TL 4: The process(es) that enable the CNO to influence organization-wide changes.

As a master’s student of Dr. Muriel Poulin, one of the original Magnet Hospital Study’s nurse researchers, the CNO was taught by her teacher and mentor to be certain to negotiate for a “seat at key tables” during her nursing executive career. Dr. Poulin also advised her to pay keen attention to the location of her office, ensuring it was in close proximity to all other senior administrators, particularly the President of the Hospital. The CNO carried these lessons forward and when she was offered the Senior Vice President for Patient Care and Chief Nurse position in 1996, she negotiated a seat at General Executive Committee as a voting member and was invited to attend all Board of Trustees and Chiefs Council meetings. In addition, her office is located on the second floor of the Bulfinch Building, strategically placed near the President of the Hospital, the President of the Mass General Physicians Organization and her Senior Vice President peers. The organizational chart for the Hospital (OOD 5.a) illustrates the position of the Senior Vice President for Patient Care and Chief Nurse (CNO) within the overall infrastructure of the organization. As a key member of the senior management team and reporting directly to the Hospital President, the CNO actively participates in coordinating the development and implementation of programs to fulfill the four-pronged mission of the organization: patient care, education, research and community.

There are numerous structures and processes at the MGH that enable the CNO to influence organizational-wide changes. These include the formal decision-making structure, committee structure (formal and informal), connection with Partners HealthCare System’s structure and initiatives, strategic and project planning retreats/forums, and the structure of Patient Care Services that includes additional committee and role-based forums, strong support departments, and a multi-faceted communications system.

A seat at the table

The highest decision-making body at Massachusetts General Hospital (MGH) is the MGH Board of Trustees. The CNO Nurse is invited to attend all meetings, and yearly, the Board requests that she present an annual report of the Department of Nursing. A significant amount of thought and planning goes into the design, message, and content of this report. It is a strategic opportunity for the CNO to “grab the microphone” and articulate what’s working, what the challenges are, and most importantly, how the Board can support nursing’s agenda. Attachment TL 4.a is the presentation slide deck for the CNO’s presentation to the MGH Board of Trustees on March 16, 2012 (Attachment TL 4.b). This year, she focused on the Innovation Unit work she is leading — a strategic interdisciplinary organization-wide effort to implement a new delivery model (TL 4EO).

The Bylaws of the Corporation and the Bylaws of the Professional Staff of the General Hospital are the principle documents that govern policy and decision-making for the hospital. These Bylaws guide the work of the Trustees and senior management team of the Hospital.

The Bylaws of the Corporation stipulate, in section 3.1, that “The Board of Trustees of the Corporation shall consist of not less than twelve or more than sixteen trustees comprised as follows:

- The Chief Executive Office of the Massachusetts General Physicians Organization, Inc. (MGPO),
- The President of the Corporation
- Four Trustees appointed annually by the Governor of the Commonwealth of Massachusetts (Gubernatorial Trustees) pursuant to the Charter;
- Six to ten Trustees (Elected Trustees) nominated by the Nominating and Governance Committee and elected by the Members pursuant to the Bylaws. The Elected Trustees shall include two members of the Professional Staff of The General Hospital Corporation, one of whom shall be a Chief of Service and one of whom shall be a practicing Physician who is not a Chief of Service.”
A full committee roster is available in attachment TL 4.c. As stipulated in section 3.8 of the Bylaws, “each Trustee shall have one vote at every meeting” and unless otherwise stipulated, “a majority of votes…shall decide every question.” The CNO is an invited attendee for the Trustees meetings. Although not a voting member, attendance at Trustees meetings positions her to have critical input into the decision-making process for long-term planning and strategic initiatives of the hospital.

In Article VI: Administrative Structure and Organization of the Bylaws of the Professional Staff of the General Corporation, there is a description of the senior management organizational structure, process, voting privileges and committee responsibilities and duties for the Hospital. The key senior management committees described in the Bylaws are charged by the Trustees to fulfill the mission of the Hospital. Key committees defined by the Bylaws are the General Executive Committee (GEC), the Chiefs’ Council and the Quality and Patient Safety Committee (QPSC). These groups are responsible for the oversight of all decisions related to functions and objective of the Hospital and the Physician’s Organization.

In section 6.05.01, the composition of the General Executive Committee (GEC) is described as follows:

a. Members

The GEC shall consist of: five representative Chiefs of Service appointed by the Chiefs’ Council; the President of The Massachusetts General Hospital; the Chief Executive Officer of the MGPO; the President of The General Hospital Corporation; the Chairs of the Executive Committee on Research and the Executive Committee on Teaching and Education; a representative of the research community appointed by the President of The Massachusetts General Hospital; two executives of The General Hospital Corporation appointed by its President; and four Members of the Active Medical Staff who shall be the two elected primary care practitioners and the two elected specialty or subspecialty practitioners who are then serving of the last two years of their three year term on the Executive Committee of the MGPO.

Since, 1996, the Senior Vice President for Patient Care and Chief Nurse (CNO) has been one of the two members of the executive team of The General Hospital Corporation appointed by MGH President to serve as a voting member of GEC. The current GEC membership roster is in Attachment TL 4.d.

Key responsibilities of the General Executive Committee (GEC) include:

• Consider and, on behalf of the Trustees, adopt policies and procedures relating to patient care and medical education;
• Consider and recommend to the appropriate committees policies and procedures relating to research;
• Acting in an advisory capacity to the Trustees and the President on all matters affecting the optimal operation of the Hospital and act as a liaison between the Professional Staff and Hospital Administration.

Attachment TL 4.e and attachment TL 4.f contain GEC agendas and minutes for the December 14, 2011 and July 25, 2012 meetings. At both of these meetings, the CNO is on the agenda to propose actions relation to the Health Professions Staff for appointments and re-appointments. At the December 14, 2011, the Senior Vice President for the Center of Quality & Safety, proposed BY 2012 institutional quality goals. The CNO participated in the GEC vote to unanimously approve the goals as presented. At the July 25, 2012, the Senior Vice President for Human Resources presented the specifics regarding a Nursing Market Adjustment. The market adjustment proposal was developed by the CNO in collaboration with MGH Human Resources.

As mentioned previously, the CNO is an invited guest to the MGH Chiefs’ Council meetings. Some responsibilities of the Chiefs’ Council include oversight of:

• Quality of care and treatment of all patients within the Services or Clinical Departments,
- Conduct and discipline of all Staff Members within his or her Service or Clinical Department, and
- Conduct and administration of all programs of education, research and clinical care within his or her Service or Clinical Department.

Attachment TL 4.g presents the membership roster for the Chiefs Council.
Attachment TL 4.h contains a set of Chiefs Council minutes citing the CNO in attendance.

Some of the key responsibilities of the Quality and Patient Safety Committee (QPSC) include:

- Review selected cases or events brought to it by the Service quality assessment chairs for the purpose of analysis and identification of opportunities for improvement of care, as well as to determine whether such cases are reportable to the Board of Registration in Medicine (BRM) and/or to the Department of Public Health (DPH).
- Advise the Medical Director, Center for quality and Safety, in the work of the quality and Patient Safety committees and the Service Quality assessment Committees.
- Review occurrence screens and other aggregate data of the Program, and
- Serve as a source of information and coordination of institution-wide activities that affect the work of service quality assessment activities.

The Chief Nurse has voting privileges on the QPSC. The Director of the PCS Office of Quality and Safety is the Chief Nurse’s designee representing Nursing on the QPSC. QPSC membership roster can be found in Attachment TL 4.i.

In addition to the formal committee structure defined by the Bylaws, another executive team referred to as the Executive Operations Committee, chaired by MGH President, is in place (attachment TL 4.j). The primary function of this group is to support and direct the operational management of the organization, including making decisions about the allocation of resources to support patient care within the organization. The CNO is an active member of this group and uses this forum to advocate for Nursing and Patient Care Services. During the annual budget process, this group plays an integral role in orchestrating the organization’s request for resources.

The CNO has the authority and responsibility for the hospital-wide development, implementation and evaluation of the plan for providing nursing care. To accomplish this charge, nurses at all levels of the organization lead and/or are represented on all relevant interdepartmental decision-making committees. A number of interdisciplinary committees across the organization can be found in the table in OOD 15. Nurses, at all levels of the organization, are positioned to influence key decisions in these key forums. For example, a sampling includes:

- At the highest organizational level, the CNO and the Director of the PCS Office of Quality and Safety represent Patient Care Services on the MGH Quality of Care Committee.
- Associate Chief Nurses co-lead the Stop Transmission of Pathogens Taskforce and are members of the Emergency Preparedness Advisory Committee and the Health Professions Staff Committee
- Nursing Directors, co-lead the Code and Emergency Response Committee, the Coronary Disease Care Redesign Team and the Vaginal Delivery Care Redesign Team. A Nursing Director is also a member of the MESAC Executive Subcommittee which oversees the medication administration safety effort at MGH.
- Clinical Nurse Specialists co-lead the Optimum Care Committee, the State Action of Avoidable Rehospitalization Initiative and the Endovascular Procedures Care Redesign Team.
• Nurse Practitioners are members of the Infection Control Committee, Needlestick Reduction Taskforce and Cancer Center Quality & Safety Committee.
• Staff Nurses serve as co-leaders of the Stroke Care Redesign Team and all of the interdisciplinary Collaborative Governance Committees. In addition, Staff Nurses are members of the MGH Excellence Every Day Coordination, Code and Emergency Response Committee, Needlestick Reduction Taskforce, Optimum Care Committee and MassGeneral Hospital for Children Family Advisory Council.

Additional illustrations of nurses at all levels in the organization leading interdisciplinary change across the organization are presented in EP 13.

The Partners HealthCare System connection

In addition to the CNO’s influence at the highest decision-making bodies of MGH, the CNO was appointed Chairperson of the Partners Chief Nurse Council (PCNC) by the President of Partners HealthCare System, Inc. in 1996. The PCNC, comprised of Chief Nursing Officers across the Partners Healthcare System (Attachment TL 4.k), meets monthly and is responsible for identifying and evaluating options for system-wide adoption of best practices. In addition, the Council has been effective in providing support to individual hospitals in learning to create change at the local level. Key areas of focus include: care delivery, quality and safety, workforce, cost management. The Council reports into the President and Chief Executive Officer of Partners HealthCare. The Partners Chief Nurse Council also meets quarterly with Chief Medical Officers across the system to address issues impacting both professions.

Similar to the influence the CNO has by presenting to the MGH Board of Trustees, as the Chairperson of the PCNC, the MGH CNO presents periodic updates to the Partners Operating Heads (Chief Executive Officers across the Partners HealthCare System). Attachment TL 4.l includes an update to the Partners Operating Heads by the CNO on January 31, 2011, presenting an update of the Patient Affordability Direct Patient Care Inpatient Care unit work she co-leads. Later that year, based on the final recommendations of this group, each Partners’ entity was charged with launching two Innovation Units to “test” new systems, processes and role to enhance care delivery. The CNO not only advances this work at MGH (TL 4EO) but also utilizes the PCNC as a forum for the Chief Nurses to share best practices about their respective Innovation Units (Attachment TL 4.m). The MGH CNO also holds strategic planning retreats with the Council members to identify goals and priorities across the system (Attachment TL 4.n). The next PCNC retreat is slated for September 20, 2012, and will focus on the system-wide implementation of a common clinical platform. The MGH CNO often communicates key areas of change launched at the Partners level, such as the design of a common clinical platform, to the MGH community via her regular column in Caring Headlines to prepare them for the work ahead (Attachment TL 4.o).

Strategic Planning Retreats

As described in TL 1, TL 3 and TL 3EO, the CNO plays an instrumental role in aligning the work of Nursing and Patient Care Services with the strategic goals of the Partners HealthCare System and the Massachusetts General Hospital. The Chief Nurse is also able to influence organization-wide changes because she has created a highly-functioning Nursing and Patient Care Service team guided by a strategic and operating planning process. The CNO participates in the strategic planning retreats and processes at the system and organizational levels and translates key information into Patient Care Services initiatives and forums (TL 1, TL 3 and TL 3EO).

The CNO also uses strategic planning retreats to advance key initiatives such as the Innovation Unit initiative which is described in detail in TL 4EO. Strategic planning retreats are also
held by front-line nurse leaders to advance changes being rolled out in the organization. Attachment TL 4.p contains a slide deck presented by the Nursing Director of the Cardiac ICU to her team presenting the key changes occurring on the global, national, organization and unit-level fronts.

**Key Structures and Processes of Patient Care Services**

In OOD 5, the structural and operational relationships to all areas where nursing is practiced is represented. It cites the clinical disciplines and programs that report to the CNO. Of note, it also describes the role descriptions of the CNO (OOD 2.a), Associate Chief Nurse (Attachment TL. 2.a), Nursing Director (Attachment TL 2.b), Clinical Nurse Specialist (Attachment TL 2.c) and Staff Nurse (Attachment TL 2.e).

One of the key structures designed and implemented by the CNO is the Institute for Patient Care (IPC). The Institute for Patient Care (Attachment TL 4.q), housed within the MGH Patient Services (PCS) is a first-of-its-kind, innovative model for advancing care. It is comprised of four centers, the Norman Knight Nursing Center for Clinical & Professional Development (SE 5), the Maxwell and Eleanor Blum Patient and Family Learning Center (EP 7), the Yvonne L. Munn Center for Nursing Research (NK 4) and the Center for Innovations in Care Delivery (NK 8). The Institute also includes interdisciplinary programs and initiatives including Collaborative Governance, the Clinical Recognition Program, Clinical Simulation and Awards and Recognition to name a few.

The Institute is a structure, designed to foster the work of each Center and practice areas to promote a synergy across Centers to advance interdisciplinary clinical work within Patient Care Services. By creating an interdisciplinary environment for the advancement of professional development, education, and research, the values and beliefs of Patient Care Services can be facilitated through teamwork in the delivery of safe, timely, efficient, cost effective quality care. The goal of the Institute is to provide nurses, therapists, social workers and other PCS staff with opportunities for growth through knowledge and experiences needed to advance personal and professional goals and patient and family care.

The Institute works to encourage efficient use of resources to promote learning and research initiatives that can be developed and supported by internal and external funding sources. The Institute also plays a leadership role in creating new directions for professional development and advancement through increased mentoring opportunities. The ongoing development of learning resources for staff, patients and families continues to focus on the promotion of culturally-sensitive, safe and effective patient care.

By linking professional groups around organizational and disciplinary goals, innovative answers are generated to respond to ongoing and new concerns. Interdisciplinary projects designed to complement and enhance patient care and professional development are encouraged and supported. It is anticipated that as the Institute grows, Centers of Clinical Excellence involving staff development, research and evidence-based practice will emerge and become focal areas for funding, research, professional advancement and recognition. The Institute serves as a clearinghouse for all initiatives and facilitates communication across all Centers and programs. In addition, the Institute partners with staff to develop project budgets that designate time, effort, personnel and resources needed to see work through to a successful completion. Goals of the Institute include:

- Foster an environment of clinical inquiry and experiential learning
- Create a synergy across all Centers to advance the goals of the Institute
- Work collaboratively to promote interdisciplinary team learning to optimize safe, effective patient care
- Participate in the development and evaluation of organizational initiatives and individual and group programs of research.
- Seek multiple funding opportunities to advance the work of the Institute and Centers
- Create opportunities to be present in the organization at the point of care and within committees across the organization.
- Assume leadership for innovation in evidenced-based practice
- Support research that advances safe and effective, evidenced-based care
- Provide leadership for innovations for staff, patients and families in learning
- Develop, implement and evaluate programmatic initiatives that impact staff and patient outcomes.
- Advance the PCS’s organizational agenda to foster interdisciplinary practice to advance patient care.
- Disseminate the work of the Institute and related Centers through multiple local, national, and international forms.

With the formation of The Institute for Patient care, the CNO has created a central entity linking disciplines and professions within Patient Care Services in order to foster teamwork, share best practices and bring an informed interdisciplinary approach to patient- and family-centered care. The Institute is the overarching structure strategically placed to connect existing centers within PCS and to help support numerous interdisciplinary programs to enhance the ability to provide high-quality care for patients and a vibrant professional practice environment for staff. Two examples of key initiatives that the Institute of Patient Care, through the synergy of its Centers has advanced, is the development and execution of education and evaluation plans for the New Graduate Residency Program (TL 7) and Innovation Units (TL 4EO).

Another key structure in Patient Care Services that the CNO leverages to advance change is the PCS Office of Quality and Safety. The Office was designed to support the interdisciplinary nature of Patient Care Services in its approach to consistently offering the safest and best care to patients, families and staff. A robust and collaborative relationship exists with all other hospital groups charged with ensuring safety and quality for the hospital community. All initiatives are based upon the Institute of Medicine’s Six Aims for Quality Improvement: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity and on the philosophy of Excellence Every Day (shared accountability and ownership across disciplines and role groups for readiness in every moment to provide the safest and best care to every patient, family and staff member (OOD 25 and EP 32).

Patient Care Services Clinical Support Services and Patient Care Services Informatics are two departments in Patient Care Services that support key decisions about the selection and roll-out of technology and information systems to support practice. In addition, Clinical Support Services plays a leadership role in facility planning and construction. These two departments are described more fully in NK 9.

**Patient Care Services Decision-Making and Communication Strategies**

The CNO recognizes that communication is essential to maintaining strong relationships with nurses and other members of the healthcare team while advancing change in MGH’s complex
environment. The CNO uses a variety of strategies to stay connected with the nurses at all levels of the organization. These strategies include:

Meetings:

- **Patient Care Services Executive Committee (PCSEC)** (Attachment TL 1.a). Under the direction of the Senior Vice President for Patient Care and CNO, the charge of PCSEC is to consider and adopt policies and procedures relating to 1) patient care; 2) education for nursing and health professionals; and 3) other matters affecting the optimal operation of Patient Care Services. Meets the 2nd and 4th Wednesdays of each month.

- **Nursing Executive Operations Team meetings**. (Attachment TL 4.r). The CNO, Associate Chief Nurses, and Support Department Directors meet to dialogue and make decisions regarding implementation plans and progress on goals supporting the departmental and organizational strategic plan. They are also utilized for sharing new information and updates, and how such may alter, support, or delay departmental initiatives and associated goals. Meets twice a week, Mondays and Thursdays.

- **Chief Nurse/Nursing Director Meetings** provides the opportunity for the CNO, Associate Chief Nurse and Nursing Directors to discuss and collaborate on issues to achieve a common understanding relative to organizational and departmental priorities, challenges, and resources. Meets every Wednesday.

- **Associate Chief Nurse/Nursing Director meetings** allow for review of quantitative and qualitative data to allow for discussion and appropriate decision-making related to service and unit-based needs. Quantitative data and information reviewed and discussed on a regular basis include quality, staff satisfaction, patient satisfaction, workload turnover and financial reports. Meets monthly on Tuesdays.

- **Combined Leadership Meetings**. Provides and opportunity for all members of the nursing leadership and triad teams (Nursing Directors, Clinical Nurse Specialists and Operations Managers) to come together to discuss and review departmental-wide or hospital-wide initiatives, policies and procedures that will be implemented on the patient care units. Participants review plans, discuss intervention and implantation strategies prior to the introduction of initiatives on the units. An example of minutes from this forum can be found in Attachment TL 4.s.

- **Nursing Director/Unit-Based Staff Meetings** provides an opportunity for the Nursing Director to dialogue with staff about issues that have a direct impact on the day-to-day operations of the unit. The Nursing Director and staff are able to share insights about practice, workload, system supports, interdisciplinary teamwork, developmental needs, and overall levels of satisfaction on the unit. These meetings provide time for the Nursing Director and staff to work together to make decisions about practice and operations.

- **Collaborative Governance Committee meetings** – Patient Care Services’ interdisciplinary committee structure led and comprised primarily by front-line clinicians to promote decision making about practice and quality of worklife (SE1).
• Staff Nurse Advisory Committee monthly meetings (1st Tuesdays) – as part of the Collaborative Governance Model, the forum allows staff nurse to communicate issues directly to the CNO and her leadership team.

**Communication vehicles:**

The CNO designed and utilizes several key communication vehicles to share key changes and information.

- Bi-weekly Patient Care Services newsletter, *Caring Headlines*, reaches all nurse and staff within PCS and across the Hospital. Every issue includes an editorial from the CNO plus an additional column called “Fielding the Issues” which uses a question and answer format to clarify information on a variety of topics and issues (Attachment TL 4.t).

- Ad hoc *PCS News You Can Use*, an electronic e-mail newsletter established in 2006, to share time-sensitive information with all nurses and staff within PCS and across the hospital (Attachment TL 4.u).

- Annual Report, formal record of the work and accomplishments of Patient Care Services produced every calendar year (OOD 3.e).

- Nursing Grand Rounds, monthly presentation sponsored by the Norman Knight Nursing Center for Clinical & Professional Development, which focuses on key topics aligned with the strategic direction of Patient Care Services. Nursing Grand Rounds are held in the O’Keeffe Auditorium and teleconferenced to off-site locations.

- Every nurse has email access at MGH and can directly email the CNO or other nurse leaders. The CNO often uses email to communicate to individuals or groups on a variety of topics. Attachment TL 4.v is an email the CNO sent to the leadership of the Innovation Units on “launch day” thanking them for their dedication to this initiative.

In addition to the detailed illustration presented in TL 4EO that describes how the CNO led the organization-wide change of implementing Innovation Units, another snapshot of how the CNO skillfully taps into many of the structures and processes outlined above pertains to how she prepared the organization and the Patient Care Services team for the changes imposed by healthcare reform.

**October 5, 2010:** CNO engages the Staff Nurse Advisory Committee in a discussion about national healthcare reform and the importance in being proactive in identifying ways to provide quality care effectively (Attachment TL 4.w). She asked them for their ideas on: reducing waste, eliminating redundancies, identifying things that don’t add value, and technologies that can help us to be more efficient.

**January 20, 2011:** CNO’s *Caring Headlines* column is titled, “Using our collective wisdom to meet the economic challenges of 2011” (Attachment TL 4.x). In this column, the CNO discusses the patient affordability work she was co-leading which is charged with identifying how to make direct care processes in the inpatient, emergency and operating room settings more efficient.

**April 21, 2011:** CNO’s Caring Headlines column is titled, “Care re-design driven by quality and safety” (Attachment TL 4.y). In this column, the CNO recaps key lessons learned at Nursing Grand Rounds presented by Maryann Fralic, on April 8, 2011. Dr. Fralic noted:

- 1) It doesn’t make any difference how high-quality patient care is if no one can afford to pay for it. When it comes to cost and quality, neither is more or less important.
2) Flexibility and resilience will ultimately determine who succeeds in health care.
3) The future is not an option. Everyone will attend. If we don’t develop new practice models, someone else will do it for us.

The CNO goes on to illustrate the important role of the MGH care redesign teams in developing new processes of care to care for select patient populations (e.g., colon cancer, diabetes, stroke, etc.).

**July 27, 2011:** The CNO provides an update to the Patient Care Services Executive Team about the Patient Affordability Direct Patient Care initiative (Attachment TL 4.z). She speaks about how the work needs to be operationalized at MGH and that she will incorporate this work into the Fall 2011 PCSEC retreat (TL 3 and OOD 3.i).

**October 13, 2011:** The CNO presents “Patient Care Delivery: The Future is Now” at Nursing Grand Rounds (Attachment TL 4.aa). In her presentation, the CNO describes the global, national and local healthcare environment and MGH’s response to it through the launch of care redesign teams and Innovation Units.

**January 19, 2012:** CNO’s Caring Headlines column is titled, “Accountable Care Organizations: Working together to coordinate care and contain rising healthcare costs” (Attachment TL 4.bb). In this column, the CNO describes what an accountable care organization is and noted that Partners HealthCare is one of 32 healthcare organizations across the county to be named a Pioneer Accountable Care Organization by the Centers for Medicare and Medicaid Services.

**Internal cultural change is often driven through external activities and relationships**

The CNO has multiple appointments that place her in various circles of influence, locally, regionally and nationally:

- Board Chair, Lunder-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
The CNO is uniquely positioned to influence and advance nursing practice on a broad scale, by providing expert counsel, support or other resources as needed. Likewise, she is in a position to broker alliances that empower nurses and impact the profession and the quality of healthcare as a whole. Because her leadership extends well beyond the walls of the MGH, she is widely viewed as an agent of change. This sets a high bar for members of the MGH community to aspire to within their own professional environments and spheres of influence. Individually and collectively, nurses at all levels throughout the organization are inspired, encouraged and supported to become agents of change themselves. The result is a culture of excellence and innovation at all levels of the organization.

The direct impact of her support and influence can be profound. For example, in 2011, she was an early and ardent supporter when the Massachusetts Action Coalition was selected as an Action Coalition by the Future of Nursing: Campaign for Action, an initiative of AARP, the AARP Foundation and the Robert Wood Johnson Foundation (RWJF), and coordinated through the Center to Champion Nursing in America (CCNA). This Coalition representing eleven statewide nursing organizations is jointly led by the Organization of Nurse Leaders, MA/RI (ONL) and the Massachusetts Department of Higher Education (DHE). Recognizing that funding and communications would be key to the Coalition’s success, the CNO convened a meeting of subject matter experts and Coalition leadership. An initial plan, operational support and a gift of “seed money” for an initial fundraising initiative raised $140,000 to help launch the group’s work.

In March 2012, a two-day kick-off to the Coalition’s IOM Future of Nursing campaign was held, with MGH hosting two of the seven events where Sue Hassmiller, PhD, RN, FAAN, Senior Advisor for Nursing at RWJF, presented an overview of the national outreach and educational campaign.

In August of 2012, Massachusetts was one of nine states to receive a $300,000 national grant from the Robert Wood Johnson Foundation to support academic progression in nursing. The funds will support the Commonwealth’s efforts in partnership with ONL. At an announcement ceremony held at the Massachusetts State House, the Chief Executive Officer of ONL thanked those involved in helping to secure the grant, including the MGH CNO, an invited speaker. In her remarks, the MGH CNO reminded the group of government, nursing, and industry leaders, that, “Nurses are the heart and soul of our healthcare system.” She took the opportunity to reinforce the central role that nursing plays within healthcare, and the importance of advancing nursing education in Massachusetts, learning from the new models we create, and leading the nation by providing novel blueprints for nursing education for the years to come. The CNO’s full remarks follow:

Good Morning Lieutenant Governor Murray, Secretary Bigby, Commissioner Freeland, Sharnn Gale, Jessica Alvarez-Montano, nursing colleagues and our colleagues in the educational and healthcare. In fact, this is a
very good morning. Today’s announcement is important news for the citizens of Massachusetts. And it comes at a critical time.

As a nurse leader, it is very clear to see that maintaining a highly-skilled nursing workforce is critical to our success. Nurses are the heart and soul of our healthcare system. How appropriate that we gather in Nurses Hall, dedicated to our great profession. Because of healthcare reform and the leadership of Massachusetts, all citizens have access to healthcare. Nursing, the largest workforce in healthcare, is key to the care of our citizens across the trajectory of healthcare. In the community, at home, or in the hospital, nurses are present.

As we have heard, in its 2010 report The Future of Nursing: Leading Change, Advancing Health, the Institute of Medicine recommends that 80 percent of the nursing workforce be prepared at the baccalaureate level by the year 2020. Today, about half of nurses in the United States have baccalaureate or higher degrees. Half. We have work to do before we meet the recommended goal.

Today’s announcement indeed supports a bold vision of partnership aimed at creating a more highly educated, diverse nursing workforce—bringing together the Robert Wood Johnson Foundation (RWJF), the American Organization of Nurse Executives (AONE), the American Association of Colleges of Nursing, the National League for Nursing, and the American Nurses Association.

In Massachusetts, the grant funds will support the continued collaboration between the Department of Higher Education and the Organization of Nurse Leaders, and innovative partnerships between nursing educators and those of us within the clinical setting. As we know from experience, these dialogues between educators and those delivering care are fundamental to our success and position Massachusetts to lead the way in advancing nursing practice.

This additional support and funding will allow us to continue to explore new models for working together to tailor nursing education to the specific demands found at the frontlines of healthcare and across the healthcare continuum—in academic medical centers, community hospitals, long-term care and home care settings. And by maintaining an active, two-way dialogue about the needs of both educators and those delivering care, we will ensure a strong and skilled nursing workforce that best meets the needs of our patients and families.

As employers, we play an important role in creating and cultivating environments of care that value and actively support life-long learning and those nurses who are advancing in their education. This can take many forms, including supporting tuition reimbursement programs, promoting flexibility in scheduling that allows nurses to attend classes, celebrating their efforts and milestones, and establishing hiring practices that do not create barriers, but ensure we place the right person, with the right skills, in the right job.

This is a significant day as we come together as a community to reinforce the central role that nursing plays within healthcare, and commit to advancing nursing education in Massachusetts, learning from the new models we create, and leading the nation by providing novel blueprints for nursing education for the years to come.

I congratulate and thank you all for your dedication and commitment, for as we all know, the ultimate beneficiaries of our collaborative efforts will be the countless patients and families who entrust us with their care.

As we gather today, I am reminded of a quote by JoEllen Koerner, in her 2001 book “Nightingale II: Nursing in the New Millennium.” In it, she states, “Wherever there are people, nursing has the opportunity to support health and well-being in partnerships with others...Through cooperation and co-creation, a synergy will be formed that can transform the total well-being of society. Alone, nursing cannot do it. Without nursing, it cannot be done.”
Care Redesign and Patient Affordability

Inpatient Innovation Units

Jeanette Ives Erickson, RN, FAAN, DNP
Senior Vice President for Patient Care Services

MGH Board of Trustees
March 16, 2012

Background

Partners Care Redesign and Patient Affordability Initiative

Primary Care
Employee Health Benefits
Patient Affordability
Care Redesign
Reputation/Communications

- Vaginal delivery
- Joint replacement
- Endocarditis
- Liver cancer
- Transplant

- Colon cancer
- ARF
- CML
- Diabetes
- Stroke

- Direct patient care
- Overhead
- Human capital

Guiding Principles

- Care delivery should always be patient and family-focused, evidence-based, accountable and autonomous, coordinated and continuous.
- It's important to know the patient.
- Inpatient and family care is provided by a designated nurse and physician who are accountable and responsible for continuity of care.
- Continuity of the team is a basic precept.
- Every novice team member deserves mentoring from an experienced clinician.
- Every patient deserves the opportunity to participate in the planning of his/her care.
- Advancements in technology create opportunity for improved provider communication and efficiency.

Agenda

- Background
- Innovation Units
- Q & A

“Patient Journey” Framework

Before
During
Post

Patient Stay: Direct Patient Care, Tests, Treatments, Procedures, Clinical Support, Operational Support
Discharge Process
Post Discharge Care

Support Functions: Disease, Information Systems, IR

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

Where Are There Opportunities to Reduce Costs Across These Processes of Care?
Innovation Units: Improve Quality and Reduce Costs

- Standardizing care practices
- Reducing variation
- Identifying and prioritizing processes
- Implementing evidence-based methods

Innovation Units
- Bigelow 14: Vascular Surgery
- White 7: General Surgery
- Lunder 9: Oncology
- Ellison 16: Medicine
- White 6: Orthopedics
- Ellison 7&18: Pediatrics
- Blake 10: NICU
- Blake 11: Psychiatry
- Ellison 9: Cardiac Intensive Care Unit (CICU)
- Blake 12: Intensive Care Unit (ICU)

Pre-Admission Clinical Data Collection

Key Information
- Patient Cell Phone
- Primary Contact Cell Phone
- Secondary Contact Cell Phone
- Disabilities (for future patient data collection)
- Discharge
  - Anticipated Discharge Date
  - Disposition

Pre-admission clinical data collection + screening & patient education = "knowing our patients"

Attending Nurse Role

- Accountable for patient/family continuing and progression along the developed overall plan of care from admission to discharge
- Ensures, along with the Attending MD, that patient care meets the unit’s clinical standards and vision of patient- and family-centered care
- Consistently present, 8-hours a day, 5-days a week
- Develops and revises the patient care goals with the clinical care team daily
- Coordinates meetings with clinicians for timely decision making and connects nurses to optimize handoffs across the continuum
- Is the primary bedside communicator with the patient and family, discussing the plan of the day, care progress, potential discharge, and answers questions/teaches/coaches

Consistent Hand-off Communication

Goal: Ensure continuity and safety when passing patient-specific information:
- From one caregiver to another
- From caregiver to patient and family
- From one type of organization to another or to the patient’s home

SBAR: Hand-Off Communication Tool

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

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

Welcome Packet

Goals
- Introduce Innovation Unit to patients
- Help patients to feel welcome and safe
- Inform patients and families of goals, invite feedback
- Encourage patients, families and caregivers to participate and to ask providers' questions
- Test innovative tools that promote patient engagement

Contents
- Welcome to the Innovation Unit letter
- Clinician-Patient Compact
- Description of Care Team/Face Sheet
- Journal/Notes/Questions/Pages
- Patient/Family Discharge Checklist/Envelope

Patient Journey Framework

Before
- Pre-admission care

During
- Administration process: ED, direct admits, transfers
- Patient stay: direct patient care; labs; treatments; procedures; clinical support; operational support
- Revise Domain of Practice
- Implement interdisciplinary team rounds
- Utilize electronic whiteboards
- Utilize communication devices
- Utilize wireless laptop computers
- Implement Discharge Planning Readiness Tool

After
- Discharge planning
- Discharge
- Follow-up Care Program

Throughout hospitalization: Relationship-based care
- Increased accountability through the attending nurse role
- Utilization of the Hand-Over Rounding Checklist

Pre-admission care
Interdisciplinary Team Rounds

- Focus:
  - Identify care gaps and improve care progression (delays in treatment, IV to IO transition, removal of lines, pain management, timely discharge decision)
  - Build a more holistic approach to patient care plan (e.g., more long-term needs discussed for frequent flyers)
  - Prevent patients from falling through the cracks
  - Help identify potential patient/family satisfaction issues for early intervention
- Occurs daily or more frequently as determined by unit
- Each participant is responsible for raising questions/issues/barriers and working with the group to resolve during rounds when possible
- The patient is part of the team

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

“Cheds” Electronic Whiteboard

Currently in use on Lunder 6-10 and Blake 12

Communication Devices

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

Discharge Screening Checklist

- Guide proactive discharge planning and identification of high-risk patients (for readmission prevention)
- Comprised of:
  - General Information
  - Work-up
  - Functional Requirements
  - Other Information
  - Education
  - Post-Discharge
  - Discharge Information

Discharge Follow-up Call Program

Guidelines

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

Enabling Technology

- Electronic Whiteboards
- Communication devices
- Wireless laptop computers

Each Attending Nurse will Carry a Wireless Laptop Computer
Innovation Unit Metrics

Throughput and Efficiency
- LOS
- TTM readiness
- Wait time for bed to be ready
- Admits
- Medication turnaround time

Patient & Staff Satisfaction
- MD & RN Communication
- Responsiveness
- Cleanliness
- Noise induction
- Staff perception of support

Quality and Safety
- Unplanned Return to OR
- Readmission Rate
- Restraint Free Rate
- Falls/Pressure Ust Reduction
- Foley Catheter Days
- Hand-off Time Out Performance

Summary

- We are attempting transformational change
- Innovation units will help us quickly identify what works and what doesn’t without ever losing sight of the needs of our patients
- Our goal is efficient, cost-effective, quality care that is patient- and family-centered

“We experience the essence of care in the moment when one human being connects to another. When compassion and care are conveyed through touch, a kind act, through competent clinical interventions, or through listening and seeking to understand the other’s experience, a healing relationship is created. This is the heart of relationship-based care.”

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

Questions
A joint meeting of the Boards of Trustees of The Massachusetts General Hospital (“MGH”) and The General Hospital Corporation (“the General” or “Hospital”) was held on Friday, March 16, 2012 in the Trustees’ Room in the Bulfinch Building.

The meeting was then called to order at 9:05 a.m. by Chair Cathy E. Minehan. Other Trustees of both Corporations present were Nesli Basgoz, M.D., Kristin S. Demong, John W. Henry, H. Robert Horvitz, Ph.D., Jonathan A. Kraft, Jerrold F. Rosenbaum, M.D., Mark Schwartz, Peter L. Slavin, M.D., Dorothy A. Terrell and David F. Torchiana, M.D. Honorary Trustees W. Gerald Austen, M.D., and Matina S. Horner, Ph.D., were present, as were Shea Sherrod Asfaw, Jan Bellack, Sally Mason Boerner, Alexander Brayton, Jeanette Ives Erickson, Gary L. Gottlieb, M.D., Tim Ferris, M.D., Carl Martignetti, Gregg S. Meyer, M.D., Colleen Murphy, and Ann Prestipino. Trustees Charles K. Gifford, Colette A. M. Phillips, Patricia F. Ribakoff, Henri A. Termeer and Stephen G. Woodsum were not present.

The minutes of the January 20, 2012 meeting were approved in the form in which they were distributed.

**Excerpt from Minutes (full minutes cannot be provided to maintain confidentiality of discussion).**

**Patient Affordability: MGH Innovation Units**

Jeanette Ives Erickson, RN, DNP, gave a presentation on the progress on the efforts of Partners and MGH to implement the care redesign initiatives. Partners has launched a comprehensive strategic planning process to ensure the continued success of Partners entities in the face of national healthcare reform and a troubling economic climate. A three-prong approach has been developed with a focus of Care Redesign, Patient Affordability and Reputation/Communications. These efforts are designed to enhance patient experience, outcomes and value. MGH has made a commitment to being a leader in Partner’s efforts to improve quality, reduce costs, and redesign care delivery.

MGH has identified 12 inpatient units as “Innovation Units”, each of which has submitted proposals seeking to participate. These units represent a cross section of patient populations that include Surgery, Oncology, Medicine, Orthopedics, Pediatrics, Obstetrics and Psychiatry. These Innovation Units will allow changes to the care delivery model to be tested and outcomes to be measured. This will be accomplished through standardizing care practices, reducing variation, identifying and prioritizing processes and implementing evidence based methods.

The Innovation Unit model describes a Patient Journey Framework with specified “Interventions” throughout a patient’s hospitalization. Enhanced clinical data collection before admission involves collecting key information from the patient such as patient primary contact, cell phone number, any known disabilities and anticipated discharge date. The patients are also given a “Welcome Packet” that will introduce patients to the concept of the Innovation Unit. The contents of this packet are geared towards helping the patient to feel welcome and safe and to keep them informed of the goals of their stay. The packet also encourages the patient to ask questions and provide feedback. The innovation structure promotes revised domains of practice and introduces the concept of inter-disciplinary team rounds. Dr. Ives Erickson then emphasized the benefits of
technology to enable this process, including the use of electronic whiteboards, communication devices such as iPhones and wireless laptops. The conclusion of a patient’s stay is summarized with a discharge screening checklist which provides a guide to proactive discharge planning. Each of the patients is also asked to participate in a discharge follow up program, where patients are contacted within 24 to 48 hours of their stay to review any concerns.

The overall goal of the program is to achieve transformational change. These innovation units will help to identify what works and what does not while fulfilling the needs of the patients. A long term goal has been set to create high performing interdisciplinary teams that deliver safe, effective, timely, efficient, and equitable care that is patient and family centered.

The meeting was duly adjourned at 10:50 a.m.
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#123042
Final Approved 5/18/12
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Board composition changed: 6/30/2012
Attachment TL 4.c continued

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Board composition changed: 6/30/2012  
GHC
General Executive Committee (GEC)
Membership List as of May 2012

**Membership:**
Dennis Ausiello, MD, Chief, Medicine
Marcella del Carmen, MD, Obstetrics and Gynecology, (MGPO representative)
Daniel Doody, MD, Pediatric Surgery, (MGPO representative)
James Godine, MD, PhD, Diabetes Center, (MGPO representative)
Jeanette Ives Erickson, RN, DNP, Senior Vice President for Patient Care and Chief Nurse
Robert Kingston, PhD, Chief, Molecular Biology
Ronald Kleinman, MD, Chief, Pediatrics; Chair of ECOTE
Anne Klibanski, MD, Neuroendocrine, (Research representative)
Keith Lillemoe, MD, Chief of Surgery
David Louis, MD, Chief, Pathology
Britain, Nicholson, MD, Senior Vice President for Medicine and Chief Medical Officer
Issac Schiff, MD, Chief, Obstetrics and Gynecology
Peter Slavin, MD, President, Massachusetts General Hospital
David Torchiana, MD, Chief Executive Officer, Mass General Physicians Organization
Katherine Treadway, MD, Internal Medicine, (MGPO representative)
Jeanine Wiener-Kronish, MD, Chief, Anesthesia

**Invited Attendees – Chiefs:**
Jose Baselga, MD, Chief, Hematology/Oncology
Michael Blute, MD, Chief, Urology
Alasdair Conn, MD, Chief, Emergency Services
Merit Cudkowsicz, MD, MSc, Chief, Neurology
G. William, Dec, MD, Chief, Division of Cardiology
David Fisher, MD, PhD, Chief, Dermatology
Daniel Haber, MD, PhD, Director, MGH Cancer Center; Chair of ECOR
Leonard Kaban, MD, Chief, Oral and Maxillofacial Surgery
Jay Loeffler, MD, Chief, Radiation Oncology
Robert Martuza, MD, Chief, Neurosurgery
Joan Miller, MD, Chief, Ophthalmology, Massachusetts Eye and Ear Infirmary
Joseph Nadol, Jr., MD, Chief, Otolaryngology, Massachusetts Eye and Ear Infirmary
Jerrold Rosenbaum, MD, Chief, Psychiatry
Harry Rubash, MD, Chief, Orthopaedics
James, Thrall, Chief, Radiology
Joseph Vacanti, Chief, Pediatric Surgery
Ross Zafonte, DO, Chief, Physical Rehabilitation Medicine

**Other:**
Shea Asfaw, Chief of Staff, Office of the President
W. Gerald Austen, MD, Chair of Chief’s Council
Richard Averbuch, Director, Marketing
Deborah Colton, Senior Vice President, Strategic Communications
William Crowley, MD, Director, Clinical Research
Jean Elrick, MD, Senior Vice President, Administration
Attachment TL 4.d continued

Timothy Ferris, MD, Medical Director, MGPO
Jack Higham, Office of General Council
Alexandra Kimball, MD, MPH, Vice President, Service Excellence and Practice Improvement
Nancy Marttila, Business Manager, Office of the President *(staff to the GEC)*
Sally Mason Boemer, Senior Vice President, Finance and MGH Cancer Center
Elizabeth Mort, MD, Director, Clinical Care Management; Interim Vice President, Quality & Safety
Harry Orf, PhD, Senior Vice President, Research
Gregg Pauly, Chief Operating Officer, Mass General Physicians Organization
Ann, Prestipino, Senior Vice President, Surgical and Anesthesia Service and Clinical Business Development
Joan Sapir, Senior Vice President, Neurosciences and Pediatrics
Peggy Slasman, Chief Public Affairs Officer
James Thompson, Vice President, Development
Linda Weinstein, Director, Medical Staff Office
Deborah Weinstein, MD, Vice President, Graduate Medical Education
THE GENERAL EXECUTIVE COMMITTEE/CHIEFS MEETING

Wednesday, December 14, 2011, 8:00 – 10:00 am
Paul S. Russell, MD, Museum of Medical History and Innovation

AGENDA

Paul S. Russell, MD, Museum of Medical History and Innovation

Welcome
David Torchiana, MD; John Herman, MD 5 minutes

Walk About 15 minutes

Overview
Peter Slavin, MD; Peggy Slasman; Peter Johnson 15 minutes

Minutes

Updates

• MGPO 10 minutes
• MGH 10 minutes

Discussion and Action

Proposed Actions Relative to the Professional Staff
dated December 14, 2011
W. Gerald Austen, MD 3 minutes

Proposed Actions Relative to the Health Professions Staff
dated December 14, 2011
Jeanette Ives Erickson, RN, DNP 3 minutes

MGH/MGPO Strategy: Plans for Renewal
Peter L. Slavin, MD; David Torchiana, MD 30 minutes

Quality and Safety Goals
Gregg Meyer, MD 30 minutes
A meeting of the General Executive Committee was held on December 14, 2011 in the Paul S. Russell, MD, Museum of Medical History and Innovation

**Member Attendees:** Dr. Slavin in the Chair; Drs. Ausiello, Doody, Haber, Kleinman, Klibanski, Lillemoe, Louis, Nicholson, Schiff, Torchiana, and Troulis and Ms. Ives Erickson

**Absent:** Drs. Haydock, Treadway, and Wiener-Kronish

**Other Attendees:** Drs. Austen, Baselga, Brinthurst, Conn, Crowley, Dec, Elrick, Herman, Fisher, Kaban, Loeffler, Martuza, McDonald, Miller, Nadol, Rosenbaum, Rubash, Russell, Thrall, Vacanti, Young, and Zafonte; and Messrs. Averbuch, Marple, Pauly, Seger, and Thompson; and Ms. Asfaw, Ms. Colton, Ms. Marcella, Ms. Marttila, Ms. Mason Boemer, Ms. McCullough, Ms. Prestipino, Ms. Sapir, Ms. Slasman, and Ms. Weinstein

The meeting was called to order at 8:20 a.m.

The minutes of the November 23, 2011 meetings were approved.

**Welcome**

Dr. Slavin welcomed everyone to the new Paul S. Russell, MD, Museum of Medical History and Innovation. He thanked Dr. Torchiana and Dr. Herman for their wassail toast prior to the meeting and hoped that the GEC enjoyed touring the building. He paid tribute to Dr. Russell for his leadership and generosity and Ms. Slasman for her leadership. Ms. Slasman stated that the opening of the museum is the final group of events for the bicentennial year. She thanked the people who were involved on a day-to-day basis in making the museum a reality and introduced Mr. Johnson, director of the museum. He spoke about how remarkable it was that the museum was completed in such a short period of time, adding that it would not have been possible without the many hardworking people who had been involved in the project over the past several years. The museum is intended to illustrate history and to be a living showcase going forward. He asked for ongoing advice, support, and collaboration. Dr. Slavin thanked Dr. Torchiana for the critical leadership role he played in making the museum a reality and said that it was fitting that the GEC was the first meeting to be held in the museum.

**Massachusetts General Physician Organization**

Dr. Torchiana announced that physicians must complete the HealthStream modules on compliance by December 31st. He then reported on the MGPO Quality Incentive Program for term 2, 2011. The measures were the timeliness of clinical documentation, with the rate of final note completion improving from 86% to 89%; H-CAHPS MD Communication, with the hospital’s rate at 81.4% slightly above the Partners target of 80.9%; and department-chosen measures, with 98% of physicians meeting their target. Over 85% of physicians will receive at
least 80% of the incentive. A departmental summary was shown for all three measures, followed by a graph depicting MD communication scores over time. In department measures, only two groups did not meet their target. The measures for term 1, 2012 will be timeliness of clinical documentation, physician Meaningful Use preparation, and department-chosen measures.

Next Monday, Partners will announce its participation in the Medicare Pioneer Accountable Care Organization (ACO) model. The ban on imposing the SGR (sustainable growth rate) adjustment to Medicare physician payments is due to expire on December 31; pending legislation would freeze it for the next two years. Some of the options for offsetting the cost of a long-term freeze involve reductions in hospital payments.

**Massachusetts General Hospital**

As Dr. Slavin was not present at last week’s Chiefs Council when Dr. Thrall’s resignation was announced, he took this opportunity to thank Dr. Thrall for his years of leadership as the chief of Radiology and also thanked Dr. Loeffler for agreeing to chair the search for Dr. Thrall’s successor. At the AAMC/COTH Leadership Forum last week there was much discussion on deficit reduction and the Medicare and Medicaid budgets. Everyone received the newest edition of *Proto* which, in honor of the bicentennial year, is dedicated to a celebration of science at MGH. Dr. Rosenbaum spoke about the biomedical research at MGH and Ms. Slasman announced that there is a smart phone *Proto* application. The volume statistics for November were a bit below budget but for December to-date, they are well above budget. The bonus program announced last week has elicited many emails of appreciation.

**Professional Staff Appointments**

The GEC reviewed the proposed actions relative to the Professional Staff as indicated on the document dated December 14, 2011, to which was added, since distribution, the name of Fred Hochberg, MD to appoint without change in title for the dates 12/14/2011 through 1/11/2012. The GEC members approved all appointments and re-appointments and recommended that The General Hospital Corporation Board of Trustees Committee on Appointments and Privileges approve each action proposed.

**Health Professions Staff Appointments**

The GEC reviewed the proposed actions relative to the Health Professions Staff as indicated on the document dated December 14, 2011. The GEC members approved all appointments and re-appointments and recommended that The General Hospital Corporation Board of Trustees Committee on Appointments and Privileges approve each action proposed.

**MGH / MGPO Strategic Planning**

Dr. Torchiana described the goals for today’s discussion and emphasized that the strategic plan will encompass all four missions of the hospital. He addressed the external environment and its impact on the MGH and MGPO. The key macro changes in health care delivery were listed as well as the cost pressures that include steady growth in per capita health care costs for the past forty years, perpetual unmet need, health insurance coverage expansion magnifying cost pressures, and the handicap in a global economy of the U.S. employer-based health insurance
system. There are also major changes in commercial contracts that will have a financial impact. The Center for Medicare and Medicaid Services has put into place pay for value programs that will bring our total cumulative financial risk through FY2017, when it is fully implemented, to $145 million. Additionally, $46 million in National Institutes of Health funding is at risk for MGH. Another financial impact will be the automatic 2% reduction to all Medicare payments effective January 2013 as a result of sequestration that, in turn, is the result of the failed efforts of the Super Committee to achieve deficit reduction. We will experience a financial impact from multiple external changes including the new Blue Cross contract, Pioneer Accountable Care Organization (ACO), vulnerability of the indirect medical education/direct medical education situation, vulnerability of research funding, and Medicare estimated Sustainable Growth Rate (SRG) for the MGPO.

Dr. Slavin spoke to the internal environment. Society is asking us to constrain cost growth to general inflation. This means that we must take more risks but must ensure that we do not put our core mission, reputation for excellent care, and our ability to attract and retain exceptional talent at risk. Given our commitment there are two strategies: manage the external environment by negotiating contracts that reward us for being more efficient and manage the internal environment by implementing strategies and tactics for improved quality and efficiency of care. Partners institutions will be in two segments of business: population health management and referral/episodic care business. Partners approach to the work and Partners strategy overview were described, along with the MGH/MGPO selected care redesign areas: vaginal delivery, joint replacement, endovascular, lung cancer, and transplant. A timeline for the MGH/MGPO strategic planning process was delineated from late fall/early winter 2011 through early spring 2013, with a retreat scheduled in spring 2012 and fall 2012. The structure has Drs. Slavin and Torchiana as executive sponsors, with an executive committee, a steering committee, work groups, analytics committee, and retreat logistics committee all to-be-determined. The next steps include populating the executive and analytic committees and beginning internal and external assessments. The June 28, 2004 special issue of Hotline detailing the MGH Clinical Strategic Plan was distributed. It briefly summarized the fifteen-month strategic planning process and described the implementation phase.


Dr. Meyer reviewed the 2011 goals and their status. They are as follows: support Partners care redesign and patient affordability initiatives - goal fully met or substantial progress; accelerate improvements in efficiency - partial progress, room for improvement; improve the experience of our patients and their families - goal fully met or substantial progress; make MGH care safer through reducing adverse preventable events - partial progress, room for improvement; and continue to advance a culture of safety at the MGH - goal fully met or substantial progress. Each of these goals was depicted by accountability and key metrics. The process for priority setting began in October with the compilation of potential targets by the Center for Quality and Safety (CQS); followed by input from the Quality Oversight Committee and then the Board Quality Subcommittee; followed by the approval of the CQS Steering Committee, GEC, and the Board of Trustees. CQS has identified 25 potential targets for institutional and CQS goals. The identification and priority process was described, with important themes and issues identified through multiple signal detection mechanisms.
The proposed CY2012 institutional quality goals are: 1. Enhance our quality & safety measurement and performance improvement infrastructure to advance six 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; and 5. Make measureable progress in efficiency, affordability and effectiveness through support of key institutional programs.

The goals were more fully described as well as the tactics necessary to achieve each goal. The next steps include final approval by the Board of Trustees, identifying further tactics and measures to track and evaluate success, and tying goals to 2012 quality incentives. The GEC voted unanimously to approve the goals as presented.

The meeting adjourned at 9:55.
THE GENERAL EXECUTIVE COMMITTEE/CHIEFS MEETING

Wednesday, July 25, 2012, 8:00 – 10:00am

Simches Research Building, Conference Center - Room 3-120

AGENDA

Minutes

Updates

- Partners 10 minutes
- MGPO 10 minutes

Discussion and Action

Disruptive Patient Behavior as a Quality and Safety Concern:
Update on MGH Response
    Anthony Weiss, MD; Robin Lipkis-Orlando, RN 20 minutes

Updates

- MGH 10 minutes

Discussion and Action

Proposed Actions Relative to the Professional Staff dated July 25, 2012
    W. Gerald Austen, MD 3 minutes

Proposed Actions Relative to the Health Professions Staff dated July 25, 2012
    Jeanette Ives Erickson, RN, DNP 3 minutes

Nursing Market Adjustment
    Jeff Davis 10 minutes

U.S. News and World Report Best Hospital Rankings Update:
    Behind the #1 Ranking
    Richard Averbuch, Frank Melanson, Elizabeth Mort, MD 25 minutes

Overview of Cooley Dickinson and Hallmark Health Mergers
    Tony James 20 minutes
A meeting of the General Executive Committee was held on July 25, 2012 in the Simches Building, Room 3120.

**Member Attendees:** Dr. Slavin in the Chair; Drs. Ausiello, Doody, Kingston, Kleinman, Lillemoe, Louis, Nicholson, Schiff, Torchiana, and Wiener-Kronish

**Absent:** Drs. del Carmen, Godine, Klibanski, Treadway and Ms. Ives Erickson

**Other Attendees:** Drs. Austen, Baselga, Blute, Conn, Dec, Ferris, Fisher, Gottlieb, Kaban, Kimball, Loeffler, Nadol, Orf, Rubash, and Weiss and Messrs. Averbuch, Davis, James, Melanson, Pauly, and Thompson; and Ms. Banister, Ms. Colton, Ms. Donelan, Ms. Lebrun, Ms. Lipkis-Orlando, Ms. Marttila, Ms. Mason Boemer, Ms. Prestipino, Ms. Sapir, and Ms. Weinstein

The meeting was called to order at 8:00 a.m.

The minutes of the July 11 meeting were approved.

**Partners HealthCare System, Inc.**

Dr. Gottlieb reported that the state’s health care cost containment legislation has an enactment deadline of July 3. There has been considerable discussion around a component of the legislation referred to and the “institution.” Dr. Gottlieb congratulated MGH on its *U.S. News and World Report* #1 ranking and called on MGH to provide expertise as all of Partners moves forward and makes substantial changes.

**Massachusetts General Physician Organization**

Dr. Torchiana reported on the results of the term 1, 2012 measures for the MGPO Quality Incentive Program, noting that this term the measures were timeliness of clinical documentation, meaningful use prep, and a department measure. Final note timeliness improved from 89% to 91%. There also was remarkable progress on the meaningful use measures – 87% viewed the dashboard, 91% achieved the problem list target, 97% achieved the Visit Summary Report target, and all those who had alternates achieved the target. Several slides illustrated the results by department. Term 2 measures for PCPs are to complete Joint Commission training by June 1 and use medication reconciliation functionality ten times in the electronic medical record (EMR); to complete Visit Summary Report within three business days for 50% of patients and to meet their department measure. Specialist measures are to complete Joint Commission training by June 1 and use medication reconciliation functionality ten times in EMR; to ensure more than 80% of patients have at least one problem in a structured field on the problem list and print out ten visit Summary Reports within three business days; and to meet their department measures. Dr. Torchiana also reported that discussions with Hallmark Health about closer affiliation are making progress.
Massachusetts General Hospital

Dr. Slavin reported that the Joint Commission has been at MGH for the past two days and all seems to be going well. The Association of American Medical Colleges (AAMC) held a meeting yesterday to brief members on the details of the Affordable Care Act (ACA). Many states are struggling with the ramifications of the ACA and there is a difference in complexity state by state. Next Monday there will be an MGH Leadership Meeting. On the agenda will be a strategic planning update, the Joint Commission visit, and the FY13 budget.

Disruptive Patient Behavior as a Quality and Safety Concern: Update on MGH Response

Dr. Weiss began the presentation with three anecdotal examples of disruptive patient behavior (DPB) taken from Safety Event Reports. Those reports show a monthly incidence of staff assault at MGH ranging in the past 18 months from 12 to 28. DPB is characterized as words or actions that directly threaten the safety of others, create a hostile care environment, and/or prevent or interfere with care. Patient causes of DPB are delirium, dementia, and/or pain; environmental causes are understaffing and/or poor coordination; and provider causes are inexperience and/or low psychosocial orientation. These causations contribute to a vicious cycle of DPB. Providing providers with tools to better manage DPB and enhancing our post-DPB response will assist in breaking the cycle.

Ms. Lipkis-Orlando reviewed the need to communicate risk via the disruptive patient icon. This icon will be initiated by a safety report event and reviewed by a multi-disciplinary committee monthly. Clicking on the icon will display a brief care note that will elaborate on the patient’s situation but will not be considered part of the formal medical record. All icons will be reviewed on a biannual basis for new information which would prompt renewal, discontinuation or modification and will be presented to the Medical Policy Committee for review.

Professional Staff Appointments

The GEC reviewed the proposed actions relative to the Professional Staff as indicated on the document dated July 25, 2012. The GEC members approved all appointments and re-appointments and recommended that The General Hospital Corporation Board of Trustees Committee on Appointments and Privileges approve each action proposed. However it should be noted that Dr. Radbeh Torabi's appointment was approved pending the approval of his limited medical license, which is anticipated to be approved today by the BORM.

Health Professions Staff Appointments

The GEC reviewed the proposed actions relative to the Health Professions Staff as indicated on the document dated July 25, 2012. The GEC members approved all appointments and re-appointments and recommended that The General Hospital Corporation Board of Trustees Committee on Appointments and Privileges approve each action proposed.
**Nursing Market Adjustment**

Mr. Davis proposed a 2% increase in the staff nurse salary minimum and in the 2-25 experience levels as well as an increase in the salary maximum of 0.5%. Also proposed for nurse practitioners was a 4.9% increase in the NP minimum salary and in the 2-25 experience levels as well as an increase in the salary maximum of 0.5%. Several comparative slides showed that MGH’s weighted average salary was below Brigham and Women’s Hospital as was the salary rate detail for both staff nurses and NPs. These adjustments will be effective in September.

**U.S. News and World Report Best Hospital Ranking Update: Behind the #1 Ranking**

Mr. Melanson reminded the GEC that the *U.S. News* ranking began in 1990, with Johns Hopkins ranked as #1 from 1991 until 2012. MGH was third or fourth from 1990 to 2006, but placed fifth in 2007-2009. There are four domains in the service line methodology: 1. structure (weighted at 30%) – patient services and advanced services; 2. process (32.5%) – reputation rankings by specialists; 3. outcome (32.5%) – case and severity adjusted mortality; and 4. patient safety index (5%) – National Quality Forum measures. The honor roll methodology was as follows: 1. hospitals were included only if they received points in at least six out of twelve specialties; 2. twelve data-driven specialties, with top ten hospitals receiving two points and those ranked eleven through twenty receiving one point; and 3. Four reputation-only specialties, with top five hospitals receiving two points and those ranked six through ten receiving one point. The honor roll trend summary for the past three years was shown as was a five-year trend summary for Rheumatology, Ophthalmology, and Urology. Initiatives to improve rankings in the four domains were shown as were MGH’s service line summary trend.

Mr. Averbuch described what we will be doing going forward, with the goal of remaining #1.

**Overview of Cooley Dickinson and Hallmark Health Mergers**

Mr. James showed a map pinpointing Cooley Dickinson Hospital (CDH) as being 100 miles west of Boston, with 140 beds and 280 physicians in the physician hospital organization (PHO). CDH will become a subsidiary of MGH and five areas were identified as being the focus once the relationship is finalized. Due diligences findings and implications were discussed in five categories: medical staff organization, financial health, pension benefits, leadership, and information systems.

A second map was shown depicting the location of the two Hallmark Health System hospitals, Lawrence Memorial and Melrose-Wakefield north of Boston. The two hospitals have a combined total of 368 beds, with a PHO of 300 physicians. Three areas were identified as being the focus after the relationship is finalized. Due diligence is in process in five areas and several framework options were discussed. A timeframe for both Hallmark and CDH was shown, beginning this month and continuing through due diligence, approvals, regulatory submissions and review process and ending sometime in 2013.

The meeting adjourned at 9:55.
CHIEFS’ COUNCIL
Membership List

MEMBERS:
W. Gerald Austen, MD, Chair, MGH Chiefs’ Council
Dennis Ausiello, MD, Chief, Medical Services
Michael Blute, MD, Chief, Urology
Alasdair Conn, MD, Chief, Emergency Services
Merit Cudkowicz, MD, Chief, Neurology Service
David Fisher, MD, Chief, Dermatology Service
Leonard Kaban, MD, Chief, Oral and Maxillofacial Surgery
Robert Kingston, MD, Chief of Molecular Biology
Ronald Kleinman, MD, Chief, Pediatric Service
Keith D. Lillemoe, MD, Chief of Surgery
Jay Loeffler, MD, Chief, Radiation Medicine
David Louis, MD, Chief, Pathology
Robert Martuza, MD, Chief, Neurosurgery
Joan Miller, MD, Chief, Ophthalmology,
Joseph Nadol, MD, Chief, Otolaryngology
Jerrold Rosenbaum, MD, Chief, Psychiatry
Harry Rubash, MD, Chief, Orthopaedics
Isaac Schiff, MD, Chief, Vincent Memorial Gynecology and Obstetrics Services
James Thrall, MD, Chief, Radiology
Thoralf Sundt, MD, Chief, Cardiology
Joseph Vacanti, MD, Chief, Pediatric Surgery
Jeanine Wiener-Kronish, MD, Chief, Anesthesia and Critical Care
Ross Zafonte, MD, Chief, Physical Medicine and Rehabilitation
William Crowley, MD, Director, MGH Clinical Research Program
Gary Gottlieb, MD, President and Chief Executive Officer of Partners HealthCare System
Daniel Haber, MD, Director, MGH Cancer Center
Britain Nicholson, MD, Senior Vice President for Medicine and Chief Medical Officer
Peter Slavin, MD, President, Massachusetts General Hospital
David Torchiana, MD, Chief Operating Officer, Mass General Physicians Organization

Other Attendees:
Deborah Colton, Senior Vice President, Strategic Communications
Jean Elrick, MD, Senior Vice President, Administration
Timothy Ferris, MD, Medical Director, MGPO
Jeanette Ives Erickson, RN, DNP, Senior Vice President for Patient Care and Chief Nurse
Michael S. Jellinek, MD, President, Newton Wellesley Hospital
Alexa Kimball, MD, MPH, Senior Vice President, Service Excellence and Practice Improvement
Anne Klibanski, MD, Director, Center for Faculty Development
Sally Mason Boemer, Senior Vice President, Finance and MGH Cancer Center
Elizabeth Mort, MD, Director, Clinical Care Management; Interim Vice President, Quality & Safety
Harry W. Orf, PhD, Senior Vice President, Research Management
Mr. Greg Pauly, Chief Operating Officer, Mass General Physicians Organization
Ms. Ann Prestipino, Senior Vice President, Surgical and Anesthesia Services; Clinical Business Development
Ms. Joan Sapir, Senior Vice President, Neurosciences and Pediatrics
Ms. Peggy Slasman, Chief Public Affairs Officer
Mr. James Thompson, Vice President, Development
CHIEFS' COUNCIL MEETING
MINUTES
March 7, 2012
8:00 a.m. – 10:00 a.m.

MEMBERS PRESENT: Dr. Austen in the Chair, Drs., Conn, Crowley, Fisher, Haber, Kingston, Loeffler, Lillemoe, Louis, Martuza, McDougal, Nadol, Nicholson, Rosenbaum, Rubash, Slavin, Schiff, Sundt, Thrall, Torchiana, Vacanti, Wiener-Kronish and Young.

OTHER ATTENDEES PRESENT: Drs., Elrick, Jellinek, Kimball, Mort, Ives Erickson, Mr. Belknap, Ms. Colton, Ms. Mason Boemer, Mr. Pauly, Ms. Sapir, Ms. Saraf (staff), Ms. Slasman and Mr. Thompson

ABSENT: (Members): Drs., Ausiello, Gottlieb, Kaban, Klibanski, Klienman, Miller, Zafonte, (Other attendees): Drs, Ferris, Meyer, Mr. Averbuch, Mr. Higham, Mr. Hynes and Ms. Prestipino

GUESTS: Ms. Asfaw, Mr. Braydon, Dr. Hooper, Ms. Weinstien and Dr. Weiss

CHIEFS’ COUNCIL MINUTES
The minutes dated February 15, 2012 were approved.

ANNOUNCEMENTS AND UPDATES

DR. AUSTEN
Dr. Austen called the meeting to order. He then turned the meeting over to Dr. Slavin who convened a session of the GEC. Dr. Austen presented Staff Appointment recommendations for approval by the Trustees Committee on Appointments. A vote was taken and three new staff members were approved. Drs., James M. Becker, Diana R. Wasserman and Omer Cumhur Aydin. GEC was adjourned.

DR. SLAVIN
Dr. Slavin reviewed the second MDPH public report released in February, “Healthcare-Associated Infections in Massachusetts Acute Care Hospitals”. In 2006 Massachusetts implemented the Infection Control Program allowing the MDPH through public reporting to improve quality by promoting transparency and give an opportunity to benchmark with a goal to help consumers better understand hospital-acquired infections and the work being done to prevent their occurrence. The CDC’s findings from the National Healthcare Safety Network (NHSN) include central line associated bloodstream infections in ICUs, surgical site infections after specific procedures and influenza vaccine rates for healthcare workers. All the data are compared against the NHSN standardized infection ratio (SIR) <1= lower than expected or >1 =higher than expected. At MGH the central line associated bactermia rates reported by ICU type were all <1 with the exception of two. Surgical site infections for the five reported procedures in most cases compared to the national average. MGH was above average for influenza vaccinations. Dr. Slavin then announced that Cooley Dickenson Hospital voted
unanimously to discuss the merger with MGH. Next steps will be to begin the process of
due diligence including reviewing finances, staff and the facility; preparing a letter of
agreement and working toward regulatory approval. He then congratulated the three
employees that received Partners Medical Association Awards. Dr. Slavin reminded
everyone that there will be no GEC next week, March 14, 2012. He then let the Chiefs
know that the financial results for February were not in yet but that early indications are
positive.

**DR. TORCHIANA**

Dr. Torchiana announced that the 2012 MGPO survey of the clinical departments
concluded on March 1st with a 94% response rate. Six departments and five units in
Medicine had a 100% response rate with the lowest group response rate at 91%.
Reporting results will begin in April. Dr. Torchiana also commented on the
conversations we are having with Hallmark Health and the physicians who are affiliated
with Lawrence Memorial and Melrose-Wakefield Hospitals about our future relationship.
He also reinforced the potential positives Dr. Slavin noted about the proposed Cooley
Dickinson Hospital relationship. He noted that there is little overlap in our service areas.
Dr. Torchiana will attend the Crico Board Meeting this weekend where the agenda will
include an update on the search for a new CEO and consideration of a 3% premium
increase. Dr Torchiana commented on the legislative front, mentioning that the Speaker
of the House made a speech this week about pending healthcare legislation and
observed that limiting health care cost increases to the level of general inflation may be
in order. A joint House and Senate bill is expected in April. Lastly Dr. Torchiana
reviewed the internal performance framework that Partners has developed to implement
new risk-based contracts with insurers. The plan includes strategic population
management investments, performance on established quality measures and an
innovative approach to setting internal trend targets and encouraging network loyalty.
The long-term goal is cost savings, improved efficiency and continued high quality of
care.

**JOINT COMMISSION PREPARATIONS**

Mr. Belknap explained that the Joint Commission Survey goal for 2012 is to complete
the survey with no direct impact findings. He highlighted the areas that need attention to
achieve this goal. First, all medical record entries must be signed, dated and
authenticated with an author’s signature and credentials, along with a pager number or
printed name. The second risk area is restraints. All patients placed in non-behavioral
restraints need to have an active order which matches the restraint type and a daily
assessment by a physician, nurse practitioner or physicians assistant indicating the
ongoing need for restraints. Each inpatient must have a documented history and
physical examination (H&P) in their medical record within 24 hours following admission
and prior to surgery or any procedure involving anesthesia services. An H&P preformed
up to 30 days prior to admission satisfies this requirement, however a brief H&P update
note must be entered into the medical record. Mr. Belknap then stressed the need to be
vigilant that we are sure medication labeling occurs and includes drug name, strength,
expiration time and date, diluent and volume and initials. This is a National Patient
Safety Goal and will be an instant direct impact finding with one observation during the
Joint Commission survey. Lastly, medication reconciliation at the time a patient enters the hospital, outpatient, ambulatory or procedural setting, including updating and reconciling a list of the patient’s current medications, and printing this list for the patient any time a chronic medication is prescribed. Mr. Belknap implored the Chiefs to emphasize these risks and the need for improvement in their department meetings and to their program directors, following up with residents and fellows to be sure that we are in compliance.

**MGH CHILD PSYCHIATRY AND NWH**

Dr. Jellinek began by announcing to the Chief’s that after 31 years as Chief of Child Psychiatry at MGH he would be stepping down. He then gave a brief history of the program and highlighted the important developments that were made throughout his career at MGH and mentioned key members of the staff that have made significant contributions to the program over the years. He explained the effect that chronic disease has on children, whether it be their own illness or a parent’s and how there are key points of time that these trained pediatric specialists can intervene to make the biggest impact and help a child through this most difficult time. He described some of the newer programs such as sports psychology and post concussive recovery, eating disorders and school consultation, all designed to help children and families when facing difficult times and trauma. Dr. Jellinek highlighted Dr. Joe Biederman’s work in Psychopharmacology and ADHD, also acknowledging that the faculty in his department has published approximately 2000 papers since 1980. Dr. Jellinek explained how he and Mike Murphy ED.D have created a pediatric symptom checklist to screen for psychosocial problems in pediatric primary care that is widely used in Massachusetts as well as internationally. He concluded by thanking his department, pediatrics, the medical staff, and MGH hospital administration for their support. He is proud to say that MGH is the national role model for cooperation and support in meeting the needs of children and their families. Dr. Jellinek then continued his presentation by explaining the mission and vision of Newton Wellesley Hospital where he currently holds the title of President. He explained that they want to treat and care for all patients and their families as we would a beloved family member and to be among the premier community teaching hospitals in the world, through the relentless pursuit of excellence, commitment to high quality and safe patient care. He discussed the relationship between MGH and the NWH and about the changes that have occurred over the past 10 years. Dr Jellinek said that the successful collaboration between MGH and NWH along with lots of hard work and continued support, has led to NWH being only 1/10 of a percent behind MGH as having the best overall clinical reputation since 2007. The NWH has worked diligently to improve patient satisfaction and tirelessly attempted to retain and recruit the best staff possible to stabilize the culture at NWH. Dr. Jellinek believes that the positive collaboration between the two hospitals has been essential to achieve these goals and and thanked the many Chiefs and the administrators for their cooperation and continuing support.

Details on all presentations are available at the following link: [http://sharepoint.partners.org/mgh/chiefscouncil/Shared%20Documents/](http://sharepoint.partners.org/mgh/chiefscouncil/Shared%20Documents/)

The meeting went into Executive Session at 9:30 AM.
Quality and Patient Safety Committee (QPSC)
Membership List

Cyrus C. Hopkins, MD, Chairperson
Elizabeth Mort, MD, Co-Chairperson

Charles Ames, Trustee
Cathy Minehan, Trustee
Judy Friend, Trustee
Sarah Arnholz, Office of General Council
John Belknap, Compliance Officer
Meg Clapp, Director, Pharmacy
Christopher Coley, MD, QA Chair – Medicine and MESAC
Theodore Benzer, MD, QA Chair – Emergency Department
Jean Elrick, MD, Chair, Safety Committee
Thomas Dodson, MD, DMD, QA co-Chair – Oral and Maxillofacial Surgery
Peter Dunn, MD, QA co-Chair – Operating Room
Dawn Tenney, RN, QA co-Chair – Operating Room
Jeffrey Ecker, MD, QA Chair – Obstetrics/Gynecology
Timothy Ferris, MD, QA Chair – Medical Director, Mass General Physicians Organization
Pablo Gomery, MD, QA Chair – Urology
Laura Riley, MD, Mass General Physicians Organization Administration
Lela Holden, PhD, RN, Center for Quality & Safety, Patient Safety Officer
Arthur Sober, MD, QA Chair – Dermatology
Anneesh Singhal, MD, QA Chair—Neurology
Peter Masiakos, MD, QA Chair – Pedi Surgery
Kent Lewandrowski, MD, QA Chair – Pathology
Marilyn McMahon, Risk Management
Rachael McKenzie, RN, Case Management
Brit Nicolson, MD, Chief Medical Officer, Chair, Clinical Policy & Records Committee
Christopher Ogilvy, MD, QA Chair – Neurosurgery
David Ring, MD, QA co-Chair – Orthopaedics
William Tomford, MD, QA Co-Chair – Orthopaedics
Edwayd George, MD QA Chair – Anesthesia
Esther Israel, MD, QA Chair – Pediatrics
Kevin Whitney, RN, Acting QA Chair, Patient Care Services
Anthony Weiss, MD, QA Chair—Psychiatry
Cameron Wright, MD QA Chair – Surgery
Paula Wright, RN, Infection Control Committee
Torunn Yock, MD, QA Chair – Radiation Oncology
Robin Lipkis-Orlando, RN, Office of Patient Advocacy
Taylor Thompson, MD, QA ICUs and Critical Care Committee
Michaeh Jaff, MD, QA, Vascular Center
Jay Fishman, MDD, QA Chair – Transplant Center
Inga Lennes, MD, QA Chair – Cancer Center
Gloria Salazar, MD, QA Chair—Imaging
MGH Senior Executive Operations
Membership

Peter L. Slavin, MD, President, Chairperson
Shea Asfaw, Chief of Staff, Office of the President
Sally Mason Boemer, Senior Vice President, Finance and MGH Cancer Center
Jeff Davis, Senior Vice President, Human Resources
Jean Elrick, MD, Senior Vice President, Administration
Jeanette Ives Erickson, RN, DNP, Senior Vice President for Patient Care and Chief Nurse
Elizabeth Mort, Interim Vice President, Quality & Safety
Britain Nicholson, MD, Senior Vice President for Medicine and Chief Medical Officer
Harry Orf, PhD, Senior Vice President, Research
Gregg Pauly, Chief Operating Officer, Mass General Physicians Organization
Ann Prestipino, Senior Vice President, Surgical and Anesthesia Services; Clinical Business Development
Joan Sapir, Senior Vice President for Neurosciences and Pediatrics
Peggy Slasman, Chief Public Affairs Officer
Partners Chief Nurse Council

Jeanette Ives Erickson, RN, DNP, FAAN, Chairperson
Senior Vice President for Patient Care and Chief Nurse
Massachusetts General Hospital

Susan Beausoliel, RN, MS, DNPc
Vice President, Home Care Services
Partners Home Care

Elaine Bridge, RN, MBA, DNP
Senior Vice President for Patient Care Services and Chief Nursing Officer
Newton-Wellesley Hospital

Bonnie Kester, RN, MSN
Vice President for Patient Care Services and Chief Nurse
Nantucket Cottage Hospital

Linda Flaherty, RN/PC
Senior Vice President for Patient Care Services and Chief Nurse
McLean Hospital

Joanne Fucile, RN, MSN, CRRN
Chief Nursing Office/Vice President of Patient Care Services
Spaulding Rehabilitation Network

Nancy Gaden, MS, RN
System Vice President Patient Care Services and Chief Nursing Officer
Hallmark Health System

Judy Hayes, RN, MSN
Vice President of Nursing
Faulkner Hospital

Jacqueline Somerville, RN, PhD
Senior Vice President for Patient Care Services and Chief of Nursing
Brigham & Woman’s Hospital

Bea Thibedeau, RN, MS
Senior Vice President of Patient Care Services and Chief Nursing Officer
North Shore Medical Center

Patricia Reid Ponte, RN, DNSc, FAAN
Senior Vice President for Patient Care Services and Chief of Nursing
Dana Farber Cancer Institute
**Inpatient Care Units: Team Charter**

**Aim Statement:** Achieve 6.5% reduction in Acute Hospital Inpatient Care Unit expenses within 3 years (FY 11-12-13)

**Target:** $56M in direct expense savings
(Plan for $111M in savings, with 50% success factor)

**In Scope:** $857M in largely Inpatient Care Unit expenses across 5 Acute Hospitals, plus Case Management and Hospitalists
- $791M (92%) in Labor
- $66M (8%) in supply and other expenses

**Out of Scope:** Procedural Areas (inpt and outpt), Hospital-based and PO Ambulatory Services, Non-Acute Hospitals

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**Approach**

A) Series of three-hour mini-retreats with all Team members
- Review of baseline data, prior efforts, external benchmarks
- Clustering of opportunities into focus areas
- Brainstorming of ideas
- Effort-impact assessment and prioritization
- First-pass high-level financial valuation
- Formed two subgroups described below

B) Nurse Staffing Data Analytic Subgroup tasked with reviewing available staffing data options to develop staffing standards across the system

C) Chief Nurse Clinical Advisory Council Supply Opportunity Subgroup tasked with driving toward product standardization and appropriate utilization. This group previously existed but has been given a new mandate, target and expanded scope

D) Synthesis of recommendations into preliminary Ops heads report

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**Priority Focus Areas**

To identify $111M in expense savings, the Inpatient Care / Direct Patient Care team recommends focusing on primary levers and key enablers

<table>
<thead>
<tr>
<th>Inpatient Care Units</th>
<th>55% Savings</th>
<th>55% Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply and &quot;Other&quot; Expenses</td>
<td>$50M</td>
<td>$45M</td>
</tr>
<tr>
<td>Staffing Strategies and Standards (inc Productivity)</td>
<td>$25M</td>
<td>$30M</td>
</tr>
<tr>
<td>Throughput and LOS Enhancements (5% Reduction beds)</td>
<td>$30M</td>
<td>$25M</td>
</tr>
<tr>
<td>Structural / Programmatic Changes</td>
<td>$50M</td>
<td>$45M</td>
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**Key Enabler:**
- Patient Care Model Re-design
- Process improvement, IT, and Technology Infrastructure

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**Our Approach: Opportunities across the Patient Journey**

**Before Admission**
- Preadmission Care

**During Admission**
- Admission Process (ED, Direct Admits, Transfers)
- Inpatient Stay: Direct Patient Care, Tests, Treatments, Procedures, Clinical Support, Operational Support

**Post Discharge**
- Discharge Process
- Post Discharge Care

**Goal:** High-performing interdisciplinary teams that deliver safe, effective, timely, efficient and equitable care that is patient and family centered.
### Patient Care Model Re-design: Relationship-Based Care

<table>
<thead>
<tr>
<th>Implementation Considerations</th>
<th>Potential Savings Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing a Innovation units at each entity requires investment</td>
<td>See below (savings to be achieved in both throughput and staffing)</td>
</tr>
<tr>
<td>Place culture change</td>
<td></td>
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<tr>
<td>Cultivate siloless territory</td>
<td></td>
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<tr>
<td>Establish care coordination, continuity of assignments</td>
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<tr>
<td>New State of the Art Nursing (Patient Care Facilitator) bridging care across the continuum (assumes this can be drawn within the current staffing)</td>
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<tr>
<td>Focus on importance of Nurse (physician aligned) for patient outcome</td>
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<tr>
<td>Support Structure, decentralized role groups for both direct and indirect care</td>
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<tr>
<td>Incentive in Patient Gateway compliance</td>
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<td>$300K / $500K</td>
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### Staffing Strategies and Standards

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<tr>
<th>Recommendation</th>
<th>Implementation Considerations</th>
<th>Potential Savings Opportunity</th>
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<tbody>
<tr>
<td>Utilize evidence-based staffing standards</td>
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<tr>
<td>Recommend data (i.e. Action CR, Qualitied and Patient Care Limit)</td>
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<tr>
<td>Convene specialty teams set standards</td>
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<td>Select comparable benchmark organizations</td>
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<td>Adopt lean six to look at data using multiple perspectives</td>
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<td>Match staff to workload</td>
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<tr>
<td>Develop flow staffing process including use of resource teams</td>
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<tr>
<td>Manage utilization of agency and others</td>
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<td>Institute hospital-wide streamlining processes</td>
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### Patient Care Delivery Model: Relationship-Based Care

### Core Model Recommendations: The medical/paramedical nature of the way this care model is designed to improve outcomes and reduce costs, especially for vulnerable patient populations.

- Based on an attending Nurse / Patient Care Facilitator (PCF) who serves as “Clinical CEO” ensuring 24-7 accountability overseeing care of 12-16 specific patients (acute and 12-20 patients), focusing on resource utilization, discharge planning and home follow-up.
- Seeks primary contacts for physicians and all members of the team, coordinates meetings with clinicians for timely handoffs, ensuring primary access to patients and families, actively engaging them in the care process.
- Seeks to improve patient outcomes by promoting teamwork, shared knowledge and continuity.
- Seeks to complete an analysis of the current care model in order to promote teamwork, shared knowledge and continuity.

### Staffing Strategies and Standards

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### Match staff to workload

- Determine minimum core staffing levels
- Account for unit workload variation: average daily workload, base workload, average swing workload
- Build a flexible workforce
- Incentives for staff flexibility (monetary, non-monetary)
- Pay parity initiatives/staffing needs
- Manage agency and sitter utilization
- Improve workforce forecasting accuracy
- Identify seasonal, day-of-week, and time-of-day trends

### Patient Care Delivery Model: Relationship-Based Care

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**Page 282**
Throughput / LOS Enhancements: So, What is it Worth?

If Volume decreases or stays flat…

...we can increase functional capacity by x%-

If Volume increases…

• Reduce unit expense
• Increase productivity with no increase in resources
• Close patient units/service areas
• Reduce fixed costs (overhead)
• Reduce variable costs (staff)
• Realign assets

Supply and Other Expenses

Recommendations:

Product Selection and Standardization:
- Manage influx of new products and technology with system-wide group using evidence-based decision process
- Standardize existing products across departments within each entity, and system-wide
- Consider lease vs. buy for all equipment (Deals, VAC, pumps, etc.)

Inventory Management:
- Enhance inventory management capability
- Increase consignment of high-dollar products when applicable
- Recompute PAB levels
- Post financial impact of hoarding
- Post-dollar ($) sign on product shelves to raise awareness of costs

Agency Use Management / Renegotiation
- Renegotiate agency rates for Nursing, OT, PT, Respiratory Therapy, etc.

Structural / Programmatic Change: Program Consolidation / Elimination

Consolidate:
- Support consolidation discussions and review opportunities to centralize.
- Adopt best practice for operating one combined transfer center to manage all aspects of the transfer process among Partners hospitals.
- Establish one “Center of Excellence” site for each of the following services: Cardiac, Burn, Transplant, Trauma, Cystic Fibrosis.

Maximize PHS patient access to all PHS Behavioral Health facilities, without regard to payment source
- Develop robust care coordination presence well beyond current Mon – Fri day shift schedule
- Review case management recommendations on the Case Management function; move further along the spectrum to coordinate centrally and execute locally.
- Develop the following PHS Centralized functions:
  - Utilization Management
  - Patient Transition Liaison functions (Admit/Discharge Planning)

Optimize Utilization (Reduction):
- Minimize leakage from Partners Community Hospitals to Partners AMC – e.g. Routine OB, hernia, varicose veins, etc. Keep lower-acuity patients in the community for specific services.
- Develop an expedited process for patient transfers for high-risk/low-volume patients from the Partners Community Hospitals to the Partners AMCs. Reduce bureaucracy and delays e.g. cross-refer, trauma patients.

Next Steps:
- Continue to refine financial analysis and further understand staffing data points
- Define common data sets
- Cost out specifics of recommendations with input from the institutions
- Other ideas for vetting
  - Evaluate opportunities to prevent readmissions
  - Further develop utilization of the therapies
- Develop systems and processes to support discharge management: Understand IT needs
- Address issues around palliative care in conjunction with Partners-wide committees
- Investigate opportunities for funding the Fat Tips program
- Improve patient / doctor communication through the use of online patient portals to push out requests for relevant information to patients
- Examine the expansion of the Nurse Practitioner role in Massachusetts
Partners Chief Nurse Council
January 26, 2012
7:00 – 8:30 AM
MGH Trustees Room, Bulfinch 225A

MINUTES

Presiding: J. Ives Erickson
Present: E. Bridge, J. Fucile, G. Gottlieb, J. Hayes, J. Somerville, B. Thibedeau,
Call-in: C. Bardwell, S. Beausoliel, L. Flaherty
Staff Support: E. Flaherty

I. Clinical Advisory Council Update
   a. The team agreed that bi-weekly meetings will be needed (at least in the short
      term) in order to keep the momentum moving and to achieve savings targets
   b. Team will review charter as well as escalation protocol at February 14 meeting
   c. Team will review entity representation
   d. Next Steps for CAC / Huron Collaboration on Inpatient Supplies: Huron will
      quantify top spend categories by entity and by department. Partners Clinical
      Advisory Council will prioritize opportunity list and identify stakeholders / team
      members for all teams
         i. Huron will conduct interviews, policy / procedure review at each involved
            entity
         ii. Sub-teams will be established based on stakeholders / team members
             identified by Partners Clinical Advisory Council
         iii. Partners Clinical Advisory Council will give final approval on initiatives
             for implementation
   e. Decision Making regarding IV sets and solutions: Hospira is current vendor and
      Baxter is contender for business. The IV Subteam did not make a decision on an
      IV vendor and is “split” in vendor preference. According to the current finances
      (pending more info), Hospira is the preferred vendor. Hospira requires no
      additional training and is more “green” than Baxter.

II. Innovations Updates: CNOs presented an update
   a. Brigham and Women’s
      i. Achievements: All innovation projects built on concepts of patient/family
         centered care, continuity, inclusivity and interdisciplinary care. 5 of the 7
         innovation projects were launched between Oct-Nov 2011. Dashboard
         created for each unit & placed on BWH BSC. BWH Innovation Steering
         Committee/Innovation Team Leaders meeting quarterly to share progress,
         ideas and learning. Initial meeting held 1/17/12. Each Innovation project
championed by a Process Improvement Facilitator to support change management strategy, create & test process measures, and develop communication plans. Unit based care coordinators assigned to 3 innovation projects. Team Leaders working with Admitting Director around regionalizing patients as much as high census allows. Components of discharge bundle being tested on some innovation units.

ii. **Challenges:** Regionalization of patients when census is high. Physical layout of Tower units. Data collection for unit based process measures. Comparing metrics across Partners facilities as BWH innovation units are both physical and virtual units, and population subsets.

iii. **Next Steps:** Process measure development to test interventions as they are introduced. Launch 6th innovation unit in next 2 months. “Cross-pollination” between innovation units

### b. Faulkner

i. **Achievements:** Initiated FACT (Faulkner Attending Care Team) Team Model. Leveraged new Hospitalist Service as Innovation Unit. Patient Care Facilitator role defined (Attending RN). Care Team identified. Team meetings with executive sponsors (every other week with CMO & CNO). Defined daily schedule for care givers. Defined metrics to be evaluated. Qualitative results: Capstone project done on perceptions of bedside rounding.

ii. **Challenges:** Cost of PCF and clinician time, availability of clinicians for rounding, new hospitalists, and ability to make continued significant changes to all roles.


### c. Massachusetts General Hospital

i. **Achievements:** Utilizing the ”Patient Journey” framework to identify gaps in care. 12 innovations being rolled out across all 12 innovation units:

   1. Relationship based care
   2. Attending RN
   3. Handover/SBAR tool
   4. Pre-Admit Data Collection
   5. Patient and family welcome packet
   6. Domains of Practice
   7. Interdisciplinary Team Rounds
   8. Electronic White Board
   9. Voalte Communication
   10. Portable Devices
   11. Discharge Readiness Checklist
   12. Discharge Follow-up Phone calls

ii. **Challenges:** Unfunded, lag in data, and alignment with LOS and Care Redesign.
iii. **Next Steps**: Communication, education, and evaluation. Target implementation date: *March 19, 2012*

d. **North Shore Medical Center**

i. **Achievements**: Innovation unit established on D5 (cardiology unit, newly renovated, designed around patient and family needs, TCAB model). Unit used to test and refine new team based delivery model designed by “Inpatient Transformation Team” (ITTC)
   1. Frontline staff of providers
   2. Consultative support
   3. Extensive improvement training
   4. Team members include former patients and families
   5. Improvement Approach-Workflow analysis/process maps and observations. Focus on throughput, LOS, care coordination, communication
   6. Time Value Analysis
   7. Documentation systems
   8. Caregiver Activity Analysis
   9. Supply/demand assessment
   10. Data-LOS, HCAHPS, ED TAT, R/A rates, etc.

ii. **Challenges**: Accountability and sustainability, managing change and moving with deliberate speed

iii. **Next Steps**: Work through “constraint to care” list by chartering more workgroups. Implement pilots, measure results. Identify additional innovation units. Coordinate work of ITTC with other “Patient Progression” workgroups.

e. **Newton-Wellesley Hospital**

i. **Achievements**: Successful trial of RN/PCA Rounding has reduced RN interruptions during med pass. Successful trial of bedside rounding. Agreement to move toward geographic assignment of patients on floor.

ii. **Challenges**: Bargaining unit influence on 6 East has slowed progress on that floor. Challenges coordinating physician team and House/Non-House assignments.

iii. **Next Steps**: Hardwire RN/PCA rounding on one side of 4W (Innovation Unit). Roll-out bedside rounds on Innovation Unit. Geographic assignments to Innovation Unit. Roll out on 6 East.

f. **Spaulding Rehabilitation Network**

i. **Achievements**: Piloting a new care delivery model in preparation for the new hospital. Focusing on 30-day readmissions and clinical handoffs.

ii. **Next Steps**: Interdisciplinary team is developing an educational program on the early recognition of sepsis and a treatment algorithm.

The meeting adjourned at 8:30 AM.

**Next Meeting**: The next PCNC meeting will be on Thursday February 23rd from 7:00-8:30 AM in the MGH Trustees Room, Bulfinch 225A.
Partners Chief Nurse Council Retreat
Monday, June 25, 2012
8:00 am – 3:00 pm
Prudential Center, 11th Floor
Warren-Hamilton Room
800 Boylston Street
Boston, MA 02199

8:00am — 8:30am Resiliency Training                                          Mary Connaughton
"What if there was a strategic vision to build resiliency in every nurse?"

8:30am — 9:30am Enterprise Clinical Systems                                        Cindy Spurr
An overview of goals, process, and timeline for Epic implementation across Partners.
What is the CNO role in this process? Next steps?

9:30am — 10:00am Non-Labor Inpatient Update                                  Ann McDonald
Clinical Advisory Council (CAC) progress (Linen, Pulse Oximetry and Advanced Wound Care teams). Update on IV sets contract and pump trial.

10:00am — 10:30am Thoughts on Quantification of Savings       Mary Anne Thadeu
Inpatient savings targets

10:30am — 10:45am                                                                 Michael Jellinek
Overview of new role

10:45am — 11:00am Patient Affordability Updates: Inpatient          Eileen Flaherty
What has changed since the last Innovation unit update (grid)? Which metrics should be tracked on Innovation dashboards?

11:00am — 12:30pm Innovation Units – Sharing of Best Practices                 All
5 minutes per entity highlighting achievements and successes.

12:30pm—1:00pm Lunch

1:00pm—2:00pm Workload Implication Discussion                                All
Work absorption and practice changes to the role of the RN

2:00pm—3:00pm Next Steps

Jeanette Ives Erickson

Common Clinical Systems

What does it mean... and why is it important?

We are one of the most advanced and sophisticated healthcare organizations in the world, but our clinical information systems have become overly complicated as technology has evolved and individual units and sites have tailored programs to meet their local needs. While customized enhancements may provide efficiency on a local level, disparate systems discourage information-sharing on a larger scale. I think we’ve all felt the tug to move toward a more integrated system where patient data can be easily shared across clinical settings within MGH and throughout the Partners network.

In May of this year, Partners CEO, Gary Gottlieb, MD, formed the Common Clinical Systems Steering Committee with widespread representation from all Partners entities. Their singular objective is to guide the planning, selection, and implementation of a clinical information solution that will:

- ensure patients receive the best, safest, most efficient care possible
- enable clinicians to seamlessly coordinate and integrate patient care across settings
- allow clinicians to choose appropriate, cost-effective therapies
- encourage patients and families to engage in their own care

foster an environment where healthcare professionals can effectively teach students, residents, and fellows to be practicing clinicians

support the management of patient populations with unprecedented ease and effectiveness

The goal is to identify a solution (select a vendor or vendors of viable information systems) by early spring of 2012. Yes, it will be daunting to shift from existing diverse applications to a fully integrated, common clinical system(s), but continuing with our current model will soon be unsustainable. Not only must we be proactive in meeting this challenge, we must keep to an aggressive timeline in doing so. We don’t have the luxury of ‘closing down for repairs.’ We will essentially have to switch horses while the horses are still running.

It goes without saying that no matter what solution is selected, some concessions will have to be made. (You can’t please all the people all the time.) Ideally, the new system(s) will meet the needs of the majority of patients and clinicians. Toward that end, a compre-
hensive effort is under way to identify the functional-
ities most valued by clinicians in all disciplines. Key
stakeholders at Partners entities are being asked:
• What are your top three criteria for selecting a com-
mon clinical system?
• What are the ‘non-negotiables’ for your site or de-
partment?
• What are the key processes you want the new system
to help improve?

The answers to these questions will help compile a
master list of prerequisites for the new system.

Earlier this month, we were fortunate to have
Cindy Spurr, RN, co-chair of the Common Clinical
Systems Steering Committee, attend an expanded
meeting of PCS leadership. She talked about the myr-
iad considerations involved in selecting a clinical sys-
tems solution and asked attendees to share their essen-
tial requirements. As you can imagine, the discussion
was lively. Conversation centered around:
• discharge planning
• medication reconciliation
• documentation
• inter-disciplinary care
• reimbursement
• patient participation and involvement in their care
• concern that a shift to an entirely electronic medical
record could result in caregivers not ‘seeing’ the
whole picture

I want to make it clear that our search for a com-
mon-clinical-system solution is not an IT initiative—
it’s an initiative to improve patient care. We want to
integrate clinical systems to link care across the con-
tinuum, enhance patient safety, and become more effi-
cient and effective as an organization.

You may wonder why we’re implementing acute
care documentation (ACD) when common clinical
systems are on the horizon. ACD is a bridge strategy to
the next generation of clinical systems. The ACD proj-
ect is laying a foundation of standardization that will
serve us well when we adopt a common clinical system.

We’re on a journey to find the best technological in-
frastructor to support clinicians as they provide
world-class care. Clinicians at the bedside have the
greatest insight into how to shape that infrastructure. So
how would you answer those three questions: What are your
top three priorities? What are your non-negotiables?
What processes do you want to improve?

Talk to your clinical specialists, managers, and di-
rectors to channel suggestions to the Common Clinical
Systems Steering Committee. Our goal is to have a
complete list of high-priority requirements by early
December and select a solution by March of next year.
If there ever was an opportunity to have a hand in
shaping our future, this is it. I look forward to hearing
your ideas.

Updates
I’m pleased to announce that Lee Ann Tata, RN, has
accepted the position of nursing director for the Ellison
16 General Medical Unit. Sandy Muse, RN, is the new
nursing director for the Blake 7 Medical ICU. And
Michelle Anastasi, RN, has accepted the position of
nursing director for the Ellison 19 Thoracic Surgery
Unit. Welcome, all.
Welcome  
CICU Spring Retreat  
March 31, 2011

Agenda
- Change  
  - Review of many up and coming changes  
  - Staying nimble & flexible during times of change  
- Conflict & Civility  
  - Questionnaire  
  - Adele Keeley – conflict expert

Global and National Changes
- Global stressors  
  - Natural disasters  
  - Uprisings  
- National - Healthcare reform  
  - Accountable Care Organizations  
- State pressures  
- Economy  
- Jobs

MGH Changes
- 200 years  
- Financial pressures  
- Healthcare reform  
- Lunder building  
- ICU of the Future  
- ACD

CICU Changes
- Staff – coming & going  
- ND – in school  
- CNS role  
- Clinical resource/resource  
- Scheduling needs  
- Peer Review  
- RN Residents/Partners  
- Bio-Patch

Quality & Safety Changes
- Increased pressure to show positive outcomes  
  - Publically reportable  
  - Financial Incentive  
  - Right thing to do  
- Pay for performance  
  - Patient/Family satisfaction  
  - Nurse Responsiveness & Communication  
  - Nurse sensitive indicators
CICU – Quality Care
- Do you “know” what to do? AND
  - Do you “do” what you know?
- Evidence Based Practice
- Are we a High Performance Unit?
- Ideas for Improvement

Conflict and Civility
- Background
- Questionnaire
- Adele Keeley RN, MA
  - Nursing Director, Women’s Health

Civility
“An authentic respect for others that requires time, presence, willingness to engage in genuine discourse, and intention to seek common ground” that governs both speech and behavior toward others.

Downward Spiral of Incivility in Nursing – Clark & Ahten (2011)
- Civil – polite, good manners, graciousness, respect, & courtesy
- Incivility – rude, disruptive, intimidating & undesirable OR bullying, aggressive, violent
- Conversations about incivility
- To respond or not to respond?

CICU of the Future
ADVANCING ORGANIZATIONAL INTERDISCIPLINARY INITIATIVES

The Institute for Patient Care consists of a collaborative of centers, programs and initiatives designed to lead and support excellence in interdisciplinary clinical work in Patient Care Services and throughout the MGH.

The mission of The Institute is to support and create new directions for professional development, to ensure that patients and families are educated consumers of care, and to generate, disseminate and integrate research in delivering evidence-based practice with the ultimate goal of providing safe, timely, efficient, cost-effective, high quality care.

Initiatives include:
- Awards and Recognition Program – Julie Goldman, RN
- Clinical Affiliations – Rosalie Tyrrell, RN
- Clinical Recognition Program – Mary Ellin Smith, RN
- Collaborative Governance – Gaurdia Banister, RN/ Mary Ellin Smith, RN
- Consultation
- Credentialing – Julie Goldman, RN
- Ethical and Clinical Decision-making – Ellen Robinson, RN
- Culturally Competent Care
- Global Nursing Education – Donna Perry, RN
- Leadership Development – Mary Ellin Smith, RN
- Organizational Evaluation – Dorothy Jones, RN
- Organizational Patient Care Initiatives, i.e. falls, geriatrics, pressure ulcers, pain relief – Deborah D’Avolio, RN; Virginia Capasso, RN; Paul Arnstein, RN
- Simulation Education – Brian French
- Workforce Development – Julie Goldman

THE NORMAN KNIGHT NURSING CENTER FOR CLINICAL & PROFESSIONAL DEVELOPMENT
Director – Gino Chisari, RN
Focus is on the dissemination and utilization of knowledge for the attainment of safe, effective and competent patient- and family-centered nursing practice.

THE YVONNE L. MUNN CENTER FOR NURSING RESEARCH
Director – Dorothy A. Jones, RN
Focus is on the development and utilization of knowledge to improve patient care and optimize professional nursing practice.

THE MAXWELL & ELEANOR BLUM PATIENT AND FAMILY LEARNING CENTER
Director – Brian French, RN
Focus is on providing the highest quality patient education and consumer health information services to MGH patients, families and staff.

THE CENTER FOR INNOVATIONS IN CARE DELIVERY
Director – Jeffrey Adams, RN
Focus is on bringing teams together to identify opportunities, estimate the impact of change, and to construct innovations.

The Institute for Patient Care is located on Founders House, 3rd Floor.
If you have questions about The Institute, please contact us at 617-726-3111 or visit our website at: www.mghpcs.org/ipc
Massachusetts General Hospital
Patient Care Services
Nursing Executive Operations

Jeanette Ives Erickson, RN, DNP, FAAN, Chairperson
Senior Vice President for Patient Care and Chief Nurse

Gaurdia Banister, RN, PhD
Executive Director, Institute for Patient Care

Debra Burke, RN, MSN, MBA
Associate Chief Nurse

Marianne Ditomassi, RN, DNP, MBA
Executive Director, Patient Care Services Operations

Theresa Gallivan, RN, MS
Associate Chief Nurse

Sally Millar, RN, MBA
Director, Patient Care Services Informatics
Interim Director, Patient Care Services Financial Management Systems

George Reardon
Director, Clinical Support Services

Steve Taranto
Director, Patient Care Services Human Resources

Dawn Tenney, RN, MSN
Associate Chief Nurse

Kevin Whitney, RN, BSN, MA, NEA-BC
Associate Chief Nurse
Interim Director, Patient Care Services Office of Quality & Safety
<table>
<thead>
<tr>
<th>Topic/Presenter</th>
<th>Discussion and Follow up Action</th>
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| Acute Care Documentation  
  ~Sally Millar, RN, PCS Informatics | Sally gave a brief history of Acute Care Documentation (ACD) at MGH; the project began seven years ago with healthcare regulations changes and meaningful use initiatives. However these have all changed in recent years, driving the decision to move towards an Enterprise Clinical System for the Partners Organization and the difficult decision to discontinue the ACD project. Much has been learned and will be carried over in moving towards an Enterprise Clinical System. Sally commended the dedication and commitment so many staff had put into developing the ACD project. Partners is currently in the selection process for a new Enterprise Clinical System to be used by all of its affiliates. This will be a tremendous change and will be an opportunity for standardized documentation system wide. |
| Safety Reports Update: Skin/Pressure Ulcer  
  ~Ruth Bryan, RN, Center for Quality & Safety | Please see attached presentation:  
  5-1-12_Skin_Pressure_Ulcer_Safety...  
  Ruth reviewed the process for reporting pressure ulcers, soon all Nursing Directors and Clinical Nurse Specialists will have access to all SKIN safety reports. To review any previous reports that may have been reported on a patient. It is important to be sure that any pressure ulcers are staged correctly and documented. If the patient arrives to the hospital be sure and document where the patient came from (home, nursing facility etc) Home is not reported to the DPH, stage 2 and above, unstageable and deep tissue injury must be reported within 7 days. Ruth reviewed the safety report and all steps related to filing a report. Photos maybe uploaded. Due to the 7 day reporting encourage staff to enter the report asap. Ruth is available to review system specifics with CNS group or Nursing Leadership. Theresa Gallivan acknowledged the work being done by Mandi Coakley and Ginger Capasso looking into past safety reports related to skin issues and areas for improvement. |
| Hazardous Medications (HazMed)  
  Beyond Chemo  
  ~ Dena Alioto, Pharmacy Compliance  
  ~ Claire Seguin, RN, Corporate Compliance | Please see attached presentation:  
  5-1-12_HazMed_Beyond_Chemo_Bar...  
  Deena and Claire reviewed the Do’s and Don'ts regarding medications. Do always return Unused Patient Specific Medications to the pharmacy for proper disposal. Don’ts never crush, open or dissolve tablets or capsules without consulting the pharmacy. Never dispose of medications down sinks, drains or toilets. New badge reminders will be distributed to all units with examples of the approved MGH disposal requirements for medications and what PPE is required when handling medications. |
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<th>Intravenous to Oral Conversion Program</th>
<th>Please see attached presentation:</th>
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<td>~Paul Arpino, RPh, Pharmacy</td>
<td><img src="5-1-12_IV_to_PO_Arpino.pptx" alt="Link" /> <img src="5-1-12_IV_To_PO_Meds_Arpino.docx" alt="Link" /></td>
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Paul discussed the change in IV to oral medications program. Policy states Pharmacists may substitute specific oral medications for equivalent IV medications and doses for adult patients. This policy has been reviewed by Infectious Disease, ICU and Surgery. Pharmacy will consult with nursing regarding patient status (has the patient received 24 hours IV, advanced diet taking po fluids). Paul also provided the policy to the group.

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<th>ID Algorithm for Unidentified Patients</th>
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<tr>
<td>~Alice Gervasini, RN, PhD, Trauma Program</td>
<td><img src="5-1-12_Patient_Information_Upd" alt="Link" /></td>
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New form will be used only when a patient can not be identified. The report is generated from the ED. This will be used on a very small number of patients. There is a report generated for the front desk and operator of patients who are not identified. Specifics required for blood transfusions are listed on the form.

The next Combined Leadership Meeting will be held on May 15, 2012 at 10 am in the O'Keeffe Auditorium
Maintaining a clean environment: a crucial part of patient care

Maintaining a clean environment is a crucial part of safe patient care. We’re fortunate to have a team of skilled unit service associates who understand the importance of maintaining a clean environment for patients and caregivers. Over the past year, Clinical Support Services embarked on an ambitious campaign to improve the products, processes, and techniques involved in keeping patient care units clean. New products, training, and practices were introduced to enhance the cleaning process and increase satisfaction with the hospital environment. Success will require the support and participation of every MGH employee.

Question: What is the new practice for cleaning patients’ rooms?
Jeanette: During daily and discharge cleaning, surfaces are disinfected using a micro-fiber cloth dipped in a cleaning/disinfecting solution. Cloths are not re-dipped; they're put in the hamper when no longer sufficiently wet or when they're visibly soiled. The solution is applied wet and must be allowed to air dry for ten minutes.

Question: Why do surfaces have to remain wet?
Jeanette: We use the most advanced techniques and hospital-grade cleaning products to ensure optimal resistance to germs. In order to be effective, the cleaning solution must go on wet and air dry. We’ve launched an awareness campaign to highlight this aspect of the new process—we’re calling it, ‘Wet is the new clean!’ One nice side-effect of the cleaning solution is that there's no harsh chemical smell like there is with many other cleaning products.

Question: Are we doing anything to increase patient awareness about our new cleaning practices?
Jeanette: Earlier this year we piloted a “Patient Perception of Cleaning” initiative, whereby unit service associates introduce themselves to patients, explain their role, and let patients know how to reach them if/when their room needs attention. Unit service associates now leave a signed card in each room verifying that rooms and bathrooms have been cleaned. The initiative was rolled out in inpatient areas July 7, 2010.

Question: How often are patients’ rooms cleaned?
Jeanette: Patients’ rooms are cleaned every day, and unit service associates are always available for additional cleaning. Rooms and bathrooms are checked on all unit service associates’ shifts and cleaned as needed.

Question: How long does it take to clean and disinfect a room?
Jeanette: To effectively clean and disinfect a room for discharge takes one person 45 minutes to an hour (less if the room is cleaned by a team).

Question: Why are operations managers interviewing patients?
Jeanette: We want to know what patients think about their environment and address any concerns they may have. We’re learning a lot through these interviews and at the same time reinforcing the message that we’re committed to a clean, safe hospital.

Question: What can we do to help?
Jeanette: Research suggests that satisfaction with cleanliness is influenced by the overall neatness of a patient’s room. To help, staff can:
- throw away wrappers from dressings or medications
- discard gloves in trash receptacles
- ask patients if you can throw away old newspapers or anything else that might be contributing to clutter
- keep windowsills and counters free of linen and supplies
- let a unit service associate know if a room needs attention so he/she can address it in a timely manner
- let it be known that we care about the cleanliness of every room

For more information, contact Stephanie Cooper, senior operations manager at 617-724-7841.
From: Fallon, Debra M. on behalf of Ives Erickson, Jeanette, R.N., D.N.P.
Sent: Friday, November 04, 2011 11:35 AM
Subject: PLEASE SHARE/POST -- PCS NEWS you can use: Nov. 4, 2011
Importance: High

PCS NEWS you can use

...News and updates from Jeanette Ives Erickson, RN, DNP, FAAN
senior vice president for Patient Care and chief nurse

November 4, 2011

- Security issue for iPad 2
- Annual Nursing Survey to update database regarding Education, Certification, Professional Development and Professional Organizations
- Honor and engage on Veterans Day, featuring two MGH nurses—Nov. 11
- Global Health Seminar—Nov. 15
- Open Enrollment Underway—thru Nov. 22
- Traditional Chinese Medicine and Inflammation-Related Disease Seminar—Dec. 1

Security issue for iPad 2
A software bug affecting the iPad 2 was recently identified. The bug allows unauthorized individuals to easily bypass the passcode lock on an iPad 2, even after the device has been locked due to inactivity. The bug allows an unauthorized user to access all applications and data on a locked iPad 2, including all email stored on the device.

What You Should Do:
Make a simple configuration change to prevent this bug from being exploited:

1. Open the Settings app.
2. Select "General."
3. Turn off the iPad Cover Lock/Unlock setting.

Apple's next update to iOS 5 is expected to correct this bug.

Finally, more instructions for securing your iPad, can be found at:
http://rc.partners.org/kb/show_article.php?id=240

Annual Nursing Survey to update database regarding Education, Certification, Professional Development and Professional Organizations
As a Magnet hospital, we are recognized as an organization that provides quality patient care, nursing excellence and innovations in professional nursing practice. To maintain our Magnet accreditation we must submit data each year on the education level and specialty certifications held by our nursing
workforce. Nursing leadership and staff have been sent an email requesting they provide their most current information for calendar year 2011 via our survey tool. It will take 3-8 minutes to complete the survey. Please note that it is helpful to have information about 2-3 continuing education programs available when you take the survey to complete that portion. The survey will run through Dec. 15, 2011.

Feel free to contact Paula Vangel (x4-3563, pvangel@partners.org) or Nancy McCarthy (x4-0944, njmccarthy@partners.org) if you have any questions or issues about the survey tool.

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**Honor and engage on Veterans Day, featuring two MGH nurses—Nov. 11**

As our nation’s conflicts in Iraq and Afghanistan are coming to a close, some 2.2 million Americans have served and more than 1.4 million have already returned or are scheduled to return home. This year on Veterans Day, Nov. 11, we encourage you to attend one of the following presentations to learn more about how you can support veterans and families:

**Beyond Yellow Ribbons: Creating a Community of Support for Returning Veterans and Families**

**9:15 -10:15a, Bulfinch Tent**
A panel discussion of MGH veterans and family members, will include two MGH nurses. Lori Pugsley, RN, nursing director, OB/Newborn Family Service, welcomed her son, Sgt. Robert Pugsley, home last August following his deployment to Afghanistan with the Massachusetts Army National Guard; he also served in Iraq. Sgt. Pugsley’s sister Molly will participate and discuss her role as a military sibling. Also participating will be Andrew Gottlieb, NP, director, MGH Occupational Health, who is a Major in the US Army Reserves, of which he has been a member for nearly 20 years. He was mobilized to serve at Walter Reed Medical Center in 2007. The panel will be moderated by John Fromson, MD, of MGH Psychiatry and the Home Base Program.

**Recognizing “the Invisible Wounds of War” among Military Veterans and Families in Clinical Practices**

**11:30a-12:30p, Thier Conference Room. CME/CEU credits. Lunch provided.**
This timely presentation will feature Elspeth “Cam” Ritchie, MD, US Army Colonel (ret), professor of Psychiatry for Uniformed Services University of the Health Sciences, chief clinical officer, Department of Mental Health, District of Columbia, and author of *Combat and Operational Behavioral Health*. She will be joined by Ross Zafonte, DO, Traumatic Brain Injury Program Leader, Home Base, Earle P. and Ida S. Charlton chair, Department of Physical Medicine and Rehabilitation at HMS, vice president of Medical Affairs at Spaulding Rehabilitation Hospital, and chief of Physical Medicine and Rehabilitation at MGH; and Naomi Simon, MD, Chief Medical Officer, Red Sox Foundation and Massachusetts General Hospital Home Base Program, and director of the MGH Center for Anxiety and Traumatic Stress Disorders and Complicated Grief Program.

MHG Patient Care Services is pleased to collaborate with the Red Sox Foundation and Massachusetts General Hospital Home Base Program to honor MGH veterans and families, and provide education about what our community can do to support veterans and their families who sacrifice in service to our country. To view the full schedule of MGH Veterans Day events, please visit:


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**Global Health Seminar—Nov. 15**

The Center for Global Health will host “Improving Global Health Delivery in Rwanda: Clinical Mentorship Models” Nov. 15, from 4:30 to 6p, in the O’Keeffe Auditorium, Blake 1, as part of its ongoing Seminar Series. The featured speaker will be Manzi Anatole, RN, director, Mentoring and Enhanced Supervision at Health Centers (MESH) Program, Partners In Health—Rwanda. To learn more about global health at MGH, please visit [www.massgeneral.org/globalhealth](http://www.massgeneral.org/globalhealth).

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**Open Enrollment Underway—thru Nov. 22**

Employee Benefits Open Enrollment will take place through Nov. 22. Open enrollment is the only time of year when you can make changes to your benefits, unless you have a qualified change of status event. Changes you
make during open enrollment will take effect in January 2012.

Pay close attention to the Open Enrollment materials you will receive at your home mail. The materials will review the changes to our health insurance plans for 2012, provide you with a Personal Benefits Summary that lists your costs for coverage, and include a chart that will allow you to compare our health plan offerings. Open enrollment materials are also posted on the MGH Benefits Intranet Site.

Among the changes you’ll see in 2012:
- Partners Plus, Partners Value, Tufts and Harvard Pilgrim will be based on a tier system.
- You may choose to see a primary care physician in any of the tiers at any time; specialty care costs will be lower when you see a Partners Preferred provider.
- You will not need to obtain a referral for specialty care
- Emergency Room co-pays will increase to $100.
- Master Health Plus and Master Medical will not be offered.

Reminder regarding Flexible Spending Accounts (FSAs)
If you wish to enroll in a FSA for 2012, you must enroll on eBenefits during Open Enrollment—even if you had an account in 2011.

Need more information about the health plan changes?
USA/OA benefits meetings will be held in the O’Keeffe Auditorium, Blake 1:
- Weds, Nov. 9, 7-8a
- Mon., Nov. 14, 2:30-3:30p

Human Resources and the Benefits Office will hold a series of general meetings:
- Tues., Nov. 1, 3-4p, Haber Conference Room (Blake 1)
- Weds., Nov. 2, noon-1p, Yawkey 2-230
- Thurs., Nov. 3, 7-8a, Haber
- Fri., Nov. 4, 1-2p, Haber
- Sat., Nov. 5, 10-11a, Haber
- Sun., Nov. 6, 1-2p, Haber
- Mon., Nov. 7, 5-6p, Haber
- Tues., Nov. 8, 2-3p, Haber
- Weds., Nov. 9, 11a-noon, Yawkey 2-210
- Thurs., Nov. 10, 1-2p, Yawkey 2-210
- Fri., Nov. 11, 9-10a, Yawkey 2-220
- Sat., Nov. 12, 11a-noon, Haber
- Sun., Nov. 13, noon-1p, Haber
- Mon., Nov. 14, 8-9a, Haber
- Tues., Nov. 15, 9-10a, Haber
- Weds., Nov. 16, 7-8a, Haber
- Thurs., Nov. 17, 4-5p, Yawkey 2-210
- Sat., Nov. 19, 9-10a, Haber
- Sun., Nov. 20, 10-11a, Haber
- Mon., Nov. 21, noon-1p, Yawkey 2-230

Benefairs and Quickstops
The Benefits Office also will offer Benefairs, where you can meet with representatives from many of the companies who work with us to provide benefits. You also can drop by QuickStops, where Benefits and HR staff will be available to answer your questions. See the schedule in your Open Enrollment package or on the MGH Benefits Home Page.

Enroll online
You can enroll instantly in your 2012 benefits by accessing eBenefits anytime through the Internet at https://ibridge.partners.org.

Public terminals with Internet access to eBenefits are available at the following locations:
- Employee Access Center (Bulfinch 107)
Traditional Chinese Medicine and Inflammation-Related Disease Seminar—Dec. 1

The MGH Chinese Scientist and Staff Association (MGH CSSA) will host an HMS-CME-credited education seminar on Traditional Chinese Medicine and Inflammation-Related Disease as part of its ongoing series of Traditional Chinese Medicine in the treatment of diseases and health conditions. The seminar will be held Dec. 1, from 6:45 to 9:30p, in the Simches Building, 185 Charles River Plaza, Conference Room 3110. This seminar will feature two sessions followed by an interactive question/answer period:

**Session I:** 7–7:45p
“Integration of Mainstream Medicine and Chinese Medicine: Study of a Traditional Chinese Medicine Formula, PHY906, as Adjuvant Therapy for Cancer Patients undergoing Chemotherapy”

Yung-Chi Cheng, PhD
Henry Bronson Professor of Pharmacology, School of Medicine, Yale University

*Expertise: Development of TCM therapy for cancer treatment*

**Session II:** 8–8:45p
“The Challenges and Opportunities of TCM in the 21st Century: Study of HLXLD for Osteoarthritis”

David Yue-Wei Lee, PhD
Director, Bio-Organic and Natural Products Research Laboratory, McLean Hospital, Harvard Medical School

*Expertise: Mechanism of action study of Chinese medicine, TCM pharmacokinetics, drug metabolism and pharmacotherapies*

**Q&A session and closing remarks:** 8:45–9p
Facilitated by Darshan Mehta, MD, MPH
Medical Director, Benson-Henry Institute for Mind-Body Medicine, MGH

All are welcome to attend. Registration is required for CME credit. Seats are limited. Please RSVP to cssa@partners.org before November 25, 2011. Admission is free when registering before Nov. 25; $10 after Nov. 25. A light dinner will be available. For more information, call x4-1757.

“It is our choices...that show what we truly are, far more than our abilities.”

— J. K. Rowling, *Harry Potter and The Chamber of Secrets*

To submit items to *PCS NEWS you can use*, please contact Georgia Peirce at gwpeirce@partners.org or x4-9865.
March 19, 2012

Dear Innovation Unit Colleagues:

This is a significant day as we officially launch 12 Innovation Units designed to test evidence-based interventions focused on improving the quality and efficiency of patient care. I want to thank you for your ongoing commitment to providing every patient and family with the safest and highest-quality care possible, and for your participation in retreats and other forums over the past few months to develop the innovation unit plan designed to shape the future of care delivery.

In the coming weeks and months, we will learn a lot about healthcare innovation as we assess the impact of interventions such as relationship-based care, our new Attending Nurse role, the Patient and Family Notebooks and discharge envelopes, and various enabling technology on patient and system outcomes. In the process, our best teachers will be our patients and families as they share with us about how best to align our care practices to meet their needs and expectations.

To help support you in this work, we have created an Innovation Unit portal http://www.mghpcs.org/innovation_units that will evolve as our work advances. The portal is full of resources and tools to help guide your work. I encourage you to familiarize yourself with this dynamic site and to let us know how we can best tailor the content for your use.

Lastly, Friday, March 16, 2012, I had the privilege of presenting an overview of the Innovation Unit plan to the MGH Board of Trustees. They were very impressed with our implementation plan. Like all of us, they are eager to see where this important work leads. Here is a link to that presentation: http://intranet.massgeneral.org/pcs/innovation_units/documents/MGH_Board_on_Innovation_Units.pdf

Thank-you for your dedication, both to this bold new initiative, and to your patients and their families.

With admiration,

Jeanette Erickson
Staff Nurse Advisory  
October 5, 2010  
11:30 a.m. -12:30 p.m., Trustees Room  

MINUTES  

Presiding:  J. Ives Erickson, RN  


Guests:  Vivian Donahue, RN, Nurse Director, Blake 8, Lin-Ti Chang, RN, Staff Specialist  

1. Physiologic Monitoring Tiger Team Recommendations- T. Gallivan, RN, V. Donahue, RN, & L. Chang, RN  

• T. Gallivan, V. Donahue, and L. Chang shared the following recommendations from the interdisciplinary work of the Physiologic Monitoring Tiger Team  

Questions/Comments  
• SNA member commented on the loud volume of "nuisance" alarms (i.e. out of paper) and how they negatively impact the environment of care. V. Donahue reviewed the ability to customize the alarms when appropriate  
• T. Gallivan reminded the group of the complexities of the monitors and the need to change the culture of how we react to alarms. It is not ok for monitors to be alarming and we must all own the problem for a positive impact to be felt.  
• SNA member asked if it would be possible to use Medicus to document when patients are monitored as a way to collect data on the numbers of patients being monitored. T. Gallivan thinks that this will be possible with the new methodologies of Quadramed.  
• SNA member commented on the frustration with the inability to turn off the alarms during the end of life and feels that it is upsetting for families to hear the alarms. V. Donahue reviewed the process for turning off the screen in the room, adjusting the parameters, and adjusting the settings for only critical alarms to be heard.  
• J. Ives Erickson reinforced the next steps with the group: upcoming pilots, training, and learning from simulation.  

2. Follow-up Discussion: Cost Saving Ideas  

• J. Ives Erickson spoke of the national issues around health care costs and the importance of being proactive in identifying ways to provide care at a reduced cost.  
• J. Ives Erickson asked the group for their ideas on: reducing waste, eliminating redundancies, identifying things that don’t add value and technologies that can help us to be more efficient.
Questions/Comments

- A SNA member verbalized the concern that staff members are always using the IPOPs as a default before calling for a live interpreter. J. Ives Erickson noted that it is less expensive to utilize video or live interpreters instead of using the telephone but recognized that the selection of device may be influenced by many variables. She thought it would be beneficial to invite a representative from this discipline to the next meeting.

- A SNA member suggested reducing the printing of the MGH Hotline and/or having an electronic version available for staff. J. Ives Erickson stated that she is supportive of "Going Green" and is looking at this topic for the PCS publications (e.g. Caring Headlines & Annual Report) as well. She did note that Caring Headlines also goes to our patients and donors so it may not be feasible for it to only be available electronically.

- A SNA member noted the large quantity of time needed to document the many devices/supplies used within the OR and asked if scanning technology was being explored as a way to reduce documentation time.

- A SNA member cited another hospital in CA who was using EMTs to watch monitors and asked if this was an option that could be explored instead of using RNs. J. Ives Erickson shared some of the background information she collected on this topic after the January event. Human monitor watch has not shown to add value to care and does not reduce the number of nuisance alarms. "Knowing the patient" is an integral part of monitoring patients and she would like to continue to focus on only monitoring patients who require it and maximizing the use of technology to support patient care.

- A SNA member asked about the timeline for accessing Video Interpreters. M. Ditomassi shared that this should be rolled-out to all areas by the end of the current fiscal year.

- A SNA member suggested increasing the amount of recycling on the units and thus reducing the trash. J. Ives Erickson reinforced that she is supportive of "Go Green" initiatives and D. Tenney suggested inviting the ESD team to share an update on what the hospital is already doing.

- A SNA member asked what was being done to teach the new MDs who often order redundant tests. J. Ives Erickson shared the Partners-wide work for standardizing care. Currently these groups are focusing on the following diseases: Stroke, Diabetes, Acute MI, CABG, and Colon Cancer. Another SNA member reinforced the need to advocate for the patients and to challenge the physicians when tests are being repeated unnecessarily.

- A SNA member asked about the use of compression stockings versus TEDS in patients with diagnosed DVTs. J. Ives Erickson informed the group of a current study at MGH looking at the need for compression boots.

- A SNA member asked if the initial RN assessment could be converted to an electronic data set. J. Ives Erickson stated that this was being worked on but was not sure of the timeframe for implementation.

- A SNA member stated that large quantities of supplies are being discarded following a discharge from precaution rooms. J. Ives Erickson shared with the group that we are starting to decentralize supplies in some areas to reduce this waste. She also noted that large quantity of linen that are being re-washed without being used and how this practice is costly to the institution. She informed the group that we will be looking at ways to reduce linen costs over the upcoming year. Do all linen items need to be changed daily?

- A SNA member voiced feeling like she is often "chasing after" medications (some items are in the Omnicell, some come from pharmacy, etc.) J. Ives Erickson agrees that this is an inefficient process that deserves a closer look.
Attachment TL 4.w continued

Action items

- Invite a representative from the Medical Interpreter Service to the next Staff Nurse Advisory Meeting.
- Invite a representative from Environmental Services to an upcoming meeting to update the group on the current hospital recycling initiatives.
- SNA members encouraged to continue to brainstorm and share any and all ideas.

Meeting adjourned at 12:30 pm

Next meeting will be held on Tuesday, November 2, 2010.
Jeanette Ives Erickson

Using our collective wisdom to meet the economic challenges of 2011

As we begin our new fiscal year, I want to keep you all informed of the work we’re doing and enlist your help in innovating care-delivery for the future. Going into 2011, the nation, and specifically the healthcare industry, are facing substantial economic challenges. I think it’s important for everyone to know that MGH and all institutions in the Partners HealthCare System are working diligently to continuously improve quality and efficiency and ensure financial success in the future.

You may recall in my December 2, 2010, column, I shared Partners’ strategic goals for the coming year. They are:
- Care re-design: multi-disciplinary teams focusing on specific conditions and episodes, such as colon cancer, coronary disease (AMI and CABG), stroke, diabetes, and primary care, paving the way for payment systems that support improved care delivery
- Patient affordability: improving process flow, reducing costs, and exploring all viable cost-management ideas
- Reputation: emphasizing Partners’ commitment to community programs through quality-focused messaging and public education

I’d like to delve a little more deeply into the ‘patient affordability’ aspect of this plan, which was also the topic of a special leadership meeting called by MGH president Peter Slavin, MD, recently. At that meeting, Dr. Slavin spoke about the importance of re-investing in our future to ensure we continue to provide leading-edge care and maintain a strong position in the marketplace. In order to do that, we need to generate a strong profit margin. That’s what allows us to make those important investments in technology and resources for the future.

Three main factors affect our ability to generate a strong margin: patient volume; payor reimbursement rates; and expenses.

Patient volume is notoriously unpredictable, so we can’t rely on it to be part of the solution. Recent healthcare legislation and the prevailing national economy are having a negative effect on payor reimbursement rates, so we can’t assume that that will be part of the solution, either. So our primary focus in terms of ensuring a strong financial future must center around cutting costs and controlling expenses.

continued on next page
As always, we want to take a thoughtful approach—we’re not considering across-the-board cuts. The welfare of our patients and families is foremost in our thinking as we look for ways to eliminate waste and make systems more efficient.

MGH has begun a budget review process similar to ‘zero-based budgeting,’ whereby all departments are being asked to look at their budgets as if they’re starting from scratch, identifying only the expenses necessary to provide optimum care and operate at peak efficiency. The hope is that this process will help identify redundancies, non-value-added services, or obsolete programs that could easily be eliminated from our expense sheet. And because all departments are participating, we should also be able to identify opportunities to consolidate services across departments when and if appropriate.

This work coincides with an effort to review and improve systems throughout the entire Partners network. Partners president, Gary Gottlieb, MD, has asked senior vice president for Clinical Excellence at BWH, Michael Gustafson, MD, and me to oversee a similar effort, focused on direct patient care for all Partners institutions. We’re currently looking at Emergency Services, Perioperative Services, and inpatient care. Our goal is to systematically:

- review the costs in each of these areas, identify opportunities for reduction, and estimate projected savings
- set standards, identify best practices, and look for opportunities to improve processes
- determine which projects should remain institution-specific and which would be better served by implementation across Partners institutions

Unlike typical budget cycles, which do take place largely behind the scenes, I expect this process to be more interactive as department leaders consult with staff to make these important assessments. And who better to have a voice in the process than those who work at the bedside and on the front lines of care-delivery every day. Many of you have already offered excellent suggestions, and I urge you to keep those ideas coming.

As Dr. Slavin reminded us, we are all stewards of a great institution—an institution that has seen its share of adversity. MGH has prospered through World Wars, epidemics, and disasters, and we will continue to prosper through these trying economic times. As leaders of a world-class hospital, it’s our responsibility to be proactive in meeting the challenges before us. And that’s exactly what we’re doing as we embark on this ambitious plan for the future.

Thank-you for the excellent care and support you provide every day. Thank-you for being an active member of the MGH community. And thank-you for your resilience and creativity as we craft these solutions together.
Jeanette Ives Erickson

Care re-design driven by quality and safety

thanks to wisdom, commitment, and insight of MGH clinicians

On Friday, April 8, 2011, we were privileged to have Maryann Fralic, RN, professor at Johns Hopkins University School of Nursing, speak as part of our Bicentennial Nursing Grand Rounds series. I was struck by how much of what she said relates to the work we’re doing around care redesign and patient-affordability. I thought three of Fralic’s observations were especially relevant:

1) It doesn’t make any difference how high-quality patient care is if no one can afford to pay for it. When it comes to cost and quality, neither is more or less important.

2) Flexibility and resilience will ultimately determine who succeeds in health care.

And my favorite:

3) The future is not optional. Everyone will attend. If we don’t develop new practice models, someone else will do it for us.

As you know, Partners launched a number of strategic initiatives last year in an effort to position MGH and the other Partners affiliates to meet the challenges of rising healthcare costs and a struggling national economy. These initiatives revolve primarily around care re-design, patient affordability, employee health benefits, and a re-energized Partners reputation and communication strategy. We recently reached a significant milestone in this work with the delivery of the first round of recommendations.

Care re-design teams with multi-disciplinary representation from institutions throughout the Partners network focused on finding new, more efficient ways to deliver care. They concentrated initially on five patient populations, selected for their prevalence across all Partners institutions: colon cancer; coronary disease (acute myocardial infarction and coronary artery bypass graft surgery); diabetes; stroke; and primary care.

Some common themes emerged as these teams began to examine existing systems. Many of their recommendations speak to a need for better scheduling and improved navigational assistance for patients and clinicians. One idea that’s been suggested is the implementation of a ‘nurse navigator’ role. Terry McDonnell, RN, an MGH representative on the Colon Cancer Team, reports, “A cornerstone of our team’s recommendation is the introduction of the nurse navigator role, modeled after the access nurse role currently used in the Cancer Center. This individual is responsible for triaging patients from diagnosis through pre-surgical work-up to follow-up care based on each patient’s individual pathology and genetic risks. We use this role to coordinate multi-disciplinary care in the Cancer Center, and it’s been very successful.”

continued on next page
Earlier this month, five new MGH care re-design teams were announced. These teams will focus on total joint replacement, vaginal birth deliveries, endovascular procedures, lung cancer, and organ and tissue transplantation. They have been asked to deliver their recommendations by fall.

Physical therapist, Kristin Parlman, PT, who sits on the Stroke Team, says, “Our group is highly motivated, not just to cut costs, but to look critically at current practice and implement changes to improve care. We’re looking at what we can do to ensure successful discharge and transition back into the home; to develop systems that take into account the ‘whole picture,’ the patient, support system, community resources, and follow-up care.”

Chelby Cierpial, RN, shares that the AMI (Acute Myocardial Infarction) Team is focusing on, “standardizing care wherever possible, minimizing the number of patient hand-offs from team to team, and ensuring appropriate support and follow-up after discharge.”

“...I'm thrilled to see that recommendations are geared toward optimizing quality and safety while reducing adverse clinical events and preventing unnecessary readmissions.”

Earlier this month, five new MGH care re-design teams were announced. These teams will focus on total joint replacement, vaginal birth deliveries, endovascular procedures, lung cancer, and organ and tissue transplantation. They have been asked to deliver their recommendations by fall.

All of the care re-design teams came together recently for a retreat to synchronize expectations, share data, and begin to manage their work more cohesively.

Patient affordability teams were asked to evaluate opportunities to reduce costs (across Partners) in emergency services, perioperative services, inpatient services, and a number of other direct-patient-care areas.

Standardization was a common theme in these groups, including recommendations for consistency of products and supplies throughout Partners and a standardized approach to the acquisition of new technology.

The Employee Health Benefit Team recommends continued focus on ways to reduce pharmaceutical spending, better manage high-risk, high-cost patients, and help employees and their families improve and maintain good health. This team is also looking at ways to increase capacity for mental-health and primary-care services.

The Reputation and Communication Team focused on publicizing and reinforcing Partners’ commitment to quality care through public education and multi-media advertising. The new Partners website (connectwithpartners.org) was created as a forum for sharing our thoughts and perspectives on current healthcare issues in Massachusetts.

Going forward, we will remain true to our mission and guiding principles, keeping patients and families at the forefront of our decision-making. I want to thank all PCS employees for your continued and unwavering commitment to our patients, our hospital, and our promise to strive for Excellence Every Day.

Update
I’m pleased to announce that associate chief nurse, Debbie Burke, RN, who has held interim responsibility for the Cancer Center since January, has accepted this expanded role on a permanent basis effective immediately.
I. (F) Patient Affordability: Direct Patient Care, (DPC)

- J. Ives Erickson, RN, DNP, gave an update on the Patient Affordability: Direct Patient Care initiative which has three prongs focusing on the emergency department, perioperative and inpatient care services. Michael Gustafson, MD, and J. Ives Erickson, RN, DNP, are the team leaders of this work, with the aim to achieve a 6.5% reduction in Acute Hospital Direct Patient Care expenses within three years (FY 11-13). The target is $190 million in direct expense savings.

- The Partners’ recommendations that were approved by the Operating Heads now need to be implemented at the hospital-level.

- J. Ives Erickson, RN, DNP, and S. McDougal, MD, will be heading up the DPC work at the MGH. Perioperative Services, Emergency Services, and Inpatient Care Services are the three subcommittees, each with their own leadership team.

- Themes common to all three Direct Patient Care Teams are supplies, staffing, throughput and efficiency, and structural changes.

- Each team submitted their charter by July 29, 2011. Included in the charter is what will feel different by October, 2011, and will be implemented by January 1, 2012.

- J. Ives Erickson, RN, DNP, will be setting up a working meeting soon and that the work for the next PCSEC retreat may focus on direct patient care.

- The Direct Patient Care summary is attached below; it will also be posted on the PCSEC Sharepoint site and emailed to the group.
II. (F) Dartmouth End of Life Update

- D. Colton shared an efficiency update, focusing on the Dartmouth Institute’s analysis of variation in end-of-life care for chronically ill Medicare patients. These Medicare patients all had one of nine chronic illnesses in their last two years of life.
- Dr. Torchiana said that the study focuses on efficiency and how the MGH stacks up against other hospitals in the Boston area as well as the other top U.S. hospitals according to *U.S. News and World Report*, using data from 2003 – 2007. Even though the study was based on data from those years, it is still very relevant information.
- The MGH scored in the middle range with regard to spending, resource utilization, ICU days, hospital days, and hospice days.
- MGH costs, for inpatient and physician care, were lower than most of the 18 institutions listed, all of which were on the 2007 *U.S. News and World Report* honor roll of hospitals.

III. (F) Lunder Move Update

- G. Reardon distributed an updated Lunder move plan schedule highlighting Periop, Cox Radiation and Inpatient unit moves. Everything has been pushed back about two weeks from the original schedule.
- G. Reardon shared that the formula used to move inpatients to the new Lunder building is two patients every 15 minutes and that simulations of the move are being conducted to trouble shoot any potential challenges and prepare for a successful relocation process.

IV. (I) Announcements

- J. Ives Erickson, RN, DNP, introduced Calvin Richardson, Administrative Fellow, to the group.
- Nurses in an Expanded Role: the attached document lists the candidates that have been reviewed and approved in July, 2011 by the Health Professions Staff Committee and the Associate Chief Nurse for the clinical area. Gaurdia Banister sent these lists to all PCSEC members and it has been approved.
Patient Care Delivery
The Future is Now
Nursing Grand Rounds 10.13.11

Mission
Guided by the needs of our patients and their families, we aim to deliver the very best health care 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.

Introduction
• Commitment to the Mission
• Current Environment
• MGH Response
• Road Map to the Future

Cost Pressures
Rising health care costs are the problem, and always will be
• Per capita health care costs have grown steadily for 40 years
• Unmet need is perpetual
• Expanding health insurance coverage magnifies cost pressures
• The US employer-based health insurance system is a handicap in a global economy

Health care reform sets Massachusetts apart

Source: 2009 presentation by Stuart Altman, PhD, Health Care Financing Administration, US Dept of the Treasury. Is our Health System "Addicted?"
Medicare cost trends are unsustainably high and threaten to bankrupt the Federal Government (along with a few other things).

Inadequate payment rates from government payers threaten the viability of hospitals, access of elderly patients to needed care and are driving unprecedented cost shifting to the private sector.

BTW the healthcare sector is a driver of local economies.

Two Competing Views of Healthcare Costs… Both are Correct

There are three ways society is combating rising costs:

- Contain rates through regulation
- Implement payment reform
- Turn patients into consumers

Our direction: Build upon exceptional clinical breadth and depth, research capability and care continuum to redesign care delivery:

- Deliver more integrated, patient-centered care
- Increase patient affordability while protecting mission
- Develop and track performance metrics to demonstrate unparalleled patient experience, outcomes and value

Mortality Trends: Relentless improvement

<table>
<thead>
<tr>
<th></th>
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<td>Heart attack</td>
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<td>Hip fracture</td>
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<td>121</td>
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<td>110</td>
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<tr>
<td>AAA repair</td>
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<td>87</td>
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<td>80</td>
<td>76</td>
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<tr>
<td>CEA</td>
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<td>5</td>
<td>7</td>
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<td>CABG</td>
<td>48</td>
<td>46</td>
<td>40</td>
<td>37</td>
<td>35</td>
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<td>Craniotomy</td>
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<td>70</td>
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<td>78</td>
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<td>Hip replacement</td>
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<td>PTCA</td>
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<td>12</td>
<td>15</td>
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</table>

Indicates rate in the previous column is statistically lower at p<0.05. 57 of 72 cells are significantly improved over the prior interval.


Prevailing Wisdom: Quality of care is deficient

Healthcare quality is measured in plane crashes and chasms.

- A 1999 IOM report, To Err is Human, asserted that:
  - 98,000 Americans die each year as a result of preventable errors in hospitals -- the equivalent of a 747 crashing every day.
- A 2001 IOM report, Crossing the Quality Chasm, asserted that:
  - “Health care harms patients too frequently and routinely fails to deliver its potential benefits. Indeed, between the health care that we now have and the health care that we could have lies not just a gap, but a chasm.”

CMS is Getting Serious

No decision is a decision: Impact of pay for value programs: once fully implemented (FY ’17) for the MGH/MGPO

<table>
<thead>
<tr>
<th>CMS Program</th>
<th>Start Year</th>
<th>Payment Mechanism</th>
<th>Annual Risk</th>
<th>Cum Risk Thru FY 17</th>
<th>Cum Risk Thru FY 17 $M</th>
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<tr>
<td>Inpatient Quality Reporting</td>
<td>2010</td>
<td>MB penalty for failure to report</td>
<td>$9 M</td>
<td>$63 M</td>
<td></td>
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<tr>
<td>Value Based Purchasing</td>
<td>2013</td>
<td>MB reduction with option to earn back based on performance</td>
<td>$4 M</td>
<td>$15 M</td>
<td></td>
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<tr>
<td>Hospital Acquired Conditions</td>
<td>2015</td>
<td>MB penalty for bottom quartile performance</td>
<td>$3 M</td>
<td>$9 M</td>
<td></td>
</tr>
<tr>
<td>Reducing Readmissions</td>
<td>2013</td>
<td>MB penalty for performance (stratified)</td>
<td>$9 M</td>
<td>$34 M</td>
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<tr>
<td>Meaningful Use</td>
<td>2015</td>
<td>MB penalty if failure to meet MU requirements</td>
<td>$6 M</td>
<td>$24 M</td>
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<tr>
<td>Total Financial Risk</td>
<td></td>
<td></td>
<td>$31 M</td>
<td>$145 M</td>
<td></td>
</tr>
</tbody>
</table>

* Annual risk when fully implemented
Partners Strategy Overview

- Episodic
- Episodic

Partners Strategy Overview

- Transplant
- Lung cancer
- Endovascular
- Joint replacement
- Vaginal delivery
- Colon cancer
- AHR
- DBT
- Stroke
- Direct patient care
- Overhead
- Human capital
- Public education
- New web site

Progress To Date

- Teams are in different places but there has been significant progress over the summer
- Value Stream maps have been completed
  - Examples to follow
- Goals have been set
- Outside resources have been identified to facilitate work
  - e.g. Intermountain Healthcare and AHRQ care maps
- Some teams are beginning to design and test specific interventions identified through their analyses
- Additional data requests are being processed

Use existing MGH/MGPO groups to manage the work whenever appropriate

Example 1: OB Care Redesign – Sample Value Stream Map

Care Redesign

- Stroke
- Diabetes
- CABG
- AMI
- Colon cancer

Care Redesign

- Human capital
- Overhead
- Direct patient care

Affordability

- New website
- Public education

Primary Care

- Reputation/Benefits
- Communications

Management

- Population
- Employee Health

Care Redesign

- Management
- Population
- Employee Health

Communications

- New website
- Public education

Primary Care

- Reputation/Benefits

Example 1: OB Care Redesign

- pursuit additional opportunities in clinical
- implement it
- translate it to the MGH/MGPO
- Particpate in the Partners effort
- redesign and patient affordability

Example 1: OB Care Redesign

- Antepartum

Example 1: OB Care Redesign

- Antepartum

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- Antepartum
**Example 1: OB Care Redesign**

**Potential Interventions**

- Decreasing LOS on labor and delivery by streamlining process of induction (e.g. giving medications on a more regular schedule to optimize pace of induction)
- Level scheduling of inductions (with multiparous women scheduled early in the day and first pregnancies scheduled for later in the day (since they are likely to labor longer))
- Moving pre-eclampsia evaluations from labor and delivery to outpatient setting
- Development of “efficiency rounds” for post-partum evaluation with entire team (nurses, physicians, midwives, lactation consultants, social workers, etc.) to ensure plan is in place to facilitate on-time discharge
- Future work to engage patients more in care redesign implementation
- OB-GYN is dedicating a portion of its faculty meetings to care redesign discussions

**Example 2: Arthroplasty Care Redesign**

**Sample of Current State Process Flow**

- The team mapped out the current state process from the surgeon’s office to discharge for THR and TKR procedures.
- Variable process steps were noted (dashed lines) and are being researched in further detail.
- The aim of this exercise is to enhance the patient experience by creating a standardized, streamlined care process.

**Accelerated Rehabilitation Pilot**

- The team hypothesized that beginning Physical Therapy on post-op Day 0, rather than the current standard of post-op Day 1, could reduce LOS by approximately one day.
- Beginning in June 2011, first case THR and TKR patients with a RAPT score between 10-12 were eligible to receive Physical Therapy within hours following their procedure.
- Over the course of eight weeks, 32 patients qualified for the Accelerated Rehabilitation Pilot, and 20 received physical therapy on Day 0. The ALOS for these 20 patients was 3.1 days. The ALOS for patients that did not receive physical therapy on Day 0 was 2.9 days.
- Physical Therapists reported a number of factors limiting the effectiveness/feasibility of Day 0 physical therapy. These factors included:
  - Clinical symptoms: hypotension, post-op nausea/vomiting, and pain
  - Space constraints: physical therapy cannot be performed in the White 3 PACU
  - Inconsistent messaging to the patient regarding expected LOS and mobility milestones
- Moving forward, the team plans to continue with the Accelerated Rehabilitation Pilot and further involve Anesthesia and Nursing

**Best Case Scenario**

- The costs savings and revenue generation estimates presented below assume the following increases from FY10 volumes for the Arthroplasty Service:
  - THR: 571 (FY10 THR cases) + 64 (11.2% volume increase) = 635 cases
  - TKR: 545 (FY10 TKR cases) + 75 (13.8% volume increase) = 620 cases
- The RAPT tool is used by Case Management to predict where a patient will be discharged to. A RAPT score between 10-12 suggests that a patient will be discharged home.

**Total Potential Gain = $2,737,988/year**

**Direct Care**

**Direct Patient Care Expenses**

<table>
<thead>
<tr>
<th>Cost Center Groupings</th>
<th>Per Capita</th>
<th>Per Added Case</th>
<th>Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>THR</td>
<td>$105</td>
<td>$148</td>
<td>$117,218</td>
</tr>
<tr>
<td>TKR</td>
<td>$105</td>
<td>$148</td>
<td>$117,218</td>
</tr>
</tbody>
</table>

- Jeanette Ives Erickson, RN
- Michael Gustafson, MD
- Fred Millham, MD
- Sanjay Pathak
- Dawn Tenney, RN
- Maryfran Hughes, RN
- Everett Lyn, MD
- Julia Sinclair
- Pharmacy/CDP
- Cardiology/Cath Lab
- Imaging
- Pathology/Labs/Blood

<table>
<thead>
<tr>
<th>Direct Care Background</th>
<th>Per Capita</th>
<th>Per Added Case</th>
<th>Per Year</th>
</tr>
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<tbody>
<tr>
<td>THR</td>
<td>$105</td>
<td>$148</td>
<td>$117,218</td>
</tr>
<tr>
<td>TKR</td>
<td>$105</td>
<td>$148</td>
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</tr>
</tbody>
</table>

- The RAPT tool is used by Case Management to predict where a patient will be discharged to. A RAPT score between 10-12 suggests that a patient will be discharged home.
“Patient Journey” Framework

Before | During | Post
---|---|---
Admission Processes, Direct Admissions, Transfers | Patient Stay; Direct Patient Care, Tests, Treatments, Procedures, Clinical Support, Operational Support | Discharge Process
Post Discharge Care
Support Functions: Finance, Information Systems, HR

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

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

Reductions Estimated from UHC LOS Benchmarking

Based on July 2009—June 2010 Data

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Patient Days</th>
<th>% LOS Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>BWH</td>
<td>276,877</td>
<td>6.1%</td>
</tr>
<tr>
<td>MGH</td>
<td>286,771</td>
<td>9.9%</td>
</tr>
<tr>
<td>FH</td>
<td>35,697</td>
<td>9.2%</td>
</tr>
<tr>
<td>NWH</td>
<td>71,131</td>
<td>4.1%</td>
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<tr>
<td>NSMC</td>
<td>99,394</td>
<td>8.8%</td>
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<tr>
<td>Total</td>
<td>769,870</td>
<td>7.8%</td>
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</tbody>
</table>

Assumes entities move all the way to the UHC benchmark for ALL DRGs

Inpatient Care Units UHC Benchmarking Data (July 2009 to June 2010 Discharges)

GH Discharge LOS*: FY09-FY11

The Road Ahead

“What nursing brings to the future is a steadfast commitment to patient care, improved safety and quality, and better outcomes.”

IOM Report, The Future of Nursing

Blueprint for the Future of Nursing

Developed four key messages that structure the recommendations presented in this report.

1. Nurses should practice to the full extent of their education and training
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression
3. Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure

Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine, 2010
The Future of Nursing: Eight Key Recommendations

1. Remove scope-of-practice barriers
2. Expand opportunities for nurses to lead and diffuse collaborative improvement efforts
3. Implement nurse residency programs
4. Increase the proportion of nurses with baccalaureate degree to 80 percent by 2020
5. Double the number of nurses with a doctorate by 2020
6. Ensure that nurses engage in lifelong learning
7. Prepare and enable nurses to lead change to advance health
8. Build an infrastructure for the collection and analysis of inter-professional health care workforce data

Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine, 2010

Where the Rubber Hits the Road

Patient Care Delivery

Throughput and LOS Enhancement Recommendations

<table>
<thead>
<tr>
<th>Before Admission</th>
<th>During Admission</th>
<th>Post Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-admission</strong></td>
<td><strong>Inpatient Stay</strong></td>
<td><strong>Discharge Process</strong></td>
</tr>
<tr>
<td>Admission Process</td>
<td>Direct Patient Care, Tests, Treatment, Procedures &amp; Support</td>
<td>Discharge Process</td>
</tr>
<tr>
<td>Preadmission Care</td>
<td>Delivery Rounds or Daily Bed Plan and QC Plan</td>
<td>Clinical Support</td>
</tr>
<tr>
<td>Admission Process</td>
<td>Daily Plan documentation &amp; Communication</td>
<td>Ancillary Support</td>
</tr>
<tr>
<td>Inpatient Stay</td>
<td>Bed Pain and Observation</td>
<td>Same Patient &amp; Family Communication and Engagement</td>
</tr>
<tr>
<td>Discharge Process</td>
<td>Patient Teaching Protocols</td>
<td>Best Practice Sharing Process across PHS entities or Stockamp-like Program at each Entity (with key metrics)</td>
</tr>
</tbody>
</table>

Best Practice Sharing Process across PHS entities or Stockamp-like Program at each Entity (with key metrics)

Relationship-Based Care

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

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

Relationship-Based Care: Enhancing Collaborative Practice

From:
- Independence
- Hierarchical relationship
- Parallel functioning
- Medical plan
- Resisting change
- Competing
- Indirect communication

To:
- Interdependence
- Collegial relationship
- Team functioning
- Patient’s plan
- Leading change
- Partnering
- Direct communication

Features/Guidelines For New Model

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

Consistency = Continuity = Coordination = Efficiency/Quality
Patient Care Model Re-design: 
Relationship-Based Care

Allocation and redeployment of staff across the continuum as care shifts from the inpatient to the outpatient and community setting

Continuum of Care
- Patient
- Family
- Community
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Social Services
- Dietetics
- Respiratory Care

Inpatient Care Outpatient and Community Care

Data collection and information flow

Inpatient Care Delivery Model: “Innovation Units”

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

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

Guiding Principles

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

Delivery of Care

• Model requirements:
  - Simplifying complex processes
  - Clarity of roles of caregivers
  - Meaningful interventions: overuse, underuse, misuse
  - Technology integration
  - Relationship based care
  - Ongoing innovation
• Key domains
  - Quality and safety
  - Healing environment
  - Research and evidence-based practice
  - Professional development and education

Challenges to Address in Care Delivery

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

MGH Innovation Units to Support Patient Flow

Clinical / Operations
- Increase data collection on key clinical information (e.g., med rec, advanced directives, discharge data)
- Establish support service standards (e.g., bed turn around, phlebotomy timing)
- Establish staffing standards to meet workload

Case Delivery
- Attending MD & Attending RN
  - Identify nurse/physician who assumes care and facilitates flow for each patient
  - Accountable for patient/family continuity and progression
  - Coordinates meetings with clinicians for timely decision making
  - Ensures that key clinical needs are transmitted to the covering clinician(s)
  - Conducts interdisciplinary rounds
  - Engages patient & family in care plan
  - Schedules discharge planning on admission (def discharge day)
  - Conducts weekly high-risk rounds
  - Implements Evidence-based practices
  - Follow up phone calls

Case Management
- Optimizes (i.e., termination of payer, bed finding)
- Transition plan and placement
- Readmission prevention strategies

Goal: High-performing interdisciplinary teams that deliver safe, effective, timely, efficient and equitable care that is patient and family centered.
Building Increased Accountability into Existing Roles

Responsible Nurse/Attending Nurse ➔
Expand staff nurse role.
• Accountable for patient/family continuity and progression along the developed overall plan of care from admission to discharge for 12 to 16 patients (Role would need to be defined for non-acutes and ICUs)
• Ensures, along with the Attending MD, that patient care meets the unit’s clinical standards and vision of patient- and family-centered care
• Develops and revises the patient care goals with the clinical care team daily
• Coordinates meetings with clinicians for timely decision making and connects nurses to optimize handoffs across the continuum
• Is the primary bedside communicator with the patient and family, discussing plan of the day, care progress, potential discharge, and answers questions/teaches/coaches

Attending Nurse: Core Competencies

Clinical Coordinator
• Accountable for working with all members of the team to design, coordinate and evaluate the plan of care and achievement of patient, system and process outcomes.
• Utilizes evidenced-based practices to ensure care is safe, efficient and effective.
• Identifies and implements best practices to ensure patient- and family-focused care.
Facilitator
• Identifies and resolves barriers to promote timely hand-offs and efficient throughput of patients.
Mentor
• Serves as a role model for interdisciplinary problem solving.

Key Process Components: Continuity & Communication

Handoffs:
• When handoffs are required, all key clinical information needs be transmitted to the covering clinician(s) in an efficient, comprehensive manner

Twice Daily Care Team Huddles:
• Care teams – including at a minimum the Attending MD & RN, housestaff, extenders, & bedside RN – meet regularly (at a minimum early morning and late afternoon) to evaluate the patient, update the plan of care, ensure the plan is understood by all care team members and communicate with the patient/family

Family Meetings:
• Continuous discussions regarding plan of care, disposition, goals of treatment, palliative care, and end of life...

Weekly High-Risk Clinical Rounds

Patient Care Delivery Model

Innovation Unit Submissions
• Bigelow 14 Vascular Surgery: Sharon Bouvier, Rich Cambria
• White 7 General Surgery: Theresa Capodilupo, Matt Hutter
• Ellison 7 Trauma and Gen Surg: Theresa Capodilupo, George Velmahos
• Lunder 9 Oncology: Barbara Cashavelly, Panos Fidias
• Ellison 16 Medicine: Kathy Hall and Dan Hunt
• White 6 Orthopedics: Kathy Myers, Harry Rubash
• Ellison 17/18 Pediatrics: Brenda Miller, Peter Greenspan, Esther Israel
• Blake 13 Obstetrics: Lori Pugsley, Laura Riley
• Blake 10 NICU: Peggy Settle and Jonathan Cronin
• Blake 11 Psych: Tina Stone, Jeff Huffman, Jonathan Alpert
• Support proposals received from IV team, pharmacy, case management, Ortho OR team, Bulfinch Medical, Admitting

Examples: Innovation Proposal Ideas
• The Attending RN will develop a care plan for each patient upon admission. The plan will be reviewed with the patient and the medical team.
• Interdisciplinary rounds will routinely address functional status, anticipated discharge date, barriers to discharge and patient/family communication.
• Discharge rounds will shift focus from discharge disposition to infant growth as an indicator of progression towards discharge.
• Surgical patients will meet with ARN as part of the preoperative visit
• “Efficiency Rounds” will be performed by clinical and operations staff.
New Care Delivery Model: Innovation Unit Metrics

- **Throughput and Efficiency**
  - LOS
  - Turn times for bed to be ready
  - Admits from ED
  - Direct admits bypassing ED
  - LOS before admitted to unit with bed ready
  - Medication turnaround time

- **Patient Satisfaction**
  - MD & RN Communication
  - Responsiveness
  - Cleanliness
  - Noise reduction

- **Staff Satisfaction**
  - Overall & Leadership is supportive.

- **Quality and Safety**
  - Unplanned Return to OR
  - Restraint Free
  - Falls Reduction
  - Pressure Ulcer Reduction
  - Foley Catheter Days
  - Pneumovax / Flu Vaccination rate
  - Bedside procedure correct site confirmation / hard-stop time out
  - Others TBD with FY12 PCSEC Goals, Q&S Goals and Contracting Goals

Quality Checklist

- This is a challenging and exciting time for all of us.
- Our heritage, our talents, and our accomplishments are remarkable assets.
- Our mission and our values will be our compass.
- We need to listen to our patients, their families, and the communities we serve.
- We will succeed, but we must do it together, learning continuously from one another.
- The diversity and strength of our system is our unique advantage.

Moving forward together

- Our future depends on our ability to execute on the vision.

Going Forward

- PCS Executive Team retreat in October
- Collect data from Innovation Units
  - Advanced Clinicians and Clinical Scholars by discipline and unit
  - Identify units with narrative culture (include narratives with annual performance appraisals)
- Meetings with the 11 Innovation Units and Executive teams in November
- Education gap analysis to be conducted and necessary education to be rolled out in November and December
- Launch of Innovation Units in December/January

Progress to Date

- Published communication in Caring Headlines
- Provided physician and hospital leadership communication
- Conducted Open Forums: 4 open forums have been conducted with nursing, therapies, social work, chaplaincy, pharmacy, admitting, etc.
- Established metrics and criteria for innovation units
- Developed RFP for unit teams
- Created summary grid to identify how proposals fit the criteria
- Developed an e-room for innovations units.
- Conducted literature search

Discussion

- Where are the gaps?
- Opportunities/concerns that have not been considered?
- What do we need to move forward?
Jeanette Ives Erickson

Accountable Care Organizations

Working together to coordinate care and contain rising healthcare costs

By now, we’ve all heard the buzz about accountable care organizations (ACOs), but in some quarters, the news that Partners HealthCare has been selected as a Pioneer Accountable Care Organization has raised more questions than it’s answered. So I’d like to use this column to explain what an ACO is, how it works, and why we’re participating.

An ACO is a group of doctors, hospitals, and other healthcare providers who join together in a contract with the Centers for Medicare and Medicaid Services (CMS) and agree to be accountable for the quality, cost, coordination, and overall care of Medicare patients. ACOs operate on a shared-savings model that rewards high-quality care, increased coordination of services, and reduction of unnecessary spending. When ACOs are successful in delivering high-quality care more economically (judged against a national benchmark), they share in the savings. When they fall short of national benchmarks, they’re held accountable for increased expenditures.

Partners is one of 32 healthcare organizations across the country (five in Massachusetts, including: Atrius Health; Beth Israel Deaconess Medical Center; Mount Auburn Cambridge Independent Practice Association; and Steward Health Care) to be named a Pioneer Accountable Care Organization. The Centers for Medicare and Medicaid Services have established a list of 33 quality measures by which to evaluate the success of Pioneer ACOs. The quality measures we will use reflect five domains affecting patient care:

- the patient and caregiver experience of care
- care coordination
- patient safety
- preventive health
- at-risk population/frail, elderly health

In December, letters were sent to the almost 50,000 Medicare patients who receive their primary care at Partners hospitals informing them of our participation in the Pioneer ACO program. We know that any time there’s change, there are questions. Some questions you might expect to hear from patients include:

Why are we doing this?

Answer: We are committed to providing high-quality, affordable care. Through the Pioneer ACO we will be working in a more coordinated way to meet your medical needs. MGH and Partners have always led the way in exploring innovative solutions to healthcare challenges; our participation in the Pioneer ACO program is another opportunity to break new ground in care delivery and re-design.

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

continued on next page
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**Will my benefits change?**
**Answer:** No. Your benefits will not change. Your health coverage, premiums, and insurance arrangements are not affected by our participation in the Pioneer ACO. You remain free to choose any doctor or hospital that accepts Medicare at any time.

**Is there a cost to patients?**
**Answer:** No. Patients incur no cost as a result of our becoming an ACO.

**How will this affect patients?**
**Answer:** Primary care physicians are participating in this program to be part of a better, more coordinated care team. The goal is to ensure that patients receive the right care at the right time in the right setting.

**Who will have access to my health information?**
**Answer:** Access to your health information will continue to be limited to your health providers and those responsible for your care. Medicare will not share specific details about your health. Medicare will combine some information (such as number of visits to the doctor, medical conditions, and prescriptions) in order to better understand how patients use healthcare services and what their needs are. This will allow us to develop better systems and improve care.

I hope this clarifies some of the questions people have about accountable care organizations. Health care is a dynamic, constantly changing, service-oriented industry. We are accustomed to challenges. We will do what we always do as we explore this new opportunity—we’ll let the safety and welfare of our patients guide us to new solutions and new ways to deliver patient- and family-centered care.

For more information about accountable care organizations, call the PartnersHealth Pioneer ACO hotline at 1-855-644-1544.

**Update**
I’m pleased to announce that Barbara Blakeney, RN, innovation specialist, has been selected to participate in the CMS Innovation Advisors Program. The program, launched by the CMS Innovation Center in October of 2011, is designed to engage individuals in the healthcare industry to refine, apply, and sustain the managerial and technical skills necessary to drive delivery-system reform. Barbara is one of only 73 individuals chosen from 23 states who will be participating in the program. Innovation advisors will work with the CMS Innovation Center, testing new models of care delivery in their own organizations, creating new partnerships, and sharing the ideas they generate regionally and nationally.

Barbara tells me she’s, “thrilled to be a part of this exciting, cutting-edge opportunity to join with others across the country to test innovations and advise CMS on emerging models of care. I look forward to sharing with the MGH community all that I am privileged to learn throughout this coming year’s work.”

For more information about this exciting opportunity, contact Barbara directly at 4-7468.

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