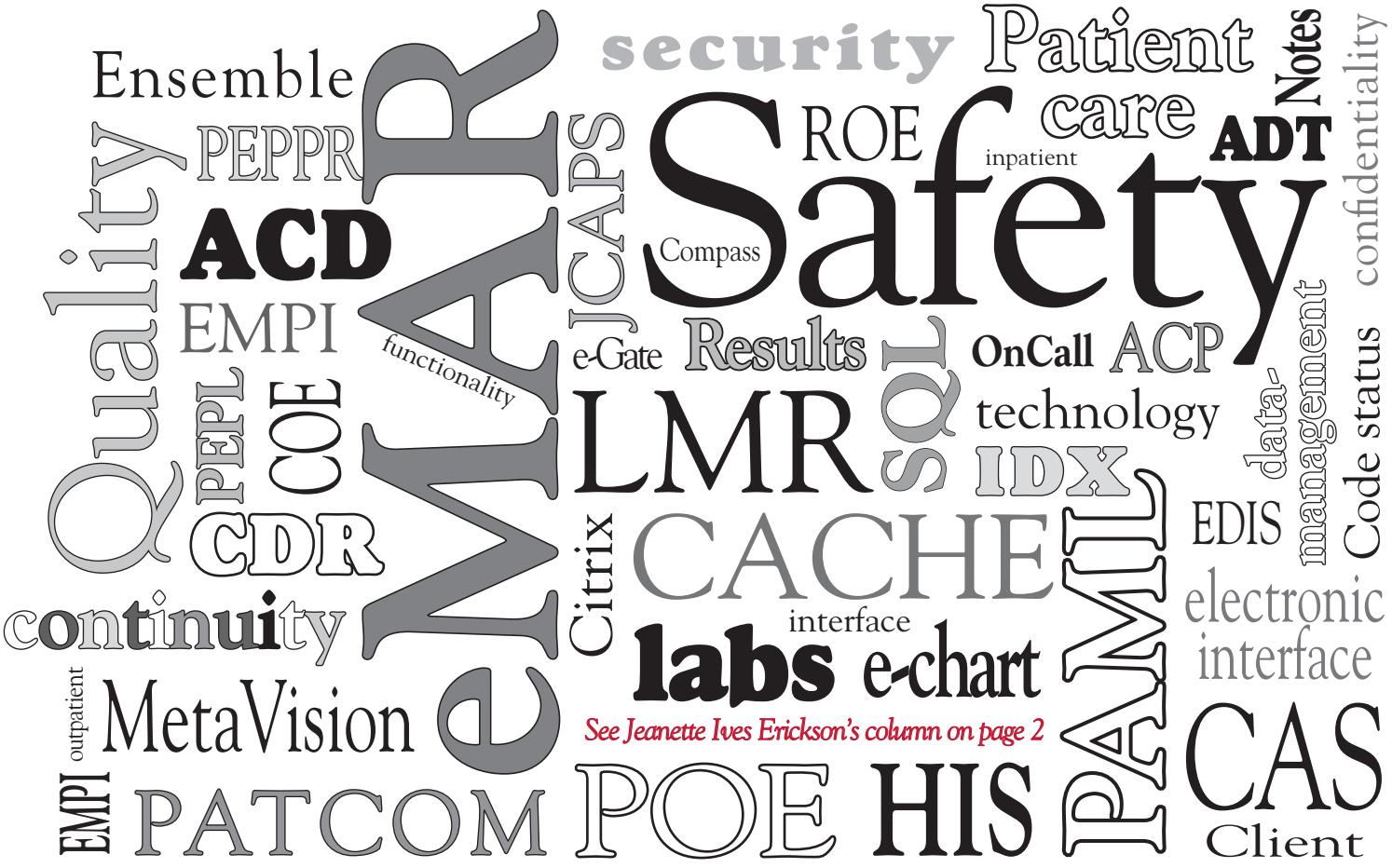
Caring Headlines
November 17, 2011

Common Clinical Systems



See Jeanette Ives Erickson's column on page 2

MASSACHUSETTS GENERAL HOSPITAL 1811 - 2011

The newsletter for Patient Care Services
Massachusetts General Hospital

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.

If you're a clinician at MGH, or any of the Partners institutions, you've no doubt (at one time or another) bemoaned the limitations of our clinical information systems. We are one of the most advanced and sophisticated health care 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

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

- 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 time line 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-

continued on next page

We're on a journey to find the best technological infrastructure 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?

hensive effort is under way to identify the functionalities most valued by clinicians in all disciplines. Key stakeholders at Partners entities are being asked:

- What are your top three criteria for selecting a common clinical system?
- What are the 'non-negotiables' for your site or department?
- 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 myriad considerations involved in selecting a clinical systems solution and asked attendees to share their essential 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 common-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 continuum, enhance patient safety, and become more efficient 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 project 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 infrastructure 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 directors 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.

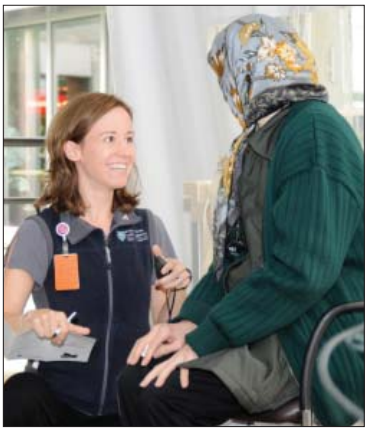
In this Issue

MGH celebrates Physical Therapy Month

—by Ann Jampel, PT, clinical education coordinator

October is National Physical Therapy Month, a time to recognize and celebrate the important contributions physical therapists make to the care of patients. On October 3, 2011, the MGH Physical Therapy Department hosted an interactive, educational event to help people learn how to maintain their balance and keep from falling. Physical therapists put visitors through their paces as scores of passers-by participated in three simple exercises and received information on how to make their home and work environments safer. According to statistics, approximately one in three seniors over the age of 65 and one in two over the age of 80 will fall at least once this year. Physical therapists can help reduce that number with individualized treatment plans that include exercises to improve strength, mobility, and balance.

Top (l-r): Ann Jampel, PT; Colleen Kigin, PT; and Michael Sullivan, PT. Below: physical therapists, Laura Foley, PT; Kathy Phillips, PT; and Erin Leidl, PT, at the "Staying on Your Feet: how to Keep Your Balance and Prevent Falls" educational event.



On October 19th, physical therapists and support staff from all seven MGH practice sites came together for their annual staff appreciation celebration. Ann Jampel, PT; Colleen Kigin, PT; and Michael Sullivan, PT, presented, "Looking Back, Looking Forward: the History of MGH Physical Therapy Services." Through stories, photographs, and personal recollections, they showed how world events and the evolution of practice at MGH helped shape physical therapy practice today. They described the challenges and opportunities for practice in the future. It was clear that the values and guiding principles of the department are deeply embedded in its rich history and the legacy of innovation, education, and commitment that came before.

For more information about the services provided by MGH Physical Therapy, call 6-2961.

Reducing healthcare costs by improving health literacy

—submitted by the Patient Education Committee

What is the strongest predictor of a person's health?

A) Age
B) Income
C) Employment status
D) Race
E) Education level
F) Health literacy

The answer may surprise you. It's 'F,' health literacy. Health literacy, as defined by the US Department of Health and Human Services, is "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." In addition to reading, patients need to be proficient in numeracy, verbal communication, use of technology, the ability to find pertinent information, and the ability to evaluate information. Unfortunately, in the United States, many people struggle with health literacy. The first, large-scale, national assessment revealed that only 12% of Americans are health literate. This can result in dire consequences for patients and the entire healthcare system.

Individuals with low health literacy have higher hospitalization rates, longer hospital stays, greater use of emergency services, and greater difficulty controlling chronic illnesses. This costs the US an estimated 238 billion dollars in additional healthcare expenditures.

To raise awareness about health literacy and provide tools for staff to effectively teach patients, the Patient Education Committee offered several events during the month of October, Health Literacy Month. First, was a presentation, entitled "How to Take an Active Role in Your Health Care," presented by Andrea Powers, RN, of Health Dialog in collaboration with the Shared Decision-Making Program. Patients learned how to articulate health concerns, accurately describe symptoms, and ask pertinent questions, all essential components of health literacy. The committee also hosted an educational booth in the Main Corridor and distributed materials to help patients become active partners in their care.

Jen Searl, health education project specialist for the The Blum Patient & Family Learning Center, presented, "Health Literacy, Just the Facts Ma'am," a talk aimed more at staff than patients. Searl spoke about the concept of health literacy, the adverse effects of low health literacy, and explained techniques like teach back/show back and plain language. Teach back/show back involves having patients 'teach back' what they've just learned. Clinicians use open-ended questions such as, "Tell me how you're going to take this medication when you get home." Plain language is a way of composing written materials so the information is simple, clear, and easy to understand. Searl emphasized that while readability (i.e., the reading grade level) is important, there are many components to plain language, including content, organization, style, and formatting.

According to Judy Gullage, RN, co-chair of the Patient Education Committee, "The committee has provided patients and clinicians with many opportunities to learn about health literacy. I'm truly impressed with the commitment of the Patient Education Committee champions to improve patient-education at MGH."


Jen Searl, health education project specialist

For more information about health literacy or to have a document edited or evaluated for plain language, contact Jen Searl at 4-3823.

New nurse learns there's more to nursing than medications and stethoscopes

As a new graduate nurse, I was very focused on the technical aspects of my job... It wasn't until I met 'Robin' that I began to realize how the art of nursing impacts the patient experience.

My name is Jane D'Addario, and I began my nursing career on the Bigelow 7, GYN/Oncology Unit, 14 months ago. In nursing school, I often heard instructors say, "Nursing is an art and a science." As a new graduate nurse, I was more focused on the science of my job. I wanted to develop a foundation of knowledge and skill in physical assessment, medication-administration, and the side-effects of chemotherapy regimens. It wasn't until I met 'Robin' that I began to realize how the *art* of nursing impacts the patient experience.

I met Robin on a Thursday afternoon. I was working an evening shift and was told by the resource nurse that I had the first admission. Robin came to the unit hunched over in a wheelchair, looking thin, pale, and exhausted. She was accompanied by her wife and a family friend. She was 40 years old and had been diagnosed with ovarian cancer only four months earlier. The tumor was extremely aggressive and despite multiple chemotherapy regimens, it had metastasized to her lungs, liver, and bones. Robin had come to MGH for a second opinion with the hope of finding another treatment to stop the tumors' rapid progression. After her initial meeting with the oncologist, Robin was admitted directly to our unit. The goal was to control her pain and nausea so she'd be well enough to try a new course of chemotherapy.

Jane D'Addario, RN, staff nurse

I spent many shifts with Robin over the next week. She was guarded and withdrawn, answering most questions with a simple, Yes or No. Although she was one of the sickest patients on the unit, she rarely called for help. I often went in to check on her only to find her curled up in a ball, clutching an emesis basin.

As time went on, Robin and I began to form a bond. I learned to check on her frequently and worked with the team to come up with a treatment plan that could control her pain and nausea. We went for walks around the unit together, and she began to open up—telling me about her latest film project, about her years

continued on next page

living in New York City, and about the day she met her wife and best friend, 'Courtney.' By the end of the following week, Robin had gained enough strength to start chemotherapy.

I returned four days later to a very different Robin. Her liver function had continued to decline, and her skin had become a light yellow. I got report from the night nurse. She told me Robin had had a tough night, had gotten little sleep, and was very confused. When I went in to assess her, I was heartbroken when she didn't seem to recognize me.

Later in the day, Robin was made DNR/DNI (Do not resuscitate/Do not intubate). We would be providing comfort measures only. She remained confused for much of the day. In her moments of clarity, she expressed sadness and anger that the disease was cutting her life short. By 7:00pm, I had reached the end of my emotional reserve and cried the entire way home.

I woke up the next day with new drive. I had one more shift before leaving for a conference that would keep me away from the hospital for a week. Robin's condition had deteriorated significantly, and I knew this could be our last day together.

Robin had a better night. Although slightly confused at the beginning of my shift, her mind seemed to clear by mid-morning. There was a constant flow of visitors, each one wanting to spend precious time with this kind, wonderful woman.

Robin woke up from a nap in the early afternoon and expressed an interest in having lunch. Realizing I hadn't eaten either, we had a picnic in her room. She sipped chicken soup and ginger ale while I ate my turkey sandwich. Robin and her wife reminisced about their life together, showing me pictures of when they first started dating almost 14 years ago. Looking at pictures of her 'Big 4-0' birthday party only months before, it was mind-boggling to see how quickly her disease had taken hold.

Robin mentioned that she was thankful to have one of the two private rooms on our unit, but disappointed that the view from her window was a brick wall and the roof of the neighboring building.

"I was hoping to see Boston," she joked.

I realized this was an opportunity. After lunch, I temporarily disconnected Robin from her IV, wrapped an extra blanket around her, and took her on a wheelchair adventure. After getting an okay from a unit that has a great view of the city, Robin, her wife, and I made our way to their family room. Despite some fog, we were able to see an incredible view of Boston, from the Charles River, to the CITGO sign over Fenway Park, to Beacon Hill, to the Tobin Bridge. The three of us sat quietly, taking it all in.

When we returned to the unit, Robin gave me a big hug. Then she climbed back in bed and settled in for a nap. I left the hospital that day much happier knowing that at this pivotal time in Robin's life I had made a difference.

Robin remained on our unit on the inpatient hospice service. She passed away about a week later.

I'm thankful to have had the opportunity to get to know Robin during this difficult transition in her life. She made me realize that the most powerful thing we do as nurses doesn't involve medications or stethoscopes. Sometimes, it's the art of nursing, the human connection—the back rub, listening to patients' fears, being present in their time of need—that makes the most difference. I feel blessed to have cared for Robin and her family. I'm confidant that I'm a better nurse because of them.

I'm thankful to have had the opportunity to get to know Robin during this difficult transition in her life. She made me realize that the most powerful thing we do as nurses doesn't involve medications or stethoscopes. Sometimes, it's the 'art' of nursing, the human connection—a back rub, listening to patients' fears, being present in their time of need.

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

How many times have we heard it? The simplest things make the biggest difference. Intuitively, Jane knew that a 'wheelchair adventure' to take in a spectacular view was just what Robin needed. The peace, the beauty, the serenity of the Boston skyline in the company of Robin's beloved wife was an inspired intervention. Gestures of comfort and kindness at the end of life, indeed, speak to the power and art of nursing.

Thank-you, Jane.

2012 Jeremy Knowles Nurse Preceptor Fellowship

—by Mary Ellin Smith, RN, professional development manager

The Jeremy Knowles Nurse Preceptor Fellowship was established in 2008 to recognize nurse preceptors who exhibit an exceptional degree of clinical inquiry, scientific knowledge, teamwork, compassion, and leadership.

The Jeremy Knowles Nurse Preceptor Fellowship was established in 2008 to recognize nurse preceptors who exhibit an exceptional degree of clinical inquiry, scientific knowledge, teamwork, compassion, and leadership. Knowles preceptors are distinguished by their extraordinary ability to educate and inspire new nurses in the course of their clinical and professional development. Those selected to be Knowles fellows receive financial support toward activities that promote their own educational and professional development as clinicians, preceptors, and mentors.

Meaghan Morrison Rudolph, RN, staff nurse, Blake 11 Psychiatry Unit

The two nurses selected to be the 2012 Knowles nurse preceptor fellows are Melissa Donovan, RN, staff nurse on the Bigelow 11 General Medical Unit, and Meaghan Morrison Rudolph, RN, staff nurse on the Blake 11 Psychiatry Unit.

Donovan is a graduate of Boston College, currently enrolled in the BC Adult Health Clinical Nurse Specialist program. In her letter of support, Sarah Callahan, RN, a nurse whom Donovan precepted, wrote, "Melissa's greatest strength is the manner in which she allows her preceptees to learn. Many instructors fall into the trap of over-instructing. Not Melissa."

Patricia Fitzgerald, RN, clinical nurse specialist, notes, "Melissa provides a very open, accepting environment where new nurses don't feel pressured to make quick decisions. They're comfortable talking through the process, even if all the thinking isn't quite perfect."

Melissa Donovan, RN, staff nurse, Bigelow 11 General Medical Unit

Morrison Rudolph is a clinical scholar and a graduate of Brandeis University and the Boston College Accelerated Master's Entry into Nursing program with a concentration in Adult Psychiatric Mental Health. Monica O'Brien, RN, whom Morrison Rudolph precepted, wrote, "Meaghan knew intuitively that being new is a challenge not only professionally, but socially. She made me feel part of the team."

Mary McKinley, RN, staff nurse, wrote, "Meaghan kept me on my toes, asking questions that constantly challenged me to review and study. During this time my enthusiasm for nursing was re-kindled."

For more information on the Jeremy Knowles Nurse Preceptor Fellowship, call Mary Ellin Smith, RN, at 4-5801.

Former Knowles fellow creates tool for sharing information

—by Jane Miller, RN

My name is Jane Miller, and I have been an oncology nurse for 22 years. I had the honor of being selected the 2010 Jeremy Knowles nursing preceptor fellow. When I applied for the fellowship, I was working full-time and going to school part-time for my master's degree. The fellowship allowed me to go to school one day a week, giving me more time to devote to my studies. I completed my master's degree in Nursing, sat for the NP boards, and was certified in August, 2010. The fellowship also enabled me to attend the Oncology Nursing Society Institute of Learning where I took the Chemotherapy/Biotherapy Trainers Course.

During my fellowship, I wanted to develop a project that would enhance the education of new orientees to the Infusion Unit. I had a wealth of clinical information stored in e-mails that I had saved over the years. I thought new nurses might be able to benefit from the clinical tips and information I had amassed. I pondered ways to make this information available to new orientees.

I initially thought a memory stick containing the data could be given to new nurses as they arrived on the unit. My nursing director felt that all nurses on the unit could benefit from this information, not just new orientees. So I began reviewing all the e-mails I had saved, discarding those that were no longer relevant. I created a folder called, New Orientee Valuable Clinical Information, and sub-folders for other categories of clinical information.

The project has become an ongoing source of information as staff nurses and clinical nurse specialists add to the folders as new information is learned. I turned management of the New Orientee folder over to the clinical nurse specialist when I accepted a position as a nurse practitioner in the Cancer Center. She continues to develop it as a teaching tool for new staff, preceptors, and other nurses.


Jane Miller, RN, nurse practitioner

It occurred to me that this kind of resource could be helpful on any unit. Preceptors would have a useful tool to help guide new nurses in accessing information and skills specific to their unit.

I used the Jeremy Knowles Preceptor Fellowship to enhance my precepting and teaching skills. Since obtaining ONS certification to teach the Chemotherapy/Biotherapy course, I've collaborated with other advanced practice nurses to teach the course.

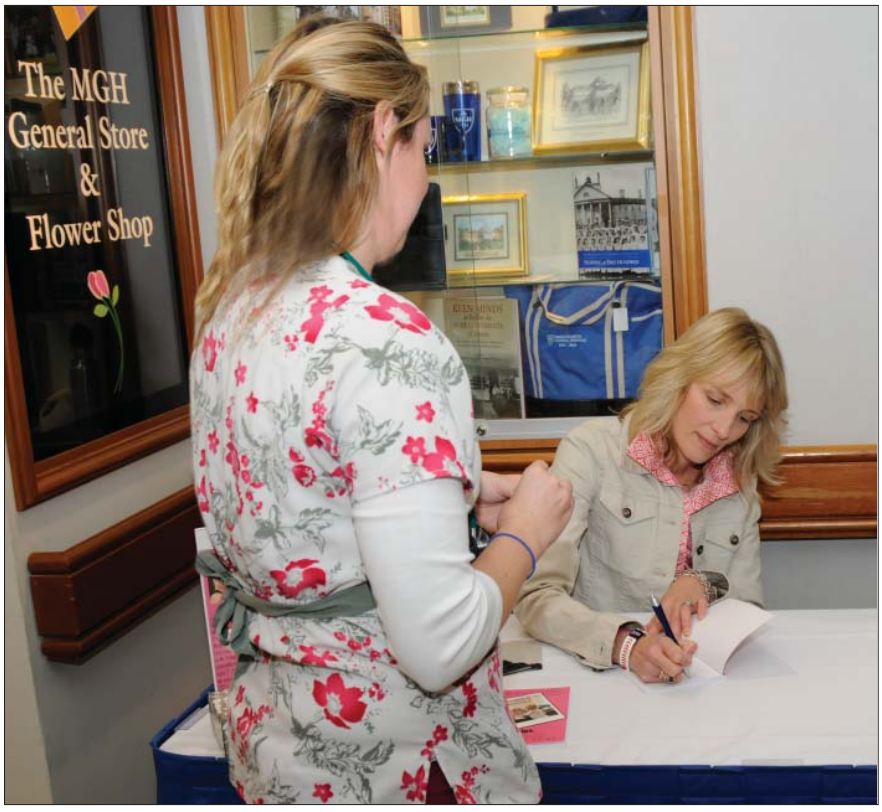
I recently began my nurse-practitioner career with a position in the Gillette Center for Women's Cancers, which required my being oriented by another nurse practitioner. I was once again struck by the importance of precepting a new clinician into an unfamiliar practice setting no matter how many years of experience they (or I) may have. I'm very grateful to the Knowles family for creating an award for expert nurse preceptors.

For me, the Jeremy Knowles Preceptor Fellowship didn't end with the calendar year. It called me to continue to observe and identify the needs of my colleagues and patients. It has become an ongoing pursuit of knowledge and the sharing of that knowledge with others to make nursing the best that it can be.

pink tips: breast cancer advice from someone who's been there

—by Ann Murray Paige

Boston-area native and sister of MGH nurse, Ellen Silvius, RN, Ann Murray Paige has written a book called, *pink tips: breast cancer advice from someone who's been there*. Paige, a two-time breast-cancer diagnosee, inspired the 2006 documentary, *The Breast Cancer Diaries*. When her cancer returned last fall, Paige decided to compile her top 50 tips on dealing with cancer in what she calls, the worst year of her life.



Ann Murray Paige signs copies of *pink tips*, at recent book-signing event outside the MGH General Store.

"When I was diagnosed, people gave me big books on other people's struggles with cancer. While I was grateful for their concern, I didn't want to read someone else's version of cancer. I needed ideas on how to make it through myself. And between surgery, chemotherapy, radiation, picking out wigs, and trying to keep my sanity, I didn't have a lot of time to read. I needed cancer *Cliffs Notes*."

So Paige decided to write them. *pink tips* is a compilation of ideas to help patients and families prepare for and cope with the breast-cancer experience.

On Thursday, October 27, 2011, Paige was at MGH to sign copies of her witty, pocket-sized book. "This is a fast, easy, helpful read," says Paige. "After ten minutes, you should be on tip number fifty and have a better sense of how to proceed." The book also contains inspirational quotes, which Paige says were important to her as she dealt with her cancer treatment.

"I had a magnet on my refrigerator that said, 'If you're going through Hell, keep going,' by Winston Churchill. I stared at that magnet every day, and I took that advice."

Paige is also the author of *Words To Live By*, an anthology showcasing 30 of the best blogs from her website, www.projectpinkdiary.com. Writing (and blogging) have helped Paige cope with her new battle with metastatic disease.

"At 46, I never expected to be thinking of my life in terms of my death. But that's my reality. So while I'm still here, I want to do something for people affected by this insidious disease. I look at my experience not with anger and sadness, but with humor, perspective, and sheer joy that I'm still here to fight. Cancer wanted to take me seven years ago, and I wouldn't let it. I don't plan to let it this time, either."

Announcements

One-stop intranet site for strategic priorities

Want to know more about the Partners-MGH patient care re-design, patient affordability, and budget review initiatives?

Visit the new MGH/MGPO intranet site:

http://priorities.massgeneral.org.

New disability indicator in PATCOM

Effective November 1, 2011, the patient registration process under Admitting & Registration Services includes a disability indicator. Including information about a patient's permanent disability in our registration system, helps staff be more proactive in meeting special needs.

To begin, disability information will be used for inpatient and surgical visits only. The disability indicator will be rolled out to ambulatory practices early next year.

For more information, call Zary Amirhosseni at 3-7148.

First annual Robert Leffert, MD, Memorial Lecture

Living Well in the Face of Serious Illness
"Connecting with Patients: Where Art Meets Science" presented by Anthony Back, MD, professor, Oncology Division
University of Washington School of Medicine

sponsored by
MGH Palliative Care Services

Tuesday, November 29, 2011
Light refreshments 4:45pm
Program 5:00–6:00pm
O'Keeffe Auditorium

For more information, call 4-9197

Clinical Recognition Program

The Clinical Recognition Review Board and Steering Committee are happy to announce a new initiative by which clinicians applying for recognition at the advanced clinician and clinical scholar levels can submit their portfolio for a preview prior to formal submission. This voluntary, anonymous process gives clinicians an opportunity to receive feedback on their portfolios from former review board members.

Reviewers will provide feedback on specific areas identified by clinicians, leadership, and review board members based on past experience.

For more information, e-mail questions or portfolios to MGH PCS Clin Rec (in the Partners directory).

Traditional Chinese Medicine

Educational Series

Traditional Chinese Medicine and Inflammation-Related Disease
Thursday, December 1, 2011
6:30–9:00pm
Simches Research Center
Conference Room 3120
(ID required)

"Integration of Mainstream Medicine and Chinese Medicine: Study of a Traditional Chinese Medicine Formula, PHY906, as Adjuvant Therapy for Cancer Patients undergoing Chemotherapy"
6:45–7:30pm

"The Challenges and Opportunities of TCM in the 21st Century: Study of HLXLD for Osteoarthritis"
7:45–8:30pm

For more information, call 4-1757.

Journal Club

Research and Evidence-Based Practice Committee

'Clinical Predictors of Necrotizing Enterocolitis in Premature Infants,' presented by
Kate Gregory, RN

Wednesday, November 9, 2011
4:00–5:00pm
NICU Conference Room
Blake 10

Contact hours: 1
All are welcome.

For more information, call 6-2763

Choosing Child Care

Partners Employee Assistance Program and Partners Child Care Services are offering a roundtable discussion for those new to parenting and childcare.

Allison Lilly, LICSW, will explore: child care options, costs, and how to find and evaluate care.

Sheryl Lauber Weden, director of Partners Child Care Services will talk about internal resources for center and back up care.

Wednesday, December 7, 2011
12:30–1:30pm
Haber Conference Room

For more information, call 6-6976

Blum Center Event

Program is free and open to MGH staff and patients. No registration required.

Healthy Living Series
"Elder Care-Giving During the Holidays"

Wednesday, November 30, 2011
12:00–1:00pm
Blum Center

Janet Loughlin, LICSW, of Employee Assistance, will discuss strategies for managing elder care-giving stress during the holiday season.

For more information, call 4-3823.

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For more information, call: 617-724-1746

Next Publication
December 1, 2011

The Center for Perioperative Care

Question: I've heard people talk about a new Center for Perioperative Care. What is that?

Jeanette: The Center for Perioperative Care is the new name for the area on WACC 3 that used to be the Same Day Surgical Unit (SDSU). When the Lunder Building opened, the Post Anesthesia Care Unit (PACU) and the operating rooms of the SDSU were integrated into the Legacy and Lunder Perioperative areas. Lunder 2, 3, and 4, house 28 operating rooms and 34 perioperative 'bays.' The vacated space on WACC 3 will be used for assessment and check-in, discharge, and a family waiting area with enhanced privacy for both adult and pediatric patients and families. This is the area we now call the Center for Perioperative Care (CPC). Think of the CPC as the 'front door' for elective surgical patients—a door that leads to world-class anesthesia, nursing, and surgical care from pre-operative to post-operative care and everything in between.

Question: What will happen to the space vacated by the WACC operating rooms and the PACU?

Jeanette: WACC 3 is scheduled to be completely renovated. The new space will have private perioperative bays, a robust registration area, an inviting patient and family waiting area, and private consult rooms. The goal is to create a space that supports quality care-delivery and enhances privacy for patients, families, and caregivers.

Question: When will renovations begin and where will the Center for Perioperative Care be located during the renovation?

Jeanette: Renovations will begin in the next few months with completion scheduled for late 2012. During renovations, beginning December 5, 2011, the Center for Perioperative Care will temporarily re-locate to White and Ellison 12. The center will continue to provide uninterrupted, high-quality, family-centered care during this time as the new Center for Perioperative Care is constructed.

Question: Where will families wait while the center is located on White and Ellison 12? How will waiting families and clinicians communicate?

Jeanette: During this interim time, families will have the option of waiting in the area on the Ellison 12 bridge, in the family waiting area on Ellison 12, or in the Gray Family Waiting Area. Nurses, operations managers, and volunteers in the Gray Family Waiting Area will continue to play a critical role in maintaining communication with families as they do now.

For more information on the Center for Perioperative Care, the move of the surgical areas to the Lunder Building, or the back-fill plan, call 4-8460.

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