

Caring

Headlines

October 20, 2011



*The
history
of*
**Physical
Therapy**
at
MGH

Since the beginning, PT practice has been driven by the rehabilitation needs of patients. Initially, those needs stemmed from injuries incurred during WWI and the polio epidemics of the early 1900s.

See story on page 4

Affordable care and cost-containment go hand in hand

One cost-reduction strategy that supports our interest in protecting the environment is eliminating waste and the over-use and mis-use of supplies and equipment.

A

s I'm sure you recall, in early 2010, Partners CEO, Gary Gottlieb, MD, 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. This planning process rendered three main areas of focus:

- Care Re-Design—a multi-disciplinary effort to identify new approaches to care by focusing on conditions and episodes not traditional procedures, visits, and admissions
- Patient Affordability—a comprehensive effort to reduce direct patient-care costs, improve patient flow, better manage human resources, and reduce overhead expenses
- Reputation—a reinvigorated campaign to spotlight Partners' care and services using multi-media messaging

Under the heading of Patient Affordability, we're looking at opportunities to reduce costs in the inpatient, emergency, and peri-operative settings. During our initial review of existing practices, standardization emerged as a common theme for achieving potential savings—including consistency of supplies and new products across Partners entities and shared rules for adopting new technology.



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

We are committed to reducing costs while at the same time bringing value to our patients by providing the highest quality care at the most efficient price. One cost-reduction strategy that supports our interest in protecting the environment is eliminating waste and the over-use and mis-use of supplies and equipment. In order to achieve appreciable savings, we can't continue with business as usual.

Toward that end, the Partners Clinical Advisory Council was convened to explore how best to reduce supply expenses in inpatient units and emergency departments across the Partners network (a separate group is looking at the peri-operative setting). I've asked clinical nurse specialists, Joanne Empoliti, RN, and Joyce McIntyre, RN, and director of PCS Clinical Support Services, George Reardon, to lead the effort at MGH. You may recall that in 2008, the original Clini-

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If experience has taught us anything, it's that we need a new approach. We want your input. Clinicians at the bedside are in the best position to make recommendations about cost-cutting ideas related to direct patient care and the supplies and equipment necessary to practice efficiently.

cal Advisory Council identified more than \$800,000 in system-wide savings by standardizing certain supplies, and MGH was a pivotal contributor to that effort.

This time around, the Clinical Advisory Council is using a four-pronged approach:

- identify, evaluate, and implement best practices
- identify products that can be standardized. We've come across a number of instances where identical products are being used but are being purchased from different vendors (items such as IV sets and dressings). It's costly to use multiple vendors for identical products (you wouldn't do that at home); it's costly to keep so many items in inventory; and this practice adds no value to the patient or the caregiver
- review internal and external practices for linen and laundry consumption. We're taking a closer look at the criteria around changing bed linens. In some cases, *clean* linens are being re-washed when there's no need—that's a completely unnecessary expense. And we're looking at product choices, trying to ensure that the right products are being used for the right jobs. Effective utilization will have a positive impact on cost-reduction and the environment
- review supplies being used for traditional and advanced wound care, including treatments for decubitus, ulcer-prevention, etc. We're fortunate to have a number of authorities on wound-care at MGH, in-

cluding our own Virginia Capasso, RN. That expertise will be key as we explore viable opportunities to cut costs and improve care in the treatment of wounds and the prevention of pressure ulcers. And additional savings may be realized through appropriate utilization of specialty beds and surfaces.

If experience has taught us anything, it's that we need a new approach. We want your input. Clinicians at the bedside are in the best position to make recommendations about cost-cutting ideas related to direct patient care and the supplies and equipment necessary to practice efficiently. Waste, over-use, and mis-use of products and supplies is an enormous drag on an organization's fiscal health. I'm interested in hearing from anyone who has an idea about how to reduce costs without compromising quality or safety; how to improve care without losing efficiency. If you think there is waste in our system, we want to hear about it.

In the coming weeks, you may be invited to join a team being formed to evaluate cost savings and share best practices. If you are, I hope you'll accept that invitation. Your input and expertise are essential to this important work. Solutions are born from ideas—and we need yours.

Please e-mail your thoughts to me, George Reardon, or Joanne Empoliti. Thank-you.

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The rich and remarkable history of Physical Therapy at MGH

—by Michael Sullivan, PT, director, Physical & Occupational Therapy, and Ann Jampel, PT, clinical education coordinator

As the hospital celebrates its bicentennial anniversary, MGH Physical Therapy looks back on its long and storied past—a past characterized by rapid growth and dramatic change. In the late 1800s, for instance, what little there was in the

way of physical therapy barely resembled the diverse and complex practice we know today. In 1872, James J. Putnam, MD, was hired by MGH to serve as ‘electrician to the hospital.’ This

was part of a movement in the United States to train physicians in the use of electrical therapies including electrolysis, ionic medication, and early forms of muscle testing.

In the latter half of the 19th century, Swedish physician, Gustav Zander, developed something called, medico-mechanical therapy. And in the early 1900s, two physicians trained in medico-mechanical therapy opened the Zander Room at MGH offering different forms of

electrical therapy, heat, hydrotherapy, and ‘gymnastics.’ The room included 64 exercise machines, precursors to what would later be known as progressive resistive exercise equipment. The Zander Room closed in 1919, and in the years leading up to World War II, the practice of physical therapy was limited to supporting ambulatory clinics that provided various forms of ‘baking and massage.’

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Physical Therapy (continued)

Marjorie Ionta, PT, (Miss Ionta, never Marjorie), chief physical therapist from 1958–1981, had a significant influence on the development of PT practice at MGH.

needs stemmed from injuries incurred during WWI and the polio epidemics of the early 1900s. During WWI, Joel Goldthwait, MGH chief of Orthopaedic Surgery, was one of several physicians commissioned by the Surgeon General to study French and British reconstruction programs for wounded soldiers. This led to the development of specialized rehabilitation facilities and the creation of training programs for reconstruction aides. Marguerite Sanderson, a therapist in Goldthwait's office, went to Washington, DC, to organize the Reconstruction Aide Training Program. Reconstruction aides were the forerunners of today's physical therapists.

In 1939, Physical and Occupational Therapy became part of the newly created Department of Physical Medicine at MGH. The department was led by neuro-

logist, Arthur Watkins, MD, and also offered services in psychology, social work, and later, orthotics and prosthetics. Again, the needs of disabled soldiers, polio patients, and the growing population of patients with central-nervous-system problems drove the development of this specialized team. At this same time, a formal clinical-education program was developed by the PT Department to help meet the increasing demand for qualified therapists.

Marjorie Ionta, PT, (Miss Ionta, never Marjorie), chief physical therapist from 1958–1981, had a significant influence on the development of PT practice at MGH. She was the first in her discipline to focus on patient-centered, evidenced-based care. Ionta's wisdom and philosophy endure to this day:

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Physical Therapy (continued)

- know your patients; they are not just arms and legs
- treatment must be individualized—two patients with the same diagnosis need to be treated differently
- provide a rationale for what you do based on specific data that you collect for each patient

During the 60s and 70s, as new approaches to neuromuscular and orthopaedic problems were developed, Ionta became an expert in proprioceptive neuromuscular facilitation (PNF) and trained staff in its application among a wide variety of patients. She hired Stanley Paris, a New Zealand-trained therapist, who introduced manual therapy to MGH well before it was an accepted PT intervention for orthopaedic patients. Ionta's involvement in the development of the Post-Professional PT Program at the MGH Institute of Health Professions brought advanced-level students to

the department in addition to entry-level students from more than 20 programs across the country.

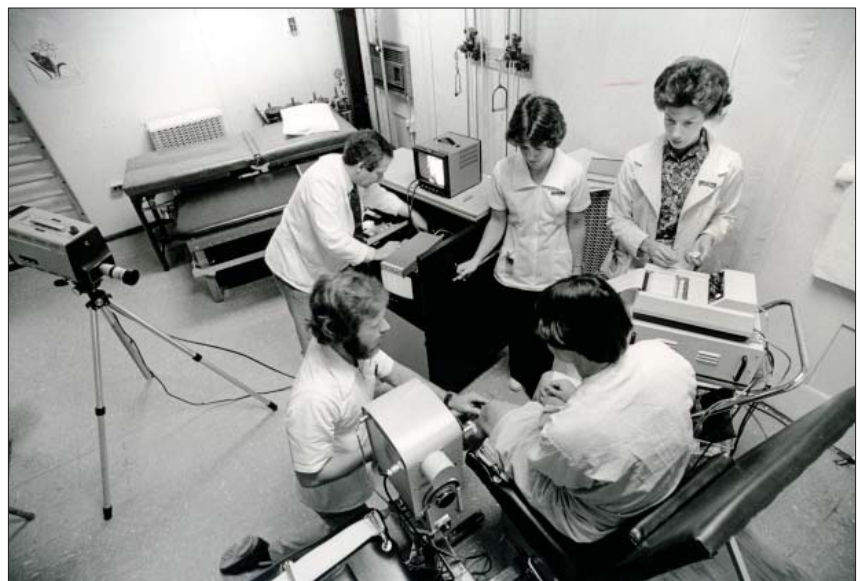
As medical care advanced and cures were found for diseases like polio, the role of physical therapists began to change. More and more patients survived acute illnesses and were sometimes left with signifi-

cant physical disabilities giving therapists new challenges. This shift drove the need for greater education and paved the way for expanded roles for therapists. And with more advanced education came a change in the entry-level requirement for new therapists from a certificate to a baccalaureate degree.

In the 1960s, to better address the needs of post-surgical patients, Henning Pontoppidan, MD, developed the Chest Physical Therapy Service within the department of Anesthesia under the direction of Mica Rie, PT. Physical therapists became increasingly important in the critical care setting providing treatment to improve pulmonary function and facilitate mobility and recovery.

In the 1970s, the profession again adjusted its entry-level-education requirement to a post-baccalaureate degree. It was at this time that specialty areas began to emerge within Physical Therapy. Colleen Kigin (director of Chest PT, 1977–1988; director of PT Services, 1988–1994), was at the forefront of this evolution and a driving force in the development of national standards and testing methodologies for these emerging specialties. Kigin established the clinical specialist role at MGH, which was originally filled by Meryl Cohen, PT, one of the first three therapists in the country to achieve board-certification as a cardio-pulmonary clinical specialist. Currently, the department boasts 50

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Physical Therapy (continued)

board-certified specialists in cardio-pulmonary, orthopaedic, sports, pediatric, neurological, geriatric, and women's health disorders.

In the 1980s, Polly Cerasoli, PT, (director, 1981–1987), envisioned a role for PT beyond the walls of the main campus. Under her leadership, PT began to be offered at the Charlestown and Chelsea health centers where therapists quickly became an integral part of community outreach programs. Cerasoli's vision continued to expanded to include PT services at health centers in Waltham, Revere, and Foxboro.

As with other healthcare professions, Physical Therapy embraced the need for evidence-based practice. In the 1990s, the American Physical Therapy Association published, *Physical Therapists Guide to Practice* codifying standard approaches to patient examination and intervention. Former director of PT (1994-1997), Andrew Guccione, PT, served as editor of this seminal text that echoed Ionta's call for patient-specific data and an individualized approach to treatment. MGH staff have been invaluable contributors to (subsequent iterations) of the Guide, and clinical evidence has become a hallmark of physical therapy practice at MGH.

In 2002, with the introduction of the PCS Clinical Recognition Program, Physical and Occupational Therapy embarked on a journey toward a better understanding of how expertise in clinical practice evolves. Under current director, Michael Sullivan, PT, (1997 to present), a trajectory of physical therapy

practice was articulated differentiating clinical aptitude from novice to expert. The Clinical Recognition Program created a common language to describe expectations for clinical practice and reinforced the value of reflecting on clinical experiences and decisions.

With heightened interest in quality and safety across the country, MGH instituted an electronic safety reporting system. Sullivan convened the first PT-OT Quality & Safety Counsel to foster a culture of safety within the department. The PT-OT Quality & Safety Counsel reviews safety events to look for trends and identify opportunities to improve care.

MGH Physical Therapy has a rich history of visionary leadership and exemplary clinical practice driven by innovation, forward thinking, and the changing needs of our patients. Today, the educational requirements for an entry-level physical therapist are a doctoral degree and a year-long internship. Guided by the wisdom of its predecessors and an unwavering commitment to patient-centered values, MGH Physical Therapy is poised to meet all the challenges the future may hold.



Professional Practice Symposium

“Strategies for Creating and Sustaining a Professional Practice Environment”

—by Donna Perry, RN, professional development coordinator

Below left: Gino Chisari, RN, director of the Knight Nursing Center, gives tour of the Bulfinch Building. Right: panel discussion with (l-r): Jones, Drenkard, Ives Erickson, and Ditomassi

On September 18 and 19, 2011, the hospital was abuzz with nursing colleagues from around the world as MGH hosted its first-ever international nursing symposium. “Strategies for Creating and Sustaining a Professional Practice Environment,” was organized by The Institute for Patient Care as a way of sharing strategies to advance professional practice. It was standing room only in O’Keeffe Auditorium with nurses of all role groups

from as far away as Singapore, China, Spain, Norway, and Bermuda, as well as attendees from New England and other US states.

The conference began with a bicentennial tea on the Bulfinch terrace where senior vice president for Patient Care, Jeanette Ives Erickson, RN, presented an historical overview of nursing at MGH. Guests enjoyed tours of the Bulfinch Building, and Ives Erickson signed copies of the commemorative book, *MGH Nursing at Two Hundred*.

Gaurdia Banister, RN, executive director of The Institute for Patient Care, moderated the symposium,

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(Photos by Michelle Rose and Paul Batista)

Nursing Symposium (continued)

which included many memorable presentations. Ives Erickson described the process of developing a professional nursing practice model at MGH. Karen Drenkard, RN, executive director of the American Nurses Credentialing Center, delivered the keynote address. She spoke about the transformative power of nursing leadership and its importance in an institution seeking Magnet recognition.

Dorothy Jones, RN, director of The Yvonne L. Munn Center for Nursing Research, and Marianne Ditomassi, RN, executive director for PCS Operations, spoke about how the professional practice model is evaluated. Jones described the Staff Perceptions of the Professional Practice Environment Survey while Ditomassi explained her recent research with the tool focusing on the 'big three' variables: internal work motivation, autonomy, and control over practice. A panel discussion following the presentations gave attendees an opportunity to ask questions and dialogue with speakers.

Afternoon break-out sessions highlighted several programs developed by MGH nurses. Topics included fall-prevention, patient- and family-focused care, the Nurse Residency Program, evidence-based practice, diversity, and collaborative governance. It was an opportunity to learn about the practical application of these important initiatives as facilitators shared best practices that attendees could implement at their own institutions.

Participants found the symposium engaging and inspiring. One attendee commented, "It was exciting and fulfilling to attend a conference devoted solely to the art and science of nursing."

For more information on the "Strategies for Creating and Sustaining a Professional Practice Environment" symposium, contact Donna Perry, RN, at 4-0340.



Top (l-r): Marianne Ditomassi, RN, executive director for PCS Operations; Jeanette Ives Erickson, RN, senior vice president for Patient Care; and Karen Drenkard, RN, executive director of the American Nurses Credentialing Center. Middle: Dorothy Jones, RN, director of The Yvonne L. Munn Center for Nursing Research; Gaurdia Banister, RN, executive director of The Institute for Patient Care; symposium attendees at tea on the Bulfinch terrace. Bottom: panel discussion

Therapist learns first impressions can be deceiving

Mr. Z is a 50-year-old gentleman, who was referred to physical therapy for chronic back and leg pain. He has an extensive medical history that includes treatment at numerous care facilities and a long list of missed appointments.

My name is Tessa Rowin, and I have been a physical therapist for three years. Working at MGH is a unique opportunity in many ways, one of which is the chance to work with our exceptional patient population. I've had the privilege of meeting patients from all walks of life, from a variety of races, cultures, and ethnicities, and from a wide spectrum of socioeconomic backgrounds. Each experience has helped me develop a greater degree of cultural sensitivity and a better appreciation for how these factors shape an individual—shape, but not define them. Each patient comes to MGH, and specifically to Physical Therapy, with a variety of beliefs and behaviors that can impact the plan of care but doesn't necessarily predict the outcome of physical therapy intervention.

A few months ago, I had the pleasure of meeting Mr. Z, who helped me better understand this phenomenon and incorporate it into my clinical decision-making. As I reflect on the experience, I have a greater appreciation of my communication skills and my ability to forge interpersonal relationships.

Mr. Z is a 50-year-old gentleman, who was referred to physical therapy for chronic back and leg pain. He has an extensive medical history that includes treat-



Tessa Rowin, PT, physical therapist

ment at numerous care facilities and a long list of missed appointments. The assessment that accompanied his referral stated: “Mr. Z has multiple vague symptoms and is convinced he has a lot of medical conditions that have not been verified. His back and leg pain are likely related to sciatica.”

From my chart review, my initial, biased impression was that physical therapy would most likely not make a difference in Mr. Z's symptoms, but a complete evaluation was clearly necessary.

During my initial examination of Mr. Z, I took my usual subjective history attempting to gain information about his symptoms and who he was as an individual. Mr. Z had been unemployed for some time and was currently residing in a group home in the setting of being homeless. He was not a great historian when it came to describing his medical issues, and he had difficulty remembering which activities intensified or im-

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I realized that my initial doubts about Mr. Z based on his background and history with other healthcare providers may have clouded my judgment about his potential to make progress with physical therapy. But my interpersonal skills trumped my doubts when Mr. Z returned after six weeks and showed me he had faithfully performed his exercises.

proved his back and leg pain. His description did not fit a musculoskeletal pattern, and he'd had no success with treatment in the past.

Mr. Z was quite vocal about the difficulty he'd had with other providers, saying he felt he wasn't receiving care that was improving his symptoms. I've treated patients before who had guarded expectations of physical therapy based on past experience, and it usually hindered their PT participation. My pattern-recognition kicked in. My gut told me that my relationship with Mr. Z and my physical-therapy interventions would probably not lead to significant functional gains.

I performed a full examination of Mr. Z, watching him mobilize and testing impairments that could potentially aggravate his symptoms. By the end of the session, I determined that he did, in fact, likely have some changes in his spine that could be contributing to the restrictions I observed. I instructed him in two basic exercises to improve his posture and mobility. Despite my initial skepticism, I spent time with him explaining the role of physical therapy and what my expectations were, both for myself and for him, to optimize his functional outcome and achieve his goals.

At the end of the session, I thought to myself: I wonder if I'll ever see Mr. Z again.

Sure enough, he didn't come to his next scheduled appointments. A week later, I received two messages from Mr. Z telling me he had a conflict and had been unable to keep his prior appointments. He said he didn't have a telephone, but he knew he had one appointment left and was planning to keep it. Mr. Z did not come to that appointment, either. I assumed there was no way to follow up with him as I had no way to contact him.

One month later, I saw Mr. Z's name on my schedule. He showed up for this appointment, and I intended to have a conversation with him about how inconsistency with physical therapy does not lead to positive outcomes. When he came into the treatment area and we began to talk, Mr. Z explained that extenuating circumstances had kept him from his appointments and, in fact, he had been doing his exercises regularly since I last saw him. Furthermore, he explained, the exercises were helping manage his pain. This took me by surprise, and I was quite happy to hear that he'd taken our discussion to heart.

I gave him a progression of exercises to do on his own, and when he returned the following week, he reported resolution of his distal symptoms and said he was making additional improvement, as well.

Unfortunately, I didn't have the opportunity to follow up with Mr. Z as he missed his last appointment and hasn't re-scheduled. However, I imagine, given his motivation and the improvement he achieved with his initial home exercise program, that he is continuing his exercise regimen and may ultimately improve his functional mobility.

This case made me truly appreciate the time I spend educating patients and explaining why physical therapy is a good decision at given times. I realized that my initial doubts about Mr. Z based on his background and history with other healthcare providers may have clouded my judgment about his potential to make progress with physical therapy. But my interpersonal skills trumped my doubts when Mr. Z returned after six weeks and showed me he had faithfully performed his exercises.

Mr. Z taught me not to underestimate the power of the patient-clinician relationship or the importance of advocating for the best interests of the patient (despite encounters they may have had with other healthcare professionals). While I always try to maintain a neutral opinion, pattern-recognition does play a role in clinical decision-making and expectations. I hope I've learned not to rely on initial impressions and to meet all my future patients with an open mind. I know that my ability to educate patients on the role of physical therapy and advocate for appropriate treatment will improve as I advance my clinical skills.

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

What's the old adage? You can't tell a book by its cover? Never is that more true than when talking about patient care. It can be difficult for clinicians to admit that preconceived assumptions affect our judgement, but we've all done it. I thank Tessa for being brave enough to share her narrative, which reminds us to use the powers of observation and clinical decision-making we've all worked so hard to develop. Every patient is different with unique needs and characteristics. As Tessa shows us, our practice needs to be the same.

Thank-you, Tessa.

One celebration of many stars

On Tuesday, October 4, 2011, on the Bulfinch terrace, Patient Care Services held its second annual multi-award presentation ceremony, One Celebration of Many Stars. Senior vice president for Patient Care, Jeanette Ives Erickson, RN, presented seven awards to 12 deserving employees. Said Ives Erickson, “This has been a year of celebration at MGH as we commemorate our bicentennial anniversary. It seems fitting to have this celebration on the Bulfinch terrace in the shade of what, 200 years ago, was the first building of the Massachusetts General Hospital.

“Throughout this year, a phrase in the MGH charter has been frequently quoted: ‘When in distress every man becomes our neighbor...’ This statement remains at the core of who we are.” Ives Erickson expressed gratitude to the patients, staff, and family members whose gen-

erosity and commitment helped make the occasion possible. “Thanks to our donors, we have a robust awards and recognition program. Many of these awards were established in memory of loved ones who worked, or were cared for, at MGH. We are grateful for your continued support, and for choosing to honor your loved ones in this meaningful way. We know these awards are a tribute to dear friends, and we thank you for letting us be part of that.”

Ives Erickson acknowledged the high caliber of nominations and thanked the nominees for their compassion, commitment, and important contributions to our patients and families.

Joined at the podium by Gaurdia Banister, RN, executive director of The Institute for Patient Care, Ives Erickson read excerpts from letters of recommendation as she presented each award. An encapsulated version of those excerpts can be found on the following pages.

The Anthony Kirvilaitis Jr. Partnership in Caring Award

This award recognizes support staff who consistently demonstrate an ability to partner with colleagues to enhance the patient and family experience.

Amy Christmas, operations associate, Neuroscience ICU

Christmas joined the MGH family in 2000 and has been a valued operations associate in the Neuroscience ICU for three years. In her letter of support, Mary Guanci, RN, clinical nurse specialist, wrote, “Amy independently created her nighttime model of care. She makes it her mission to meet families, visit the waiting area frequently, and communicate the needs and concerns of families to the nursing staff.” Christmas says one of the things she likes best about her role is being able to come alongside patients and families and help them navigate through challenging times.

Congratulations, Amy.



Amy Christmas, operations associate, Neuroscience ICU



Mark Clarke, unit service associate, Medical ICU

Mark Clarke, unit service associate, Medical ICU

Clarke has been a unit service associate on Blake 7 for about a year. He was nominated for the Anthony Kirvilaitis Partnership in Caring Award by operations manager, Dan Gordon, who wrote, “Mark treats every patient as if they were his family. He touches their hearts with his humor and humility. Mark never sits still—he’s always moving, always looking for ways to assist patients and colleagues. He takes on difficult tasks and is a leader among his peers.” Clarke has five children and loves nothing more than spending time with his family.

Congratulations, Mark.

Recognition (continued)

The Brian M. McEachern Extraordinary Care Award

This award recognizes employees who exceed expectations and embody extraordinary care through advocacy, compassion, and empowerment.

Sacha Field, CCLS, child life specialist, Ellison 18

Field began her career at MGH in 2004. She was nominated for the Brian M. McEachern Award by pediatric clinical nurse specialist, Mary Lou Kelleher, RN. In her letter of nomination Kelleher wrote, "Sacha is a person whose passion is evident in every part of her being. She is tenacious as she steps up to meet every moment of every day, and this is her greatest gift." Field says the best part of being a child life specialist is helping children and families in crisis through some of life's most unimaginable experiences.

Congratulations, Sacha.



Sacha Field, CCLS, child life specialist, Ellison 18

The Norman Knight Award for Excellence in Clinical Support

This award recognizes clinical support staff for excellence in patient advocacy, compassion, and quality care.

Carrole Caillet, medical assistant, Infectious Disease

In his letter of support, Christopher Shaw, RN, wrote, "Carrole has made it her mission to visit patients who are admitted so they know they're not lost to us. One woman, well known to our clinic, was very ill with AIDS, cardiac disease, and diabetes. When she was hospitalized, she felt alone and afraid and found it difficult to maintain her impeccable appearance. Carrole would go to her room on her own time to bathe her, fix her hair, and do her make-up, helping her maintain her hope and dignity."

Congratulations, Carrole.



Carrole Caillet, medical assistant, Infectious Disease

The Marie C. Petrilli Oncology Nursing Award

This award recognizes oncology nurses for their high level of caring, compassion, and commitment as reflected in their care of oncology patients.

Katie Guerino, RN, staff nurse, Infusion Unit

Guerino gained medical and surgical experience for five years before pursuing her passion in oncology nursing. In her letter of nomination, Joanne LaFrancesca, RN, nursing director of the Infusion Unit wrote, "Katie demonstrates a keen grasp of oncology nursing by listening carefully to her preceptors and mentors, but mostly to her patients. Katie is a relentless patient advocate. Patients are always come first, and she's always the first to volunteer to care for acutely ill patients. She thrives on challenges. Patients instantly feel her compassion, and shortly after, appreciate her competency."

Congratulations, Katie.



Katie Guerino, RN, staff nurse, Infusion Unit



Jolene Marangi, RN, staff nurse, Gynecology Oncology

Jolene Marangi, RN, staff nurse, Gynecology Oncology

In her letter of support, gynecology clinical nurse specialist, Liz Johnson, RN, wrote, "I have observed Jolene provide impressive nursing care to women with acute, complex, gynecological malignancies. She consistently embraces patients with expertise, skill, compassion, and dedication. In all instances, Jolene rises to the occasion, providing individualized care to patients and families while assisting and coaching less experienced staff to provide the same standard of care."

Congratulations, Jolene.

The Norman Knight Preceptor of Distinction Award

This award recognizes clinical staff who consistently demonstrate excellence in educating, precepting, coaching, and mentoring other nurses.

Richard Soria, staff nurse, Medical ICU

Soria chose to become a nurse because he didn't want to be a teacher like his father and three aunts. But in her letter of support, staff nurse, Christine McCarthy, RN, wrote, "Richard has a joy for teaching. He tailors his teaching style to meet the learning needs of his patients and orientees. Richard cheers their successes and celebrates their milestones." Soria is known among his colleagues for his knowledge, respectful approach, and ability to alter his teaching style as needed.

Congratulations, Richard.



Richard Soria, staff nurse, Medical ICU

The Jean M. Nardini, RN, Nurse Leader of Distinction Award

This award recognizes staff nurses who demonstrate excellence in clinical practice and leadership and a commitment to the profession of nursing.

Mary Ellen McNamara, RN, staff nurse, Cardiac ICU

McNamara has been a nurse for 38 years, 36 of those years at MGH. Staff nurse, Sharon Sullivan, RN, wrote in her letter of nomination, "Mary Ellen has an unwavering commitment to patient- and family-centered care and to caring for her colleagues. In her clinical practice, she is the ultimate nurse leader, always striving for the best outcomes for her patients. And when survival isn't possible, she uses every resource at her disposal to bring a peaceful and dignified death."

Congratulations, Mary Ellen.



Mary Ellen McNamara, RN, staff nurse, Cardiac ICU



Bravo! to the stars of Patient Care Services

The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award

This award recognizes direct-care providers whose practice exemplifies the expert application of our vision and values by providing care that is innovative, guided by knowledge, built on a spirit of inquiry, and based on a foundation of leadership and entrepreneurial teamwork.

*Janet Callahan, PT,
physical therapist*

Callahan was drawn to physical therapy because of the science. In her role as physical therapist, she is continuously confronted with challenges that push her beyond her comfort zone. In her letter of support, Rebecca Fishbein, PT, clinical director, wrote, "Janet is a gifted teacher and a talented mentor. She is someone whom others seek out for opinions and guidance because they know she is willing to engage in discussion and think about issues. She has a national reputation and is considered a leader in the care of neurological physical therapy patients."

Congratulations, Janet.



Janet Callahan, PT,
physical therapist



Julie Park, OTR/L,
occupational therapist

*Julie Park, OTR/L,
occupational therapist*

Park knew she wanted to work with children with disabilities when she volunteered as a 'buddy' to children with disabilities in junior high school. In high school, she volunteered in the Occupational Therapy Department at a local hospital, which solidified her decision to become an OT. She loved the idea of helping people regain function in their daily lives. In her letter of nomination, clinical director, Jane Evan, OTR/L, wrote, "Over the years Julie has contributed to the education of the team through her countless in-services and trainings to staff."

Congratulations, Julie.

*Todd Rinehart, LICSW,
social worker*

Rinehart treasures opportunities to develop relationships with patients and families and address their physical and spiritual needs. In the course of his career, he has worked with patients with HIV/AIDS and practiced on hospice units. Rinehart was nominated by nurse practitioner, Connie Dahlin, RN, who wrote, "Todd has a wealth and breadth of knowledge and skills that enable him to be an effective social worker in providing comprehensive care. He shares his humor, humility, and clear thinking in everyday practice and in crisis situations."

Congratulations, Todd.



Todd Rinehart, LICSW,
social worker



Katrina Scott, MDiv,
staff chaplain

*Katrina Scott, MDiv,
staff chaplain*

Scott entered divinity school in 2001 and fell in love with hospital chaplaincy. She completed her seminary education while participating in the Clinical Pastoral Education Program here at MGH. Scott says what she likes best about being a chaplain is the opportunity to be a companion to oncology patients, families, and staff by providing a safe space to reflect on their spiritual journeys, hopes, and concerns. She knows it's a privilege to accompany patients as they deal with life-threatening illnesses.

Congratulations, Katrina.

Pain-management a topic of great interest to many

At recent Blum Center event, clinical nurse specialist, Paul Arnstein, RN, presents, "Communicating with Your Doctor About Pain."

In honor of Pain Awareness Month (September), The Maxwell & Eleanor Blum Patient and Family Learning Center sponsored lectures every Thursday during the month of September focusing on pain-management. The goal was to inform and support MGH patients and the general public. According to Blum Center health educator, Jen Searl, "We usually host a lunch-time talk once a month as part of our National Health Observance Series, but because pain is such a widespread and multi-faceted issue, we thought it warranted an entire series."

On Thursday, September 1, 2011, clinical nurse specialist, Paul Arnstein, RN, kicked off the evening series with a presentation entitled, "Communicating with Your Doctor About Pain." Arnstein stressed the importance of establishing a good relationship with your healthcare provider and gave tips on how to reach a SMART (Specific, Measureable, Attainable, Realistic, Timely) solution for managing pain.

Subsequent lectures were presented by, Ronald Kulich, "Coping with Chronic Pain"; Adam Carinci, MD, "Pain Control after Surgery"; and Shihab Ahmed, MD, "Cancer Pain."

Said Arnstein, "This public education series provided much-needed information about common misunderstandings related to pain and its treatment. This summer, the Institute of Medicine called for widespread education about pain to dispel some common myths and misconceptions. Millions of Americans live with pain and don't know where to turn for current information and reliable advice. This lecture series, offered during National Pain Awareness Month, provided clear, concise, accurate information. Many who attended expressed validation and gratitude at being given strategies for working with healthcare professionals to find the safest, most effective way to improve their comfort and relieve their pain."

After attending one of the lectures, a participant wrote, "I feel more confident, relaxed, and prepared for my surgery at MGH. I learned when and how to talk to my anesthesiologist. Thank-you so much."

All Pain Month lectures were recorded and will be available on-line and on the MGH Patient Education Television Channel.

For more information about events offered by the Blum Center, contact Jen Searl at 4-3823.



(Photo by Paul Batista)

The Norman Knight Visiting Scholar Program

—by Mary Ellin Smith, RN, professional development manager

When conflict prevents professionals from working together as a team... harm can come to patients, to professional relationships, and to morale.

Norman Knight visiting scholar and nationally recognized speaker and author, Judith H. Lower, RN

Conflict is inevitable and not always a bad thing. When two professionals disagree about a course of action, it can be beneficial to engage in a dialogue that allows them to share their views and develop a plan where both of their perspectives are considered. But, when conflict prevents professionals from working together as a team and results in a negative environment for staff, harm can come to patients, to professional relationships, and to morale.

Conflict-management was the theme of this year's Norman Knight Visiting Scholar Program, September 22, 2011. Judith H. Lower, RN, a nationally recognized speaker, author, and former Neuroscience ICU nurse manager at Johns Hopkins Hospital, was this year's visiting scholar. Her visit helped launch the new Conflict-Resolution Program offered by The Norman Knight Nursing Center for Clinical & Professional Development.

In a four-hour workshop, Lower reviewed behaviors and attitudes that can be disruptive and offered strategies for how to address them. The goal, she said, is not to lose the individual to the organization, but to stop the behavior that's preventing the individual from being the best clinician she can be.

At a luncheon of emerging leaders, staff shared specific situations and behaviors that had challenged them, and with Lower's guidance identified ways to handle the situation without attacking the individual.

The day ended with the standing-room-only presentation, "Creating the Ideal Co-Worker in You," in which Lower advised staff to first look within themselves to see if they possess the qualities and behaviors they want to see in others. With humor and honesty, she identified those

qualities and suggested ways they can be used to create a healthy work environment.

The Knight Visiting Scholar Program is possible due to the vision and generosity of Mr. Norman Knight. It enables nationally recognized nurse scholars to come to MGH to share their knowledge and expertise through consultation, teaching, mentoring, and research.

To register for the Conflict-Resolution course offered by the Knight Nursing Center, call 6-311 or email at KPCS@Partners.org.



(Photo by Paul Batista)

Patient-affordability and innovation units

Effective care models must encourage coordination of services, prevention of hospital re-admissions, and efficient use of staff and resources. The idea behind innovation units is that MGH assumes greater responsibility (and risk) for the cost, utilization, and quality of services provided to certain patient populations.

Question: I've read about innovation units in past issues of *Caring Headlines*. What's driving this new concept?

Jeanette: Mounting economic pressure and concern about continued increases in healthcare costs and insurance premiums are shaping how MGH will be reimbursed for care in the future. Effective care models must encourage coordination of services, prevention of hospital re-admissions, and efficient use of staff and resources. The idea behind innovation units is that MGH assumes greater responsibility (and risk) for the cost, utilization, and quality of services provided to certain patient populations.

Question: I thought I read that Partners had a good third quarter financially. So why are innovation units necessary?

Jeanette: Current financial performance is a reflection of current hospital activity and reimbursement rates, both of which are likely to change in the near future. Massachusetts now has a five-year history of near-universal health care, so we've experienced its impact on capacity and the rising cost of care. This is very different from the kind of change we've experienced in the past, and the political debate on this topic is rigorous. In order to position ourselves for success, we need to improve care for patients while being more efficient and cost-effective. We need to be creative and resourceful, and innovation units are one of the strategies we're using to achieve that goal.

Question: Innovation units are going to introduce a new role—attending nurse. Won't that *add* to the cost of the care model?

Jeanette: No additional costs are anticipated. A fundamental principal of innovation units is relationship-based care, and the role of attending nurse is an important part of the model. Relationship-based care means that all care providers have highly effective relationships with patients and families. Attending nurses oversee the coordination of care, enabled by a cohesive, high-functioning team working toward mutually agreed upon patient-centered goals.

Question: How will we know if the concept of innovation units is successful?

Jeanette: It's essential that we evaluate and measure the changes that occur on these units. If a strategy is working (or not working) we want to know as quickly as possible so we can share it with other units or abandon it in favor of a better idea. We're fortunate to have extensive baseline financial, operational, and patient-experience data for comparison. Each innovation unit can select the metric(s) that best reflect the impact of changes being implemented.

In volatile economic times, it's better to be proactive than reactive. And innovation is always a good thing. I'm very excited to see where the ideas generated on these innovation units will take us.

Announcements

October is Health Literacy Month

The Patient Education Committee invites you to:

"Health Literacy: Just the Facts Ma'am"
Speaker: Jen Searl, health educator,
Tuesday, October 25, 2011
12:00–1:00pm
Haber Conference Room

For more information,
call 4-3085.

October is Domestic Violence Awareness Month

"Children Who Witness Partner Abuse,"
presented by Maxine Weinreb,
EdD, Child Witness to Violence
Program at BMC
October 27th
12:00–1:00pm
Yawkey 2-210

For more information,
call 6-7674.

Blum Center Event

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

National Health Observance
Lecture:
"In Our Own Voices"
Thursday, Oct 20, 2011
12:00-1:00pm
Blum Center, White 110

Volunteers from the National
Alliance on Mental Illness will
share their stories about living
with a mental illness.

For more information,
call 4-3823

American Assembly for Men in Nursing

Seeking members for new chapter

The American Assembly for
Men in Nursing (AAMN) is
seeking members to launch a
New England chapter. AAMN
is a national organization that
provides a framework for nurses
to meet, discuss, and influence
factors that affect men in nursing.
The AAMN offers scholarships,
continuing education programs,
and advocates for research and
education for the recruitment and
retention of men in nursing.

Membership is open to all nurses,
male and female. For more
information on joining the New
England chapter, e-mail Gerald
Browne, RN, or visit aamn.org.

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).

Nursing Research Seminar

sponsored by
the Nursing Research Doctoral
Forum

"Recovery from an Acute
Coronary Event: Understanding
the Patient's Journey,"
presented by Laura Rossi, RN

October 27, 2011
1:30–2:30 pm
O'Keefe Auditorium

For more information, call 4-0340.

pink tips book-signing

Author, Ann Murray Paige,
will be on hand to sign copies of
her new book, *pink tips: breast
cancer advice from someone who's
been there*.

Thursday, October 27, 2011
11:00am–1:00pm
at the MGH General Store

Paige is the sister of MGH nurse,
Ellen Silvius, RN, and a former
MGH patient whose battle with
breast cancer was chronicled in
the award-winning documentary,
The Breast Cancer Diaries.

For more information,
call 6-3732.

Pastoral Care Week

October 24–28, 2011

Educational booth
Tuesday, October 25th
9:30am–2:30pm
Main Corridor

Blessing of the Hands
Thursday, October 27th
6:30–8:00am; 11:30am–1:00pm;
3:00–5:00pm
MGH Chapel

In affirmation and appreciation
for the many tasks our hands do
to provide comfort and care.

Sacred Space, Sacred Pace
Labyrinth walk
8:30am–1:00pm

All Are Welcome

Published by

Caring Headlines is published twice
each month by the department
of Patient Care Services at
Massachusetts
General Hospital

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Submissions

All stories should be submitted
to: ssabia@partners.org
For more information, call:
617-724-1746

Next Publication
November 3, 2011

Are you seeking nursing research opportunities?

—submitted by The Yvonne L. Munn Center for Nursing Research

The Yvonne L. Munn Center for Nursing Research serves as a platform for clinically focused nursing research. By providing opportunities to challenge current thinking and identifying new ways to shape and influence nursing

practice, we enhance patient care and promote health and wellness. To date, 30 research awards and eight post-doctoral fellowships have been awarded through the Center.

The Yvonne L. Munn Nursing Research Awards are presented annually to MGH staff to fund nurse-initiated research to advance nursing knowledge and practice. A doctorally-prepared nurse serves as consultant and mentor to each research team. Applicants seeking an Yvonne L. Munn Nursing Research Award must work full-time as a nurse at MGH. Studies must support PCS strategic goals, and all funded research proposals must be approved by the MGH IRB before the study is conducted. Recipients must submit a progress report to the Center annually until the research is completed; completed studies are featured during Nurse Recognition Week each May.

Please note the following important deadlines:

- 12/15/11 Letters of intent and nursing director support are due
- 1/6/12 Initial proposals for the 2012 funding cycle are due
- 1/20/12 Applicants receive feedback following internal review for completeness
- 2/1/12 Final proposals are due

Applicants are informed of funding decisions in April, and awards are publicly announced on Research Day during Nurse Recognition Week. For more information about the Munn Research Awards, contact Paul Arnstein, RN, (at 4-8517) or Marion Phipps, RN, (at 6-5298). Information sessions will be held on October 26, 2011, at 10:00am in the Sweet Conference Room (GRB4); November 1st at 4:00pm in POB-419 (275 Cambridge Street); and November 2nd at 2:00pm in Yawkey 4-810.

The Yvonne L. Munn Post-Doctoral Fellowship in Nursing Research provides doctorally prepared nurse researchers with time and resources to advance their research and develop proposals in areas of nursing inquiry that can be submitted for funding.

The fellowship includes 400 hours of practice time and related expenses over a two-year period up to \$2,500 to allow the fellow to develop a proposal to submit for funding. At the conclusion of the fellowship, the nurse presents his/her research to the MGH nursing community.

The deadline for applications is February 3, 2012. For more information, contact Diane Carroll, RN (at 4-4934) or Mandi Coakley, RN, (at 6-5334).



Returns only to:
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