nd retreat</td>
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### Planning
- Workgroup Introduction
- Workgroup Launch

### Retreats
- 1st Retreat
- 2nd Retreat

### Development
- Recommendation Development
- Strategic Plan Finalized
- Implementation Planning
Organizational Structure

MGH & MGPO Boards of Trustees

Peter L. Slavin, MD / David F. Torchiana, MD

Executive Committee

“Blue Sky” Advisory Group

Communications Committee

Analytics Committee

Logistics Committee
Work to Date (Pre-Retreat)

- **Launched Strategy Committees**
  - Executive
  - Blue Sky
  - Analytics

- **MGH/MGPO Case Development**
  - HBS style case
  - Stakeholder interviews
  - Multimedia component

- **April 20th Retreat**
  - 135 participants
  - Case discussion and mission-focused breakout sessions
Highlights of Jim Cash’s Key Takeaways from Strategy Retreat

- **Globalization**: Having truly global reach in all four missions
- **Coopetition**: Collaborators in one segment; competitors in another
- **Distributed Innovation**: Sourcing innovation from beyond MGH’s walls
- **New Value Definitions**: Perceived Experience \( \frac{\text{Total Cost}}{\text{price plus effort to receive services}} \) (better or worse than expected)
- **Reverse Innovation**: Look to cost-constrained environments for new designs
Strategic Planning Overview

- One-on-one interviews with >40 key individuals across MGH
- In-depth analysis of internal and external trends
- MGH “case”: articulation of key strategic opportunities and challenges
- Strategy retreat: identification of strategic priorities
- Launch of workgroups based on strategic priorities

We are here
Assumptions From Our Work to Date

The case writing and April 20th retreat

1. Validated our commitment to all four missions

2. Confirmed an approach to planning that is concentrated on targeted areas of strategic focus and validated existing strategic efforts already underway (i.e. population health)

3. Highlighted that the need/desire for ‘transformational change’ varies by mission
**Structuring the Work**

**By Mission**

- 1-2 workgroups for each of the 4 missions; 1 combined workgroup

**Clinical** (2 workgroups)

**Research** 
- Clinical (1 workgroup)

**Research** (1 workgroup)

**Education** (1 workgroup)

**Community** (1 workgroup with local focus)

**Foundational teams**

- Cost Accounting / Finance
- IT/Data Management
- Analytics / Forecasting
- Real Estate / Facilities

**Workgroups:**

- In addition to key leaders for each mission, each workgroup will have representatives from the following areas as appropriate:
  - Project Management
  - Communications
  - IT
  - Quality/Safety
  - Workforce
  - Analytics/Finance
  - Facilities/Real Estate

- Each workgroup will be given a specific charge with an initial set of targeted questions.

**Foundational Teams:**

- Populated by the associated representatives of each of the mission-related workgroups

- Timing of the launch of these teams may vary
Leadership of Each Group

- Teams lead (top row) is responsible for day-to-day leadership of the team.
- Executive sponsor (middle row) is a member of the strategy executive committee and serves as a liaison between the group and the committee.
- EDs/ADs will provide project management support (bottom row).
- Teams will be pre-populated with representatives in key areas as appropriate.
- Team leads are responsible for selecting the remaining members of their team.
Strategic Planning Process Organization and Roles

- Provide oversight and direction to overall process
- Review and approve workgroup recommendations
- Participate on workgroups as executive sponsors

- Manage strategic planning process on day-to-day basis
- Link to rest of MGH/Partners organization
- Develop overall approach

- Support project management as necessary
- Provide external view; external analysis as needed
- Participate in/facilitate meetings and synthesize output as needed

- Review/assess work to date (deeper dive if necessary)
- Develop high level strategies and tactics

- Provide foundational support to teams
- Assess implications of workgroup recommendations
- Develop content-specific strategies
Clinical 1: How do we redesign our delivery system to succeed at population health?

- How can we increasingly leverage team-based care (e.g., innovation units, patient centered medical home)?

- How should we change the delivery system to:
  - improve quality management and patient outcomes?
  - be more cost effective as measured through total medical expense?
  - ensure appropriate use and development of technology that leverages communications with and education for patients?
  - ensure the most effective use of our workforce?
Clinical 2: How can we better differentiate MGH episodic care?

• How do we more clearly define the role of traditional clinical departments and multi-disciplinary centers? How should we brand MGH episodic care?

• How can we differentiate ourselves in quality management/outcomes?

• How can we improve referrer access and satisfaction?

• How do we ensure continuity of care for our patients over the course of their disease state?

• How do we leverage and build upon the work being done in the following areas to ensure we provide superior service to patients and referring physicians?
  - Care Redesign – with a particular focus on cost-effective episodic care
  - Network Development/Access and Referral Management
  - International/Development
  - Executive Registry/Concierge Medicine
Research ⇔ Clinical: How can we better integrate the clinical and research missions?

- How can we better enhance MGH clinical care with research?
  - How do we prepare MGH for a future of personalized medicine?
  - How can we do a better job of bringing innovation to clinical care?

- How can we enhance MGH research via closer engagement with the clinical care mission?
  - How can we increase clinical and translational research at MGH?
  - What additional infrastructure is needed to enable translational research (e.g. tissue banking, bioinformatics, biostatistics)?
  - How can we engage MGH patients more in the research mission?
Research: How should we organize MGH research for greatest success and impact?

• How can we create a more visible “front door” for external partners, including industry?

• How should we improve the internal research infrastructure, including better communication among, and support for, MGH investigators?

• Is a virtual institute part of the answer, and if so, what would it look like?

• How do we ensure MGH can continue to attract and retain the best investigators?

• Are there new opportunities for interdisciplinary research centers a la Simches?
Education: How should we redefine the teaching model to prepare trainees/staff for the changing healthcare landscape?

• How should we change the training model…
  - To deliver more effective training in a more cost-efficient way (e.g., via simulation, social media, new technologies)?
  - To better prepare our trainees to work in teams both within and across their own fields/disciplines?
    – To emphasize resident learning versus resident service?

• To execute this new model, should we develop a dedicated group of teachers/faculty?

• How do we leverage existing and/or develop new tools and programs to more effectively deliver educational content (ex. Health Stream, CME).

• Are there/will there be opportunities to disseminate and market MGH education? How to pursue these opportunities?

• How can we establish the value of the education mission? How should we communicate the value to internal and external audiences?
**Community:** How can the (local) community mission be more explicitly linked to the other missions, to strengthen/enhance them?

- How can we better integrate, and enable bidirectional learning between community and our other missions?
  - In particular, for population health management

- How should we focus our community efforts? e.g., focus on a limited number of community issues, in specific geographic locations with community input?

- How should the community mission be organized/structured? Should there be an “ECOR” for community?
Key Questions/Considerations for All Teams

• How can we diversify our revenue sources to support each mission?
  – E.g., philanthropy

• How can we streamline our efforts and manage costs where possible?

• How can we best leverage IT/the Epic system to support each mission?

• How will we be able to maintain our unique MGH culture?
Workgroup Organizing Principles

1. Keep the big picture in mind
   - Ask: what are our long-term goals?
   - Consider broader environmental factors
   - Start with strategy, not tactics
   - Keep ultimate focus on the patient

2. Build on work to date
   - Leverage MGH strategy prep work to date: analytics team output, MGH case, retreat discussion notes
   - Leverage existing teams and incorporate relevant recent/ongoing strategy work (e.g., MGPO, PHS)

3. Focus on assigned charge
   - Address assigned sub-questions as a minimum, but go beyond if desired

4. Identify what not to do
   - Critically assess all proposals – recommend only those with the highest value to the organization
   - Seek opportunities to cut existing unproductive activities
Next Steps

1. Leadership triads selecting team members

2. Populate work groups with foundation team members

3. Work group launch – August 1st
Patient Care Services
Strategic and Annual Operating Plan
2010-2011
Mission

Guided by the needs of our patients and their families, we deliver the very best health care in a safe, compassionate environment; we advance that care through innovative research and education; and, we improve the health and well-being of the diverse communities we serve.
MGH Patient Care Services Vision Statement

As Nurses, Health Professionals, and Patient Care Services support staff, our every action is guided by knowledge, enabled by skill, and motivated by compassion. Patients are our primary focus, and the way we deliver care reflects that focus every day.

We believe in creating a practice environment that has no barriers, is built on a spirit of inquiry, and reflects a culturally-competent workforce supportive of the patient-focused values of this institution.

Core Values

It is through our professional practice model that we make our vision a demonstrable truth everyday by letting our thoughts, decisions, and actions be guided by our values. As clinicians, we ensure that our practice is caring, innovative, scientific, and empowering, and is based on a foundation of leadership and entrepreneurial teamwork.
Core Processes

Patient Care Delivery: Deliver Patient Care Effectively and Efficiently
- Care is patient-and family-centered
- Patients and families receive timely and appropriate patient education
- Clinicians advance their clinical practice through orientation, training and continuing educational programs
- Staffing is matched to workload
- Clinicians deliver evidenced-based practice; translate research into practice

Care Access Management: Ensure Timely Access to Care through the following initiatives:
- ED divert initiatives
- Cath lab recovery
- Pediatric transport program
- Neuroscience variability study
- Admission turn-around time: ED & PACU
- Therapy consult response time

Quality & Safety: Assure Quality and Safety in Care and Practice through:
- Delivery of care that is safe, effective, patient-centered, timely, efficient and equitable implementation of an action agenda for quality and safety
- A blame-free culture
- Multi-disciplinary teamwork
- Education
- Unit rounds
- Incident reporting system

Clinician and Staff Development/Support: Pay Keen Attention to Creating an Environment Supportive of Clinicians and Support Staff:
- Use unit dashboards to track key HR data
- Maximize management visibility
- Advance the clinical recognition program
- Continue awards and recognition programs
- Provide continuing education programs to grow careers
- Maintain and grow presence in media, advertisements, publications, conference presentations, influencing legislation, etc.

Fiscal Accountability: Demonstrate Fiscal Accountability for Respective Areas and Patient Care Services as a Whole
- Trend and analyze financial data
- Implement productivity enhancements
- Allocate and re-allocate resources based upon priorities

Environmental Change Management: Conduct Environmental Scanning and Respond to Changes in the Environment, e.g.
- Changing Workforce
- Changing Patient Population
- Economic indicators
- Regulations
Guiding Principles

- We are ever-alert for opportunities to improve patient care; we provide care based on the latest *research* findings.
- We recognize the importance of **encouraging patients and families to participate** in the decisions affecting their care.
- We are most effective as a team; we continually strengthen our relationships with each other and actively promote **diversity** within our staff.
- We enhance patient care and the systems supporting that care as we work with others; we eagerly enter new **partnerships** with people inside and outside of the Massachusetts General Hospital.
- We never lose sight of the needs and expectations of our patients and their families as we make clinical decisions based on the most **effective use of internal and external resources**.
- We view **learning as a lifelong process** essential to the growth and development of clinicians striving to deliver quality patient care.
- We acknowledge that maintaining the **highest standards** of patient care delivery is a never-ending process that involves the patient, family, nurse, all healthcare providers, and the community-at-large.
FIRST AND FOREMOST WE STRIVE TO DELIVER EVER SAFER AND MORE EFFECTIVE CARE.

WE SUPPORT THE EFFORTS OF EVERY MEMBER OF THE HEALTHCARE TEAM TO DELIVER THE BEST CARE POSSIBLE

- We view accountability for patient harm or potential harm in the context of individual and system influences.
- We commit to supporting simplification, standardization, effective teamwork and open communication in order to foster an environment to minimize error.
- We believe that individuals are accountable for their own performance but should not carry the burden for system flaws.

WE PROMOTE OPEN DISCUSSION within our organizations to learn about adverse events and potential causes of patient harm.

- We commit to developing and maintaining easily accessible and constructive ways for healthcare workers and patients to discuss adverse events and concerns about the safety of care delivery.
- We encourage sharing what we learn within the Partners organizations because this information helps lead us to actions that improve the healthcare environment.

WE PROMOTE INTERDISCIPLINARY DISCUSSION and analysis of adverse events and potential patient harm.

- We commit to eliciting different points-of-view to identify sources of patient harm and to use the information to improve safe delivery of care.
- We believe that patient input is indispensable to the delivery of safe care and we commit to promoting patient participation on our care deliver teams.
- We commit to analyzing episodes of patient harm or potential harm in an unbiased fashion to determine the contribution of system and individual factors.
- We commit to fostering a team approach to the analysis of adverse events and potential patient harm and the actions taken to address them.

WE WILL ACT TO IMPROVE SAFETY by implementing changes based on our analysis of adverse events and potential patient harm-

- We commit to identifying actions designed to address the causes of adverse events.
- We commit to assigning responsibility for implementing actions to specific individuals or groups.

WE WILL INFORM PATIENTS AND FAMILY MEMBERS, HEALTHCARE PROVIDERS, LEADERSHIP AND TRUSTEES ABOUT ACTIONS that have been taken to improve patient safety.

- We commit to fostering an environment that is concerned with safety through continuous education, reminders and leadership.
- We commit to ensuring that our leaders and all healthcare workers are cognizant of the complexities of delivering safe patient care and support the efforts to address those complexities.

WE WILL MEASURE OUR SUCCESS IN PROMOTING AN ENVIRONMENT COMMITTED TO QUALITY AND PATIENT SAFETY.

Copyright: Partners HealthCare System
Our strengths and capabilities allow us to manage change to our advantage. Our vision will be achieved by matching our internal capabilities with the changing demands and opportunities of the outside world.

**External Trends:**

1. **Economic Issues**
   - Continued economic downturn
   - Health care reform
   - Continued trend toward outpatient or home care
   - Shorter lengths of hospital stays
   - Higher wages for health professionals

2. **Regulatory Updates**
   - Improve the accuracy of patient identification
   - Improve the effectiveness of communication among caregivers
   - Improve the safety of using high-risk medications
   - Eliminate wrong-site, wrong-patient, wrong-procedure surgery
   - Improve the safety of using infusion pumps
   - Improve the effectiveness of clinical alarm systems

3. **Societal Issues**
   - Workforce shortages
   - Emphasis on technology management
   - Increased focus on wellness and alternative therapies
   - Increased consumer expectations and needs
   - Decrease in women selecting healthcare as career
   - Aging patient population
   - Aging nursing staff workforce
   - Concerns for bioterrorism and other terrorist activities

**Internal Trends:**

- Increasing focus on effectiveness
- Data-driven culture
- Emphasis on revenue generation
- Commitment to broad definition of diversity
- Inspired/dedicated employees
- Limited capital funds
- Clinical research growth
- Basic system inefficiencies
- Increased staff expectations
- Workforce composition changing
- Cost containment pressure
- Intolerance for ambiguity and inefficiencies
- Increased reliance on technology
- Increased desire for personal recognition
- Emphasis on personal safety
- Emphasis on teamwork
The MGH Patient Care Delivery Model where mission, vision, values and long-range goals converge to support the delivery of patient care. Our model depicts the dynamic and therapeutic interaction that occurs between the professional care provider and the patient around issues of health and illness. The model reflects an open, evolving interactive system where there is continuous exchange occurring between the clinician and the patient. The model also depicts the multiple internal and external forces that impact upon the patient’s experience as well as the structures supporting the delivery of patient care.

The model contains three major components. The inner circles depict the dynamic interaction between person, health and clinician. The lines of the internal circles are interrupted to represent the open and fluid nature of the model. The larger circle surrounding the core represents the interdisciplinary partnerships within the multiple settings where patient care is delivered. The internal forces reflect the vision, guiding principles, and our long-range goals. The external forces are depicted as the components of professional standards, credentialing and privileging standards, regulatory structures, and reimbursement practices. These forces continuously interact with the internal environment and the inner core.
Patient Care Services is positioned to have a strong voice in advancing and supporting the organizational mission and our vision for:

- Quality Patient Care,
- Excellence in Clinical Practice,
- Cost Effectiveness and Efficiency

### PCS Strategic Goals... 2011

#### Meet or Exceed Expectations of Patients and Families
- Enhance staff communication and responsiveness to patients and families
- Implement hourly safety rounds
- Ensure equitable care for patients
  - Create proactive Advocacy Program
  - Implement Disabilities Program plan
  - Improve communication with efficient use of resources and technology
- Reduce hospital-acquired pressure ulcers
- Improve hospital cleanliness

#### Enhance Care Delivery by Improving the Efficiency and Effectiveness of Systems
- Increase efficiency and quality of documentation
  - Acute care documentation design and integration
- Revise the payroll system
- Increase direct care time
  - Supplies at the bedside
- Learn ways to prevent unnecessary readmissions
- Execute a successful move into the Lunder Building
- Reduce non-salary expenses

#### Ensure Staff Have a Strong Voice in Design of Care and Services
- Enhance staff input in decision-making that influences care delivery
  - Implement re-designed Collaborative Governance model
- Create and implement a diversity leadership fellowship
- Increase efficiency and effectiveness of educational offerings across PCS departments
Purpose of the Annual Operating Plan

**Strategic Framework:** Aligns long-range goals with patient and employee needs

**Annual Operating Plan:** Addresses short-term tactical issues

**Patient Care Services Annual Operating Plan**
- Establishes priorities for the year
- Aligns priorities with long-range goals
- Guides decision making

**Communicates goals**

**Provides framework for accountability**

**Is evaluated through the performance measurement process**

Components of the Annual Operating Plan

- **Goals and Annual Organizational Priorities**
  Annual decisions prioritizing work to advance the long-term goals

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

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

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

**Plan → Check → Do → Act**
### Developing the Annual Operating Plan

<table>
<thead>
<tr>
<th>What are employees telling us?</th>
<th>What patients are telling us?</th>
<th>What administrative decisions impact us?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership makes a difference</td>
<td>Patients report:</td>
<td>New leadership at Partners Healthcare, Inc.</td>
</tr>
<tr>
<td>Good staffing and collegial support are important</td>
<td>High loyalty to hospital</td>
<td>Strategic planning goals</td>
</tr>
<tr>
<td>Opportunities to discuss patient care issues are essential</td>
<td>High ratings for care by doctors and nurses</td>
<td>New quality and safety structure</td>
</tr>
<tr>
<td>Physician/clinician relationship is important to feeling like a partner in decision-making</td>
<td>Pleased with help in arrangements for home care</td>
<td>JC accreditation</td>
</tr>
<tr>
<td>Staffing shortage is a problem in some areas</td>
<td>Involvement of patients and families in decisions</td>
<td>Magnet recognition</td>
</tr>
<tr>
<td>Poor communication between physician/clinician and therapies can compromise effectiveness of patient care</td>
<td>Respect for patient's preferences</td>
<td>New compliance programs</td>
</tr>
<tr>
<td>System delays in accessing information about a patient takes up valuable time</td>
<td>Improve in areas of:</td>
<td>Ethics initiatives</td>
</tr>
<tr>
<td>Communicating with staff across shifts is essential</td>
<td>Efficiency of admission and discharge processes</td>
<td>LOS targets</td>
</tr>
<tr>
<td>Positive reinforcement for a job well done is important and promotes mutual respect/self esteem</td>
<td>Discharge instructions</td>
<td>Diversity initiatives</td>
</tr>
<tr>
<td>Inflexible leaders create an ineffective work environment</td>
<td>Room cleanliness</td>
<td></td>
</tr>
</tbody>
</table>

### What collaborative governance is telling us? What regulators are telling us? |

| Adequate support services are critical | There is increased collaborative governance decision-making at the unit-level | Design processes well; monitor, analyze and improve outcomes of care |
| Effective leadership addresses conflicts and provides support and guidance to others | Staff feel empowered | Include clinicians in decision-making |
| Conflict resolution needs to occur open forums to build consensus | Staff have heightened awareness of other disciplines’ domains of practice which has led to enhanced collaboration | Analyze errors to improve systems |
| Continued support for professional advancement and educational opportunities is essential | Align PCS strategic direction with collaborative governance committees via review/revising committee charges/goals | Correlate patient outcomes with performance and quality indicators. |
| While staff believe they are motivated to do their best, they do not always feel valued or appreciated | | |
Annual Performance Measures
Including but not limited to:

- Patient Satisfaction Surveys
- Clinical indicators
- Clinical narratives
- Staff perception of the professional practice environment survey
- Employee focus groups
- Employee safety indicators
- Length of stay
- Formal education
- Certification

- Environment of care surveys
- Filled positions
- Employee turnover rates
- Workload measures
- Financial indicators
- Time of discharge
  - # of hours
  - Wait/delay
- Efficiency of admission and discharge processes
- Patient preparedness for discharge and self care
Massachusetts General Hospital
Patient Care Services

2012 -2013 Strategic Plan
Patient Care Services
Strategic Plan

Hospital Mission

Guiding Principles
Patient Centered Care
Environmental Scanning

Vision

Strategic Goals

Environment of Care
Patient Care Delivery
Excellence Every Day

Strategic Framework

Annual Tactical Plan

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

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

Plan
Act
Do
Check

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

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

Guided by the needs of our patients and their families, we deliver the very best health care in a safe, compassionate environment; we advance that care through innovative research and education; and, we improve the health and well-being of the diverse communities we serve.
As nurses, health professionals, and Patient Care Services support staff, our every action is guided by knowledge, enabled by skill, and motivated by compassion. Patients are our primary focus, and the way we deliver care reflects that focus every day.

We believe in creating a practice environment that has no barriers, that is built on a spirit of inquiry, and reflects a culturally-competent workforce supportive of the patient-focused values of this institution.

It is through our professional practice model that we make our vision a demonstrable truth everyday by letting our thoughts, decisions, and actions be guided by our values. As clinicians, we ensure that our practice is caring, innovative, scientific, and empowering, and is based on a foundation of leadership and entrepreneurial teamwork.
We are ever-alert for opportunities to improve patient care; we provide care based on the latest research findings.

We recognize the importance of encouraging patients and families to participate in the decisions affecting their care.

We are most effective as a team; we continually strengthen our relationships with each other and actively promote diversity within our staff.

We enhance patient care and the systems supporting that care as we work with others; we eagerly enter new partnerships with people inside and outside of the Massachusetts General Hospital.

We never lose sight of the needs and expectations of our patients and their families as we make clinical decisions based on the most effective use of internal and external resources.

We view learning as a lifelong process essential to the growth and development of clinicians striving to deliver quality patient care.

We acknowledge that maintaining the highest standards of patient care delivery is a never-ending process that involves the patient, family, nurse, all healthcare providers, and the community-at-large.
Our Most Important Value is Patient Centered Care. We believe that care delivery is driven by Compassion—As clinicians and support staff we demonstrate empathy for the patient's well-being, we utilize our expertise to alleviate suffering and to address patient and family needs.

- **High Quality Care**
  - Designed with patient at the center
  - Provided through seamless healthcare
- **Comprehensive**
  - Clinical and non clinical care
  - Designed through the eyes, ears, thoughts and emotions of a patient
  - Provided consistently and without redundancy
- **Accessible**
  - Physically convenient
  - Responsive
  - Flexible to patients’ needs
- **Supportive**
  - Reduces anxiety for patients and their families
  - Includes all appropriate staff
- **Personalized**
  - Responsive to individual concerns
  - Private
  - Patient friendly

**Relationship Based Care:**
- Knowing the patient
- Coordination of care
- Consistency of teams
- Building plan of care around the patient
- Clinical support aligned around patient populations rather than transactions
- Learn lessons from the past
- Consistency=Continuity=Coordination=Efficiency/Quality
2012 Annual Operating Plan

- Establishes priorities for the year 2012
- Aligns priorities with long-range goals
- Guides decision making
- Communicates goals
- Provides framework for accountability
- Is evaluated through the performance measurement process
Strategic Goals

Goals we will pursue to advance/support the organizational mission and our vision

2012 Strategic Goals

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

Goal #2: Lead Patient Affordability and Care Redesign initiatives

Goal #3: Design and implement new programs to improve patient and family satisfaction

Goal #4: Advance the culture of Excellence Every Day

Goal #5: Design and implement clinical and business information systems that support patient care, education, and research
2012 Organizational Priorities

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

**Tactics:**
- Establish 12 innovation units to test the elements of the care delivery model across the care continuum
- Capture and integrate best practices and spread to other units
- Conduct patient and family focus groups to inform our work
- Ensure robust measurement systems to capture outcomes of innovation units
- Focus on patient and staff satisfaction
- Address inequities in quality and access to care: conduct unit level culture rounds
Goal #2: Lead Patient Affordability and Care Redesign initiatives

**Tactics:**
- Reduce supply expenses (inpatient, ED, and OR)
- Develop inpatient, ED, and OR staffing standards.
- Ensure appropriate utilization of ED resources; reduce ED LOS for both admitted and discharged ED patients.
- Utilize best practice strategies to contribute to a hospital wide initiative to reduce LOS.
- Create new process for safe and effective transitions of care including those to outpatient practices and with Partners Continuing Care (PCC).
- Participate in Care Redesign team efforts and integrate ideas generated from these teams into practice.
- Ensure care is equitable across the continuum.
Goal #3: Design and Implement new programs to improve Patient and Family Satisfaction

**Tactics:**
- Design and develop new tactics to improve cleanliness, noise reduction and staff communication
- Engage interpreters more in patient and family dialogue and in quality related activities
- Increase volunteer presence at information desks to proactively support patients, families, and visitors
- Increase presence of Patient Advocates to patients, families and clinicians; engage volunteers in this work
- Develop and implement Cultural Competence education program
- Utilize Service Excellence program to create a greater "presence" with patients and families
Goal #4: Advance the culture of Excellence Every Day (EED)

**Tactics:**

- Develop structures for collecting and submitting Patient-Centered outcome measures
- Further develop Excellence Every Day portal as a practice resource for staff
- Inform, educate and engage others in advancing the PCS strategic goals
- Develop a strategic communication plan to promote Excellence Every Day culture
Goal #5: Design and implement clinical and business information systems that support patient care and research

**Tactics:**

- Participate in design and implementation of new documentation and safety enhancement systems

- Implement new Timekeeping systems

- Participate in Enterprise Clinical System Development

- Educate the workforce regarding utilization and compliance of new electronic applications, e.g., electronic white-boards, i-phones
Annual Performance Measures
Including but not limited to:

**Patient Experience**
- Patient Satisfaction survey (HCAHPS)
- Follow-up Phone Calls (post-discharge)

**Staff Experience**
- Staff Satisfaction (SPPPE and PES-NWI surveys)
- Clinical Recognition Advancement
- Certification and Formal Education
- Filled positions with focus on recruitment of diverse staff
- Employee vacancy and turnover rates

**Clinical Quality Indicators**
- Catheter-Associated UTI (CAUTI)
- Central line infection
- Ventilator-Associated Pneumonia (VAP)
- Hospital-Acquired Pressure Ulcers
- Falls and Falls with Injury
- Restraint Utilization
- IV Infiltrates (pediatrics only)
- Specialty-specific indicators (as identified)

**System-Centered Measures**
- Length of stay reduction
- Readmission rates
- Environment of care surveys
- Safety culture survey
- Safety event reporting
- Workload measures
- Financial indicators: Unit Cost reduction

**External/Regulatory Measures**
- Successful Joint Commission visit
- Successful Department of Public Health (DPH) Infection Control visit
- Successful Magnet Redesignation submission
MGH/MGPO Quality and Safety Goals & CQS Quality and Safety Goals

2012 Goals and progress updates
2012 MGH/MGPO Quality & Safety Goals
2012 MGH/MGPO Quality Goals

1. Enhance our quality & safety measurement and performance improvement infrastructure to advance the six Institute of Medicine (IOM) aims

2. Achieve outstanding external review results via Excellence Every Day efforts

3. Advance our safety culture

4. Reduce harm events through better handoffs, improved transitions and reduced readmissions

5. Make measurable progress in efficiency, affordability and effectiveness through support of key institutional programs
2012 MGH/MGPO Quality Goals

Proposed Tactics

1. Enhance our quality & safety measurement and performance improvement infrastructure to advance six IOM aims

   - Ensure measurement & reporting are timely, accurate, and well coordinated
   - Leverage our electronic information systems to promote meaningful, reliable and efficient use of performance improvement data e.g., E-Chart and Enterprise Clinical Systems
   - Specify accountability for performance improvement
   - Prioritize our efforts and highlight measures of particular importance e.g., patient experience, racial/ethnic disparities, and end of life care
   - Provide frontline staff with meaningful data and the tools to improve upon their performance, prioritizing high stakes initiatives including care redesign
2012 MGH/MGPO Quality Goals

Proposed Tactics

2. Achieve outstanding external review results

- Accelerate Excellence Every Day (EED) initiatives
- Enhance EED efforts to sustain an ongoing focus on high-risk areas of regulatory compliance
- Complete submission of our Magnet re-designation report
- Complete an external peer-to-peer audit of our quality and safety program
2012 MGH/MGPO Quality Goals

Proposed Tactics

3. Advance our safety culture

- Complete follow up safety culture survey and identify priorities for improvement based on findings
- Pilot unit/team based safety culture improvement interventions
- Advance programs for professional conduct and disruptive behaviors
- Continue to build just culture into our root cause analysis (RCA) reviews
2012 MGH/MGPO Quality Goals

Proposed Tactics

4. Reduce harm events through better handoffs, improved transitions and reduced readmissions

• Improved handoffs through promoting compliance with handoff policy
• Promote effective transitions across the continuum of care
• Establish hospital-wide approaches to reduce avoidable readmissions
2012 MGH/MGPO Quality Goals

Proposed Tactics

5. Make measureable progress in efficiency, affordability and effectiveness through support of key institutional programs

- Support care redesign initiatives, at both Partners and MGH
  - Help establish performance dashboards
  - Support the work of newly established teams

- Support direct patient care/patient affordability initiatives, at both Partners and MGH
  - Inpatient, Emergency Department and Perioperative Services

- Support institutional length of stay reduction initiatives

- Advance efforts on population health management
## Goal 1: Enhance our quality & safety measurement and performance improvement infrastructure to advance six IOM aims

<table>
<thead>
<tr>
<th>Further description of Goal #1</th>
<th>Executive Sponsor</th>
<th>Operational Lead(s)</th>
<th>CQS Ops Contact</th>
<th>Tactics / Metrics</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure measurement &amp; reporting are timely, accurate, and well coordinated</td>
<td>Liz Mort</td>
<td>Liz Mort</td>
<td>Liz Mort</td>
<td>• Create comprehensive accountability matrix for major Q&amp;S initiatives,</td>
<td>Matrix has been drafted</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cy Hopkins, Andy Karson, Taruna Banerjee, Karen Lynch, Martin Spera</td>
<td>• Develop plan to deploy our resources to support these major initiatives with project management and resources.</td>
<td>CQS resources are being deployed for Q&amp;S, Care redesign, Efficiency efforts.</td>
</tr>
<tr>
<td>Leverage our electronic information systems to promote meaningful, reliable and efficient use of performance improvement data e.g., E-Chart and Enterprise Clinical Systems</td>
<td></td>
<td></td>
<td></td>
<td>• Create structure to ensure we get the right information to the BOT.</td>
<td></td>
</tr>
<tr>
<td>Specify accountability for performance improvement</td>
<td></td>
<td></td>
<td></td>
<td>• Make sure our intranet sight illustrates and reinforces what we are focusing on.</td>
<td></td>
</tr>
<tr>
<td>Prioritize our efforts and highlight measures of particular importance e.g., patient experience, racial/ethnic disparities, and end of life care</td>
<td></td>
<td></td>
<td></td>
<td>• Conduct a needs and gap analysis of front line staff’s access to meaningful data and tools to help improve performance.</td>
<td></td>
</tr>
<tr>
<td>Provide frontline staff with meaningful data and the tools to improve upon their performance, prioritizing high stakes initiatives including care redesign.</td>
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</tbody>
</table>
Goal 1 planning process

- Identify major institutional performance improvement activities
  - Review what’s at stake, exec accountability, measurement and improvement accountability
  - Identify gaps in resource requirements

- Address gaps through prioritization, coordination, and redeploying existing resources first

- Build in reporting structures and mechanism for QAPI data flow to Board of Trustees
GOAL 1: Enhance our quality & safety measurement and performance improvement infrastructure to advance six IOM aims Priority Q&S programs MGH/MGPO

<table>
<thead>
<tr>
<th>Institutional Owner</th>
<th>Program</th>
<th>What’s at risk</th>
<th>Accountable Exec sponsor</th>
<th>Accountable For measurement</th>
<th>Accountable For Improvement</th>
<th>Level of Concern</th>
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</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>TJC</td>
<td>accreditation</td>
<td>JB</td>
<td>CQS, PCS, PI data owners, tracers, EED dash</td>
<td>SVPs, EED, CQS, PCS via EED structure</td>
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<td>Hospital</td>
<td>CMS VBP</td>
<td>$2.1M FY 2013</td>
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<td>Hospital</td>
<td>CMS Readmissions</td>
<td>$2.8M FY 2013</td>
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<td>LM</td>
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<tr>
<td>Hospital/PO</td>
<td>Care redesign</td>
<td>__</td>
<td>DT/LM/</td>
<td>PHS, Depts., CQS</td>
<td>Michael Jaff, Care redesign teams</td>
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<tr>
<td>Hospital</td>
<td>Patient Affordability</td>
<td>__</td>
<td>JIE/BWN</td>
<td>PCS, Depts.</td>
<td>Innovation units, Dept Chiefs ALOS</td>
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</tbody>
</table>
GOAL 1: Enhance our quality & safety measurement and performance improvement infrastructure to advance six IOM aims
Priority Q&S programs MGH/MGPO

<table>
<thead>
<tr>
<th>Area</th>
<th>Program</th>
<th>What’s at risk</th>
<th>Exec sponsor</th>
<th>Accountable For measurement</th>
<th>Accountable For Improvement</th>
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<tbody>
<tr>
<td>Hospital</td>
<td>GPRO</td>
<td>$200</td>
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<td>Paul Pecororror Karen Lynch</td>
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<td>PO</td>
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<td>1580 EP’s x $18,000 = $28.4M</td>
<td>D Ting</td>
<td>PAI</td>
<td>PAI, D Ting</td>
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<tr>
<td>PO</td>
<td>PQRI/PQRS</td>
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<td>JH</td>
<td>PBO/CQS</td>
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<td>PO</td>
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<td>TF/GM</td>
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<td>$500K*</td>
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<td>Both</td>
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<td>$2 M (est)</td>
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</table>
GOAL 1: Enhance our quality & safety measurement and performance improvement infrastructure to advance six IOM aims Priority Q&S programs MGH/MGPO

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</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Safety reporting system</td>
<td>Q&amp;S Reputational</td>
<td>SVP CQS</td>
<td>CQS</td>
<td>CQS, QA Chairs and Departments</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>Departmental registries</td>
<td>Q&amp;S Reputational risk</td>
<td>Many SVPs/CQS/BWN/JIE</td>
<td>Depts. for the most part</td>
<td>Departments for the most part</td>
<td></td>
</tr>
<tr>
<td>Hospital PO</td>
<td>OPPE/FPPE</td>
<td>TJC issue</td>
<td>Ferris</td>
<td>Ferris, Weiburg, Rao</td>
<td>Depts QA chairs</td>
<td></td>
</tr>
</tbody>
</table>

Others?
## Goal 2: Achieve outstanding external review results via Excellence Every Day efforts

<table>
<thead>
<tr>
<th>Further description of Goal #2</th>
<th>Executive Sponsor</th>
<th>Operational Lead(s)</th>
<th>CQS Ops Contact</th>
<th>Tactics / Metrics</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accelerate Excellence Every Day initiatives</td>
<td>Peter Slavin</td>
<td>John Belknap</td>
<td>John Belknap, Liz Mort, Lela Holden, Cy Hopkins, Andy Karson, Katie McCullough</td>
<td>• Complete JC survey with 0 direct findings</td>
<td>On track</td>
</tr>
<tr>
<td>Enhance EED efforts to sustain an ongoing focus on high-risk areas of regulatory compliance</td>
<td>Dave Torchiana</td>
<td></td>
<td></td>
<td>• Completion of JC Training for 90% of eligible participants.</td>
<td>Pending</td>
</tr>
<tr>
<td>Complete submission of our Magnet re-designation report</td>
<td></td>
<td></td>
<td></td>
<td>• DPH Infection Control Survey with no Condition Level findings</td>
<td>Pending</td>
</tr>
<tr>
<td>Complete an external peer-to-peer audit of our quality and safety program</td>
<td></td>
<td></td>
<td></td>
<td>• Complete peer-to-peer survey</td>
<td>Johns Hopkins in the fall proposed</td>
</tr>
<tr>
<td></td>
<td>Kevin Whitney</td>
<td></td>
<td></td>
<td>• Timely Submission of Magnet Documentation</td>
<td>On track</td>
</tr>
<tr>
<td></td>
<td>Kevin Whitney</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Executive Sponsor**
- Peter Slavin
- Dave Torchiana

**Operational Lead(s)**
- John Belknap
- Liz Mort
- Lela Holden
- Cy Hopkins
- Andy Karson
- Katie McCullough
- Elizabeth Martinez
- Kevin Whitney

**CQS Ops Contact**
- John Belknap
- Liz Mort
- Lela Holden
- Cy Hopkins
- Andy Karson
- Katie McCullough
- Elizabeth Martinez
- Kevin Whitney
### Goal 3: Advance our safety culture

<table>
<thead>
<tr>
<th>Further description of Goal #3</th>
<th>Executive Sponsor</th>
<th>Operational Lead(s)</th>
<th>CQS Ops Contact</th>
<th>Tactics / Metrics</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete follow up safety culture survey and identify priorities for improvement based on findings</td>
<td>Liz Mort</td>
<td>Lela Holden</td>
<td>Lela Holden Cy Hopkins Katie McCullough</td>
<td>• Complete culture survey with &gt;60% response rate and disseminate results by Dec 2012</td>
<td>• Complete response rate is close</td>
</tr>
<tr>
<td>Pilot unit/team based safety culture improvement interventions</td>
<td></td>
<td></td>
<td></td>
<td>• Assess differences between 2008 and 2012 survey findings</td>
<td>• Underway</td>
</tr>
<tr>
<td>Advance programs for professional conduct and disruptive behaviors</td>
<td></td>
<td></td>
<td></td>
<td>• Launch unit-based culture improvement efforts (identify 2 units for interventions)</td>
<td>• Evolving new policy</td>
</tr>
<tr>
<td>Continue to build just culture into our RCA reviews</td>
<td></td>
<td></td>
<td></td>
<td>• Assess staff satisfaction with Prof Conduct model; repeat survey from 2010</td>
<td>• Underway</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Increased #s of RCA using Just Culture Format</td>
<td></td>
</tr>
</tbody>
</table>
**Goal 4:** Reduce harm events through better handoffs, improved transitions and reduced readmissions

<table>
<thead>
<tr>
<th>Further description of Goal #4</th>
<th>Executive Sponsor</th>
<th>Operational Lead(s)</th>
<th>CQS Ops Contact</th>
<th>Tactics / Metrics</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved handoffs through promoting compliance with handoff policy</td>
<td>Liz Mort</td>
<td>Andy Karson Mary Cramer Liz Mort</td>
<td>Andy Karson Liz Mort</td>
<td>• Improve Score on Partners HPM Defect-Free Discharge Scorecard</td>
<td>• Defect free gaps in POE queue</td>
</tr>
<tr>
<td>Promote effective transitions across the continuum of care</td>
<td></td>
<td></td>
<td></td>
<td>• Complete Phases 1 and 2 of Joint Commission Transforming Handoff Improvement Projects</td>
<td>• On track</td>
</tr>
<tr>
<td>Establish hospital-wide approaches to reduce avoidable readmissions</td>
<td></td>
<td></td>
<td></td>
<td>• Each department participating in at least one hospital endorsed readmission reduction project.</td>
<td>• Students surveying</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Monitor and support that elements of readmission bundle are being implemented</td>
<td></td>
</tr>
</tbody>
</table>
**Goal 5:** Make measureable progress in efficiency, affordability and effectiveness through support of key institutional programs

<table>
<thead>
<tr>
<th>Further description of Goal #5</th>
<th>Executive Sponsor</th>
<th>Operational Lead(s)</th>
<th>CQS Ops Contact</th>
<th>Tactics / Metrics</th>
<th>Status</th>
</tr>
</thead>
</table>
| Support care redesign initiatives, at both Partners and MGH | Dave Torchiana | Liz Mort Brit Nicholson | Mary Cramer Liz Mort Katie McCullough | • Demonstrate measurable progress from 2011 teams on metrics such as:  
  - ALOS  
  - Readmissions  
  - Excess Medicare days  
  - Unit cost TBD  
  - Cost/CMAD  
  - Cost Per Episode of Care TBD  
  - HCAHPS Scores  
  - Pharmaceutical utilization | • Report card in design, collaboration with finance to develop |
| • Help establish performance dashboards | Jeanette Ives Erickson | | | | |
| • Support the work of newly established teams | | | | | |
| Support direct patient care/patient affordability initiatives, at both Partners and MGH | | | | | |
| • Inpatient, Emergency Department and Perioperative Services | | | | | |
| Support institutional length of stay reduction initiatives | | | | | |
| Advance efforts on population health management | | | | | |
| Support care redesign initiatives, at both Partners and MGH | | | | | |
| • Help establish performance dashboards | | | | | |
| • Support the work of newly established teams | | | | | |
| Support direct patient care/patient affordability initiatives, at both Partners and MGH | | | | | |
| • Inpatient, Emergency Department and Perioperative Services | | | | | |
| Support institutional length of stay reduction initiatives | | | | | |
| Advance efforts on population health management | | | | | |
2012 Proposed CQS Goals
CY 2012 Proposed CQS priorities

• Close the loop on QAPI reporting and documentation through QPSC

• Continue evolution of QPSC
  – Incorporate the research world into QPSC activities
  – Ensure that every RCA has just culture embedded into it.
  – Promote training on disruptive colleagues, patients and families

• Support MGPO Quality Incentive (QI) program
  – Increase D4Q efficiency and usability through training, new data feeds, application development and documentation.

• Develop approach for more broadly disseminating serious safety reports
  – Increase use of harm reports
  – Explore and define ways in which events can be presented more consistently to chiefs
CY 2012 Proposed CQS priorities (2)

• Expand external visibility of MGH/MGPO quality and safety program
  – Update the Center for Quality and Safety intranet site with employee health measures and our Adverse Events Policy

• Expand quality and safety training opportunities
  – Explore opportunities to collaborate with other hospital training resources such as the Knight Center, the Simulation Center, etc.
  – Maximize use of IHI Open School
  – Explore NPSC Certification

• Advance literature on the value of Academic Medical Center care
  – Apply for additional grant opportunities

• Develop and implement external audit plan for the Center for Quality and Safety
CY 2012 Proposed CQS priorities (3)

- Continue to work with CRICO on Settlement agreement
  - Start early offer of recovery settlements to patients within the 5-day wake of an event to cover related expenses.

- Implement hospital-wide mortality review

- Promote patient representation on key quality committees (e.g. care redesign, quality improvement teams, etc)
  - Add a voting PFAC member to the Quality Oversight Committee, to serve a 2 year term.

- Aggressively advance institutional utilization of D4Q
## CY 2012 Proposed CQS priorities – Accountability and Key Metrics

<table>
<thead>
<tr>
<th>QPSC evolution</th>
<th>Executive Sponsor</th>
<th>Operational Lead(s)</th>
<th>CQS Ops Contact</th>
<th>Metrics</th>
<th>Status</th>
</tr>
</thead>
</table>
|                | Liz Mort          | Cy Hopkins          | Cy Hopkins      | • Continue education of Just Culture principles with each major Root Cause Analysis  
• Incorporate the research world into QPSC activities: identify a research representative to become a member of QPCS  
• Reassess the roles and support for the QA Chairs | QA chairs are using this format |
|                |                   |                     | Lela Holden     |         |        |
| Support MGPO QI program | David Torchiana | Liz Mort | Liz Mort, Henry Chueh, Martin Spera, Tauna Banerjee, Karen Lynch, Terry Arcudi | Increase D4Q efficiency and usability through:  
• # trained on D4Q  
• new data feeds  
• application development  
• documentation  
• Technical documentation solid | • Training: 60 added 30 new users, 2 Access SQL training, user group  
• Patcom, POE, Labs, PAML, Scheduling, EMPI, EMAR Billing,  
Survey tool for tracer, Meaningful Use Reporting, Front end Population management |
## CY 2012 Proposed CQS priorities – Accountability and Key Metrics (2)

<table>
<thead>
<tr>
<th>Broader dissemination of serious safety events</th>
<th>Executive Sponsor</th>
<th>Operational Lead(s)</th>
<th>CQS Ops Contact</th>
<th>Metrics</th>
<th>Status</th>
</tr>
</thead>
</table>
| Liz Mort                                       | Lela Holden        | Lela Holden Cy Hopkins John Belknap | - Send Harm Reports to designated groups beyond leadership  
- Distribute the Year-in-Review for 2012  
- Dissemination of the board Subcommittee Chair report: Share DPH reports with QPCS and share DPH reports and QPSC Summaries with GEC/Chiefs  
- Determine process for sharing topics and events with Patient Safety Organization | - Two have been done  
- Done  
- QPSC done, need to advance to GEC and Chiefs | |

<table>
<thead>
<tr>
<th>Expand external visibility of MGH/MGPO quality and safety program</th>
<th>Executive Sponsor</th>
<th>Operational Lead(s)</th>
<th>CQS Ops</th>
<th>Metrics</th>
<th>Status</th>
</tr>
</thead>
</table>
| Liz Mort                                                          | David Shahian      | CQS Ops             | - Update External Site  
- Present to external audiences  
- Complete >1 Publication  
- Presence at National Committees and meetings (NPSF, IHI, NQF, PCPI) | - SREs maintenance  
- Have exceeded 20 presentations  
- 3-4 publications  
- Document for all reports/presentations | |
## CY 2012 Proposed CQS priorities – Accountability and Key Metrics (3)

<table>
<thead>
<tr>
<th>Executive Sponsor</th>
<th>Operational Lead(s)</th>
<th>CQS Ops Contact</th>
<th>Metrics</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expand training opportunities</strong></td>
<td>Liz Mort</td>
<td>Mary Cramer, Lela Holden, Katie McCullough, Liz Mort, Kevin Whitney</td>
<td>Mary Cramer, Lela Holden, Katie McCullough</td>
<td>• Explore opportunities to collaborate with other hospital educational resources (i.e. Knight Center, the Simulation Center, etc.)&lt;br&gt;• Maximize use of IHI Open School&lt;br&gt;• Track Staff who receive training&lt;br&gt;• Get 2 volunteers to test the NPSF Certification</td>
</tr>
<tr>
<td><strong>Advance literature on the value of AMC care</strong></td>
<td>Liz Mort</td>
<td>David Shahian, Xiu Liu</td>
<td>Liz Mort, David Shahian</td>
<td>• Publications, presentations, grants</td>
</tr>
<tr>
<td><strong>Develop and implement plan for external audit of CQS</strong></td>
<td>Liz Mort</td>
<td>Liz Mort, Katie McCullough</td>
<td>Liz Mort, Katie McCullough</td>
<td>• Complete external peer-to-peer audit with Johns Hopkins by December 2012&lt;br&gt;• Joint Commission Findings&lt;br&gt;• CRICO Risk Appraisal and Plan (RAP) 200K</td>
</tr>
</tbody>
</table>
## CY 2012 Proposed CQS priorities – Accountability and Key Metrics (4)

<table>
<thead>
<tr>
<th>Executive Sponsor</th>
<th>Operational Lead(s)</th>
<th>CQS Ops Contact</th>
<th>Metrics</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-wide mortality review</td>
<td>Liz Mort</td>
<td>Cy Hopkins Liz Mort</td>
<td>Cy Hopkins Paul Nordberg David Shahian</td>
<td>• All in-house deaths will be reviewed by our Mortality Review Tool by the end of 2012, collaboration with BWH</td>
</tr>
<tr>
<td>Promote patient representation on key quality committees</td>
<td>Liz Mort</td>
<td>Liz Mort Katie McCullough</td>
<td>Liz Mort Katie McCullough Liza Nyeko</td>
<td>• Designate a patient representative to the Quality Oversight Committee</td>
</tr>
</tbody>
</table>
Patient Care Services
Office for Quality and Safety Strategic Plan
FY 2012 (Oct 2011-Sept 2012)

Introduction
The Patient Care Services (PCS) Office of Quality & Safety (OQS) embraces the Massachusetts General Hospital (MGH) vision of “leading the nation in quality and safety”. Our message is to offer patients and one another our best in every moment. The PCS OQS is responsible for developing, implementing and supporting strategies for improving health care quality.

Philosophy
The PCS OQS is committed to the Excellence Every Day (EED) philosophy adopted across the MGH community. This philosophy represents an MGH commitment to providing the highest quality, safest care that meets or exceeds all standards set by the hospital and external organizations. The main message and goal for all MGH staff is that staff across role groups and disciplines is striving to provide the best possible care to every patient and family in every moment of every day.

Framework
The Institute of Medicine’s SIX aims for quality improvement; outlined in 2001 Crossing the Quality Chasm: A New Health System for the 21st Century, are used as a framework for program design and evaluation. These six aims are operationalized at MGH as follows:

1. **Safety — no needless death, injury, pain or suffering for patients or staff.**
   - **For our patients:** harm no patient in our care.
   - **For our staff:** ensure the safest possible work environment.
   - **For our hospital:** seek out and maximize any opportunity to learn and improve; support and encourage every effort aimed at ensuring safety.

2. **Effectiveness — care and service will be based on best evidence, informed by patient values and preferences**
   - **For our patients:** care and service at the MGH will always reflect the best evidence, always informed by patient values and preferences.
   - **For our staff:** equip staff with the education and resources needed to perform at their best and to learn continuously.
   - **For our hospital:** develop systems and a culture that makes it easy to do the right thing.

3. **Patient Centeredness — all care and service will honor the individual patients — their values, choices, culture, social context and specific needs.**
   - **For our patients:** partner with patients to incorporate and respect their needs and preferences in all we do.
4. **Timeliness — waste no one’s time; no unnecessary waiting.**
   - **For our patients:** provide care without delay.
   - **For our staff:** treat staff time as one of our most valuable assets.
   - **For our hospital:** develop systems to facilitate and enhance timely interactions between patients and staff.

5. **Efficiency — remove all unnecessary processes or steps in a process; streamline all activities.**
   - **For our patients:** focus on getting it right the first time, valuing patients’ time, money and other resources.
   - **For our staff:** support our staff with systems that maximize their ability to do their best work.
   - **For our hospital:** remain open to all ideas to decrease waste and improve efficiency, while assuring the quality of patient care and staff life is not compromised.

6. **Equity — all care and service will be fair and equitable — the system will treat all patients equally.**
   - **For our patients:** provide every patient with the same high level of quality and safety.
   - **For our staff:** ensure an environment in which all staff are treated with dignity and respect and provided opportunity to realize their goals.
   - **For our hospital:** develop programs, policies and practices that do not discriminate against patients, employees or clinicians.

**Stakeholders**

There are many constituencies within Patient Care Services that require accurate, timely, and meaningful data to guide the analysis of care management processes. Improvement opportunities as well as sustaining and celebrating success are not possible without the information on current performance. The staff of the PCS OQS considers all clinical and support staff leadership as well as front-line staff as its primary stakeholders. These include:

- Senior leaders within the PCS Division
- Nursing Directors and Clinical Nurse Specialists at the unit level
- Clinical and support staff providing direct care to patients and families
- Collaborative Governance councils and committees

In addition to the primary stakeholders the PCS OQS collaborate closely with the Center for Quality and Safety and other institution-wide committees that are charged with quality and
patient safety initiatives. OQS staff actively participates and represent PCS on committees and task forces that include a quality and safety focus.

**Purpose and structure**
The PCS OQS has responsibility to work with PCS staff to understand and translate regulatory compliance issues, to implement state-of-the-art safety programs, and to translate evidence into the creation of the highest quality and safest care environment for patients and staff. Our overall goal is to positively effect change, transform the culture, and promote clinical excellence.

The operational framework for the work of the department focuses on three (3) primary areas:

1. **Regulatory readiness** to assess and assure compliance with established requirements and safe practice
2. **Early signal detection** of safety events to identify trends and subsequently assist with the design, implementation and measurement of performance improvement initiatives to enhance systems of care and safety of the practice environment
3. **Nursing sensitive and clinically significant indicators** to provide data and support to local nursing leaders and front-line staff in efforts to continuously improve patient outcomes and mitigate harm

The main strategies to achieve a positive impact in these areas include education, consultation, and measurement. PCS OQS staff are readily available to consult with all clinical care team members within the PCS division to achieve desired goals.

**Performance Improvement (PI) Model**
The MGH has adopted the PDCA (Plan-Do-Check-Act) model for performance improvement activities as the standardized approach across the organization. This “step-by-step” approach is a proven method to assure that all quality improvement initiatives, at all levels in the organization, will include the necessary sequence of events to lead to sustainable change.

The 4 steps include:
- **Plan**: Identify the problem, assess the current process, and develop a plan for improvement
- **Do**: Implement the plan
- **Check**: Evaluate the plan and modify the plan if necessary
- **Act**: Continue with the plan and monitor for results

**Identification of Performance Improvement (PI) Initiatives**
Opportunities for performance improvement fall into three general categories:

1. Those that improve on existing performance where the outcome is highly desirable (i.e. performance may already be adequate)
2. Those that improve on existing performance when deficiencies are identified
3. Those that reflect the organizational priorities of Patient Care Services

**Data Sources**
Identification of PI initiatives arises from multiple data sources. These sources include:
<table>
<thead>
<tr>
<th>1. Patient</th>
<th>2. Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Satisfaction and Perception Surveys</td>
</tr>
<tr>
<td></td>
<td>Patient/Family Advisory Councils</td>
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<td></td>
<td>Clinical Indicators</td>
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<tr>
<td></td>
<td>Nursing Sensitive Indicators</td>
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<td></td>
<td>Patient and Family Focus Groups</td>
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<td>Blum Family Learning Center</td>
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<td>Clinical Narratives</td>
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<td>Staff Perceptions of the Professional Practice Environment Survey</td>
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<td>NDNQI RN Satisfaction Survey</td>
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<td>Employee focus groups</td>
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<td>PLEN survey- staff educational needs</td>
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<td></td>
<td>Safety Culture Surveys</td>
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<td>Employee Safety Indicators</td>
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<table>
<thead>
<tr>
<th>3. Administrative</th>
<th>4. Environmental</th>
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<tbody>
<tr>
<td></td>
<td>Filled positions</td>
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<tr>
<td></td>
<td>Employee turnover rates</td>
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<tr>
<td></td>
<td>Workload measures</td>
</tr>
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<td></td>
<td>Financial Indicators</td>
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<td></td>
<td>Environment of Care Surveys</td>
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</table>

**Feedback Mechanisms**

The PCS OQS recognizes that improvement opportunities start with accurate, timely, and meaningful outcomes data. A critical component in this process and an important goal for the department is to develop and maintain a robust and collaborative relationship with all groups charged with ensuring safety and quality for the hospital community.

To encourage this collaboration, ongoing dialogue and assessment is done with the key stakeholders of the department to respond to their data needs. New methods of data display and dissemination are implemented when necessary to increase the meaningful nature of the data and the ease at which staff can access data.

Data are disseminated in a variety of ways:

- Nursing sensitive data, patient satisfaction data, and nursing satisfaction data; including comparison data, are posted to a shared drive as current data become available.
- Printed copies of the most current data are created and disseminated to the appropriate units.
- Outcomes data are shared at the Collaborative Governance Councils as requested.
- Outcomes data are updated posted to the Excellence Every Day portal pages that have been developed for a specific care management area.

**2012 Goals and Tactics**

The goals and tactics for 2012 have been developed utilizing two important documents; the PCS Vision Statement and the PCS FY 2102 Strategic Plan.
The Patient Care Services Office of Quality and Safety supports the overall quality and patient safety goals of Massachusetts General Hospital. This is done by understanding the overall vision of the organization as a national leader in quality and safety as well as the vision and strategic plan of Patient Care Services (PCS). The work of the department is to contribute to the strategic goals of PCS.

Massachusetts General Hospital (MGH) Vision
To lead the nation in quality and safety

Patient Care Services (PCS) Vision
As nurses, health professionals, and Patient Care Services support staff, our every action is guided by knowledge, enabled by skill, and motivated by compassion. Patients are our primary focus, and the way we deliver care reflects that focus every day. We believe in creating a practice environment that has no barriers, that is built on the spirit of inquiry, and reflects a culturally-competent workforce supportive of the patient-focused values of this institution. It is through our professional practice model that we make our vision a demonstrable truth everyday by letting our thoughts, decisions, and actions be guided by our values. As clinicians, we ensure that our practice is caring, innovative, scientific, and empowering, and is based on a foundation of leadership and entrepreneurial teamwork.

Patient Care Services Office of Quality and Safety (OQS) Vision and Mission
Patient Care Services Office of Quality and Safety embraces the MGH vision “leading the nation in quality and safety”. Our message is to offer patients and one another our best in every moment. The PCS Office of Quality and Safety is responsible for developing, implementing and supporting strategies for improving health care quality.

The PCS Office for Quality and Safety has responsibility to work with PCS staff to understand and translate regulatory compliance issues, to implement state-of-the-art safety programs, and to translate evidence into the creation of the highest quality and safest care environment for patients and staff. Our focus is to effect change, transform the culture, and promote clinical excellence.

The following FY2012 (October 2011-September 2102) Strategic Tactics reflect the commitment to advance the quality and patient safety components of the Patient Care Services. This plan will inform the work of the PCS Quality and Safety team and will be a fluid document, which will change if needed, to accommodate the needs of the PCS Strategic Plan for 2012.
Patient Care Services FY 2012 Strategic Goals

Goal #1
Develop an efficient and effective patient and family centered model of care delivery advancing relation-based care philosophy

Goal #2
Lead Patient Affordability and Care Redesign initiatives

Goal #3
Design and implement new programs to improve patient and family satisfaction

Goal #4
Advance the culture of Excellence Every Day

Goal #5
Design and implement clinical and business information systems that support patient care, education, and research.

Patient Care Service Office for Quality and Safety 2012 Strategic Plan and Tactics (utilizing the PCS 2012 Strategic Goals as an organizer)

Goal #1 Tactics
- Support Innovation Unit leadership by sharing best practices and respond to requests for data
- Design and maintain Innovation Unit dashboard; including patient outcome and satisfaction data
- Measure and report staff satisfaction
- Participate on Patient and Family Advisory Councils and focus groups to obtain feedback

Goal #2 Tactics
- Collect and submit staffing data to national and state databases to assist in comparing performance with external sources
- Design and maintain Innovation Unit dashboard, including LOS data
- Actively participate on MGH Care Redesign Teams

Goal #3 Tactics
- Guide, support and measure unit–based performance for patient satisfaction improvement efforts
- Participate in MGH initiative with the Picker Grant
- Identify patient satisfaction improvement opportunities and engage constituents for action planning

Goal #4 Tactics
- Engage and collaborate quality and safety constituents by participating on committees, task forces, and Tiger Teams
- Expand data collection, measurement, and reporting of patient-centered outcome metrics
- Report data to national benchmarking organizations and measure performance compared to other organizations
- Identify patient care improvement opportunities and engage constituents for action planning
- Develop and maintain quality, safety and regulatory content for EED portal
- Conduct signal detection, analysis and response to safety reports for PCS
- Perform documentation audits and tracers to assess adherence to philosophy of Excellence Every Day
- Design and disseminate communication tools to promote Excellence Every Day

Goal #5 Tactics
- Enhance data tracking tools
- Create and maintain databases for storing data
- Be prepared to actively participate in system-wide design and implementation electronic medical record system