

Caring

Headlines

November 7, 2013

Thank-you, MGH!

Staff nurse, Jess Kensky, RN,
wants you to know she's on
the road to recovery and
very, very grateful.

(See story on page 4)

At left, Marathon bombing survivors,
Jessica Kensky, RN, and husband, Patrick
Downes, with their multi-talented
service dog, Rescue

One patient, one record, one team

Partners eCare: a single, integrated health-information system

The revenue-cycle portion of the program is being built and tested as we speak; testing is expected to run through May, 2014, and go live (at MGH) in July. The clinical portion of the system will be brought on-line in 2016.

One year after partnering with Epic to design and implement an integrated, electronic health-care system, Partners Health-Care is well into the first phase of the transition. Phase I of Partners eCare, as the new system is called, focuses on the ‘revenue cycle.’ This is the portion of the system that supports administrative tasks such as scheduling patient appointments, billing, coding, and admissions. After months of validation sessions and input from hundreds of MGH employees to guide the design of the new system, the revenue-cycle portion of the program is being built and tested as we speak. Testing is expected to run through May, 2014, and the (revenue-cycle portion of the) program is scheduled to go live at MGH in July. The clinical portion will be brought on-line in 2016.

The guiding principle for implementation of Partners eCare is, “One patient, one record, one team, one Partners statement” — the goal being to allow clinical and administrative information to be shared throughout the Partners network, thereby improving coordination of care, reducing duplication of efforts, avoiding unnecessary tests, and ultimately reducing healthcare costs.



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

Obviously, a change of this magnitude is going to affect Patient Care Services, and I’m sure clinicians and support staff are wondering how. Without going into too much detail at this early stage of development, I can tell you that Partners eCare will be comprised of a number of modules. The modules related to the revenue cycle include:

- *ADT/Prelude*
Prelude is the registration software designed to help coordinate ADT (admit/discharge/transfer) information to improve bed-management, room turn-over processes, and communication. ADT/Prelude will replace PatCom and CBEDS
- *Cadence*
Cadence is the new patient scheduling system designed to be more patient- and family-centered. It will allow schedulers to take patients’ preferences

continued on next page

into account, provide patient-specific instructions, schedule rooms and equipment as well as caregivers, and quickly identify solutions for conflicting appointments. Cadence will replace IDX and PatCom

● *Resolute*

Resolute is the software that will manage inpatient, Emergency Department, and outpatient billing. Using information taken from ADT/Prelude and clinical systems, Resolute will automatically populate appropriate fields and submit claims. A highly sensitive cross-screening function will help accelerate reimbursement and minimize the chance of claims being rejected. Managers and administrators will like having summaries of trends and metrics by payor, type and time period

Implementation of Partners eCare revenue cycle will encompass more than 850 departments. Nearly 8,000 employees will need to be trained as once-familiar technology is replaced by the first installment of our enterprise-wide integrated system.

For many within Patient Care Services, the biggest change when the new revenue cycle goes live will be the shift away from CBEDS for capacity-management. As you know, CBEDS is the system

that supports patient-placement, bed assignments, arrival times, intra- and inter-unit transfers, and discharges. CBEDS alerts unit service associates when turn-over room-cleaning is needed, unit service associates update the status after cleaning, then CBEDS shares that information with the Emergency Department and perioperative services to support continuous patient flow. Partners eCare will support all these capacity-management and room turn-over functions. Naturally, it will be an entirely different interface, and there will be a learning curve, but the overall flow of information and communication will be similar to current practice.

Many PCS staff members have been involved in this process for more than a year, gaining understanding of Partners eCare functionality and providing valuable input into the new eCare system.

We have only to wait another eight months to reap the benefits of their efforts. July, 2014, will be here before you know it.

For more information or to stay abreast of milestones in the Partners eCare implementation, you can go to <https://partnersecare.partners.org/> and sign up for e-mail updates, or call George Reardon, director of PCS Clinical Support Services, at 617-726-5392.

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Road to recovery is arduous but paved with kindness and generosity

If it's been a while since you were reminded of the true meaning of 'Boston Strong,' you need only look into the eyes (and smiles) of staff nurse, Jessica Kensky, RN, and her newlywed husband, Patrick Downes. Since the Marathon bombings that so drastically altered their future, they have been working hard to re-gain some of the normalcy they lost that day. With the support of family, friends, the MGH community, and indeed, total strangers, they're making great strides in that direction.

Kensky and Downes have both been fitted with prosthetic limbs to replace the ones they lost. They've moved into a handicapped-accessible home, and they still deal with daily challenges, including hearing loss, burns, shrapnel-extraction, and a host of other residual issues. A bright spot in their recovery has been the introduction of

a new member of their family—a beautiful black lab, service dog, named Rescue.

Spaulding Rehabilitation Hospital has become Kensky's, "home away from home," where she's met some incredible travelers on this still-surreal journey. Staff and fellow patients have been a source of great comfort and support. Kensky's father has taken considerable time away from his job in California to be with his daughter as she recovers. At a recent therapy session, he observed, "This was obviously a tragic, horrific event. But Jess and Patrick have met the most amazing people because of it. It really makes you realize, there are some very special people in the world."

For many months now, Kensky has struggled with how to thank the MGH community for its 'overwhelming outpouring of support.' The letter on the opposite page is her very eloquent attempt to do just that.

(See letter on next page)



Kensky, literally, gets put through her paces by physical therapist, Michelle Kerr; PT, at the new Spaulding Rehabilitation Hospital in Charlestown.

An open letter to the MGH community from Jessica Kensky, RN

To my MGH colleagues,

This thank-you letter is long overdue, but it's taken some time for me to get to this point. The outpouring of love and support from the MGH community has been a source of great comfort for me and my family during this incredibly challenging time. My transition from a nurse working on Lunder 10 to a patient in a bed at Boston Medical Center was sudden and unexpected. And the response from all of you was immediate and unconditional. I had only been a member of this community a short time, but that didn't prevent thousands of you from treating us like family.

During the first few days after the bombing, and countless times since, so many questions have gone through my mind. Why did this happen? How could so many innocent people have been injured or killed? Why our city? Why Marathon Monday? What's going to happen to me and Patrick, my new husband? Will we recover?

But at some point, we realized the truth of the saying, "One day at a time." So that's what we're trying to do. In many respects, we're only able to do that because of what you've done for us. You've been our friends. You donated literally *thousands* of hours of your precious vacation time. As an employee, I know how important that time is to you and your families. Patrick and I were overcome by your kindness and generosity. Not only does that time enable us to worry less as we pay our bills, it allows me to maintain my status as a full-time employee with healthcare coverage. Your kindness is more than just appreciated, it has been crucial in easing our suffering and ensuring our continued care and financial stability. We've been at a loss as to how to express our gratitude; but please know we are forever in your debt.

Several months have passed since the bombing. Some days are harder than others. But I never lose sight of the precious gifts I have—the love of my husband and our families, the support of friends, the unprecedented generosity of the MGH community, and indeed, life itself.

When I started working at MGH, I knew its world-class reputation for quality care, compassion, and innovation. I was proud to be a member of that team. But the kindness you've shown makes being part of this organization even more special. MGH leadership helped us navigate medical care, locate housing, and never ever wavered in their support. The love and encouragement we received from Ellen Fitzgerald and the staff of Lunder 10 will stay in our hearts forever. To this day, we continue to receive homemade meals, blankets, letters, and visits.

I'm also proud of the role MGH played in caring for other survivors of the Marathon bombings. Their lives are undoubtedly better for the quality of care they received and for the relationships I'm sure they developed with their caregivers here.

As Patrick and I progress in our recovery, there are many challenges ahead. On good days, I thank each of you for giving us the opportunity to focus on the work we need to do to build a new life for ourselves. On difficult days, I find strength in knowing that tomorrow will be another day, and I'll have another chance to try again.

Thank-you, my MGH family, again and again, for your generosity, good wishes, and support.

Sincerely,
Jessica Kensky, RN

PATA Phone Evaluation Program

—by Sharon Kelly-Sammon, RN, and Donna Van Kleeck, RN

The purpose of the Pre-Admission Testing Area (PATA) is to evaluate, assess, and educate patients who undergo elective surgery at MGH. The clinic is open Monday through Friday and sees about 50–60 patients each day. This accounts for approximately 30–35% of surgeries performed at MGH. PATA visits usually involve patients with complex health problems. During these pre-operative visits, patients meet with an anesthesiologist or anesthesiology nurse practitioner and a nurse, and a plan of care is developed for each patient. This includes evaluating their health history and medications and providing patient-specific instructions on how to prepare for surgery. This is also when discharge planning begins.

PATA staff recognized that certain patients could be screened by phone versus coming into the hospital, making the pre-admission interview more convenient and less stressful for patients. PATA nurses developed a comprehensive screening tool with a strong focus on airway- and medication-safety that could be used during telephone interviews. It was decided that the nurse conducting the interview would also perform the Initial Nursing Assessment and begin pre-operative teaching. One PATA nurse would be assigned to the phone program each day.

Surgeons were encouraged to enter eligible patients under 60 into the telephone program. The criteria has since expanded to include older orthopedic patients in good health. 'Routine' pediatric screenings are conducted over the phone as well as cardiac nursing assessments and pre-operative teaching. Currently, phone interviews are only available in English.

Many patients who have surgery at MGH come from other states or countries. The

phone screening program is especially helpful to them. But even patients within driving distance are happy to have the pre-surgical assessment conducted over the phone, saving them a trip into the city.

The program utilizes an on-line assessment tool called, One Medical Passport (OMP). Patients can access OMP from the MGH website (www.massgeneral.org/omp) and complete an electronic questionnaire at their convenience. The information is private and secure, and an added benefit is that patients always have access to their health records. They can update their medical histories any time and download copies to bring to appointments. This preparation by patients allows more time for pre-operative teaching, medication instruction, and answering questions about their surgery.

The PATA phone program is currently staffed by six nurses: Sharon Kelly-Sammon, RN; Michelle McDonald, RN; Karen Miller, RN; Karen Parmenter, RN; Janet Roche, RN; and Donna Van Kleeck, RN. Nurses from the PATA clinic help out during times of increased volume, and Melody Fatal is the operations associate.

Says Parmenter, team leader, "Pre-operative evaluation and education is critical to ensuring patient safety; being able to do that over the phone adds a level of convenience for patients and families."

Under the leadership of medical director, Adam Carinci, MD, the PATA phone program continues to expand. The goal is for all patients to have a PATA encounter prior to surgery to prevent delays and cancellations. Utilizing OMP and calling patients at home are helping to make this goal a reality.

For more information, call 617-643-2555.

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The Connell Nursing Research Scholars Program

—by Susan Lee, RN,

The Connell Nursing Research Scholars Program is made possible through the generous gift of the William F. Connell Family. The program provides opportunities for participating MGH scholars to be mentored by national nursing leaders. On Wednesday, October 16, 2013, one day before receiving the American Academy of Nursing's highest honor by being named a Living Legend, Jean Watson, RN, came to MGH as a visiting Connell research scholar.

(L-r): Christine Gryglik, RN; Jean Watson, RN; and Stephanie Ball, RN



(Photo provided by staff)

During the course of the day, Watson met with the Connell nursing research scholars, the Doctoral Forum, and AgeWISE nurses. In her presentation in O'Keefe Auditorium, she challenged attendees to participate in 'whole systems change' by placing caring and healing at the center of our work with humanity. "A caring moment," she said, "is a heart-centered, love-filled energetic field of presence, intentionality, and authenticity."

Historically associated with her grand theory of human caring, Watson is now widely known for the ten Caritas processes that describe caring-healing ways of being with patients, families, and staff. She called upon attendees to transform health care by moving from the 'case' to the 'face'; from medical diagnosis to the *meaning* of the illness; from performance to presence; from industrial models of health care to creative, mature professional models of caring-healing. She attributed many of her beliefs to Florence Nightingale, "whose vision of health care is yet to be fully realized."

Watson described her collaboration with Magnet hospitals, many of which have embarked on whole-system transformations, resulting in measurable impact on HCAHPS scores and other key indicators. She invited staff to re-discover their own practice of human caring, to document caring practices in patients' records, and to conduct research on caring patient outcomes. Watson has collaborated with Susan Lee, RN, in her research proposal to test the feasibility of a family-support intervention bundle in the ICU. Lee has submitted the proposal to the National Institute of Nursing Research.

For more information, call Lee at 3-0431.

A glimpse into the care of babies with neonatal abstinence syndrome

Within a month, our first neonatal abstinence syndrome (NAS) patient was admitted. I became her primary nurse. Baby J was just ten days old when she was transferred to our unit.

My name is Caroline Connell, and I have been a nurse at MassGeneral Hospital for Children for six years. I currently work on the Ellison 17 Pediatric Unit. I've cared for patients with a wide variety of diseases and injuries, but none stand out more than patients with neonatal abstinence syndrome (NAS). NAS refers to infants who were exposed to narcotics while in utero and experience withdrawal symptoms when they come into the world. Some do well without medical intervention, but most require narcotics to help wean off the drugs they've been exposed to.

In the fall, our clinical nurse specialist advocated for staff nurses to become 'super users' at transitioning NAS infants into our unit and being a resource for other staff. Knowing how vulnerable these patients were, I knew I could make a difference in this role, so I volunteered.

The first step was to meet with the clinical nurse specialist for the Special Care Nursery to be educated about this patient population and the medications we'd be administering. After receiving formal education, I asked if I could shadow other nurses as they cared for these infants. I spent some time preparing myself and thinking about questions I wanted to ask. When the day came to shadow another nurse, I was like a sponge. I took notes on how they cared for these babies, the environment, supplies, and especially the discharge checklist and paperwork they used to ensure they completed all the necessary tasks



Caroline Connell, RN, pediatric staff nurse

for a safe discharge. Afterward, I was excited to put my new knowledge into practice. I wanted to share my knowledge with everyone on my unit. So I worked with my CNS to create a HealthStream course that would be comprehensive but not overwhelming. I reached out to Social Work, Case Management, Physical and Occupational Therapy, and the Chaplaincy. I quickly became the resource person whenever anyone had a question about NAS.

One challenge when caring for NAS babies is the need to constantly readjust medications based on frequently changing withdrawal scores. It's not unusual for NAS babies to be living with single parents, residing in substance-abuse treatment facilities, or be in the custody of the Department of Children and Families (DCF). Parents need a lot of support and education, as this patient population is very delicate.

Within a month, our first NAS patient was admitted. I became her primary nurse. Baby J was just ten days old when she was transferred to our unit. No parents accompanied her, so I spent some time

continued on next page

I was off for a few days prior to Baby J's discharge, but I was there the day she was scheduled to go home and was able to help with discharge teaching. The next day, I made a follow-up phone call, and Mom told me how confident she was feeling and how well Baby J was doing.

getting to know her and reading about her medical and social situation. I made her as comfortable as possible with a quiet, dark environment and minimal stimulation. Later, Baby J's mother and father arrived, and it was obvious how much they loved her and how much they needed to learn. This was especially evident when the dad came frantically looking for help because his daughter had dirtied her diaper and he didn't have any idea what to do. I calmly walked him through the task, and afterward he was very proud. I oriented them to the unit, explained our plan of care for Baby J, and developed a time line for how we could conduct the necessary teaching.

I slowly got to know Baby J's parents. They were loving and attentive but they had significant social barriers that put them at risk. Both Mom and Dad were recovering drug addicts who attended a methadone clinic every morning. Mom disclosed that at eight months pregnant she had used cocaine. She felt guilty knowing her baby was going through this because of her drug use. But both parents wanted to give their daughter a loving home environment, so we worked together to get them off to the best possible start.

We created a routine as close to their home routine as possible so when they brought their baby home, they'd feel confident in their ability to care for her. We went over bathing, car seats, CPR, safe sleeping, etc. They were very attentive but something was troubling them. Mom's 9-year-old daughter (who lived with her grandfather and spent weekends with her) was having trouble adjusting to the idea of a new baby as weekends were the only time she had with her mom. The daughter had not met the baby yet, as children aren't allowed in the nursery. We developed a plan to have the daughter draw pictures and cards for her sister to decorate her hospital room and come in to meet her sister one weekend. The parents were ecstatic. That weekend, the sister came in to visit. She was apprehensive at first, but slowly over the next few weeks, fell in love with her sister and became a big helper.

It was necessary to frequently assess Baby J using the Modified Finnegan Neonatal Abstinence Score Sheet. Every two to four hours, depending on the previous score, I would assess her for a long list of withdrawal symptoms including tremors, seizures, spasticity, mottling, fevers, poor feeding, vomiting, tachypnea, etc. Baby J had been doing well, and every day we slowly reduced her narcotics.

One day, at the start of my shift, I noticed her scores starting to increase. She was exhibiting poor feeding, poor sleeping, spasticity, increased respiratory rate, and mottled skin. I did a full assessment and although she seemed stable, I worried that she wouldn't be able to sustain such a high respiratory rate much longer. I quickly reviewed her medications for the past 24 hours. I paged the intern and advised that I thought Baby J needed an extra dose of medication, a boost on her narcotic dose. I got the medication so it would be readily available if the doctor agreed with my assessment. She did, and I administered the extra dose of narcotic. Baby J responded, and her respiratory rate came back down. We adjusted her narcotic dose for the day, and I coordinated her care with the rest of the team to ensure minimal interruptions.

I was off for a few days prior to Baby J's discharge, but I was there the day she was scheduled to go home and was able to help with discharge teaching. The next day, I made a follow-up phone call, and Mom told me how confident she was feeling and how well Baby J was doing. Staff came together to review the case and share feedback so we could all learn from the experience. We've had several NAS patients since Baby J, and although I wasn't their primary nurse, I continue to be a resource for staff.

I observe patients and parents caring for their babies, and it's evident how well staff are doing and how confident they feel caring for NAS babies.

Though we don't see NAS babies frequently, I feel my colleagues and I are helping patients and families. We're making a difference for a patient population we hadn't seen before.

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

What's striking about this narrative is what's missing—judgment. Caroline didn't focus on the drug abuse or judge Baby J's mom in any way; she saw the love they had for their baby and the commitment they showed to learning how to care for her. Caroline gently interjected herself into this family and helped them work together to recover and rebuild. Not only did we see Caroline's clinical skill and decision-making, we got a glimpse into knowledge-acquisition and practice-improvement on her unit and greater awareness of the medical and psycho-social issues faced by this patient population.

Thank-you, Caroline.

Espousing the benefits of innovations in care-delivery

—by Barbara Blakeney, RN, innovation specialist

The American Organization of Nurse Executives' Center for Innovation and Transformation (CIT) initiative strives to improve patient care and employee satisfaction through collaboration, innovation, and leadership-development. The CIT initiative teaches inter-disciplinary teams how to innovate and then evaluate the changes effected through innovation.

Hospitals across the country are working 'together' as a learning community in a two-year program that has its root in the groundbreaking, Transforming Care at the Bedside initiative. And MGH is one of those participating hospitals.

On September 19, 2013, the CIT team on Phillips 21 hosted nursing leaders from the Boston Health Care for the Homeless Program (BHCHP). Pooja Bhalla, RN; Barbara Giles, RN; and Cheryl Kane, RN, nursing director

of McInnis House, toured Phillips 21 and met with staff to learn more about what it means to be part of the CIT program. McInnis House, a respite program for homeless men and women, is considering applying to become part of the CIT program. If successful, McInnis House would be the first non-hospital-based program to participate.

The visit was coordinated by Barbara Blakeney, RN, innovation specialist and vice-chair of the BHCHP Board of Directors. The BHCHP team toured the unit, met with Kristen Nichols, RN, and Michelle Connolly, RN, key leaders of CIT activities, and learned how the CIT program has helped drive a culture change on Phillips 21. Nursing director, Adele Keeley, RN, clinical nurse

specialist, Julie Cronin, RN, and an enthusiastic core team described how helpful CIT projects have been in bringing about a change in culture to one that's more engaged in finding solutions and testing and implementing change quickly and effectively.

The visit reinvigorated interest in the BHCHP team to become part of the CIT program and to be mentored by Phillips 21 staff throughout the process. For more information on the CIT initiative at MGH, call Barbara Blakeney, RN, at 4-7468.



(Photos by Paul Batista)



Above: Barbara Blakeney, RN, innovation specialist, describes Innovation Unit work to BHCHP team. Below: Phillips 21 team shares benefits of participating in Center for Innovation and Transformation program.

Trichotillomania

raising awareness through education and research

—by Jim McCarthy, operations manager

Every year since 2007, I've requested that Governor Deval Patrick issue a proclamation designating the first week of October Trichotillomania Awareness Week; and every year his office has complied. The occasion passes unnoticed by most people, but for those of us who know about trichotillomania from personal experience, the proclamation holds special significance. What was once an unspeakable secret is slowly becoming more understood through education, research and public awareness.

In October of 1992, I was stunned to see an article in an MGH publication, entitled, "Unravelling the Mystery of Compulsive Hair Pulling." For the first time in my life I was reading a description of a condition that had confused and troubled me since 1965 when I experienced Trichotillomania for the first time. The article put a name to my secret and let me know I wasn't alone or 'crazy,' a label I had applied to myself since age 13. And more importantly, it told me the disorder was being researched. Trichotillomania (TTM) is an "overwhelming compulsion to pull out one's hair. Once thought to be extremely rare, it now appears to be much more common than previously believed." Research suggests that TTM has many characteristics of other obsessive-compulsive disorders such as body-focused repetitive behavior and Tourette's syndrome.

TTM sufferers pull hair excessively from their scalp, eyebrows, and eyelashes, which among children can lead to teasing, ridicule, shame, and isolation.

I learned that TTM was being researched at MGH, by Nancy Keuthen, co-director of the Trichotillomania Clinic and Research Unit and chair of the Scientific Advisory Board of the Trichotillomania Learning Center, the only organization in the world that focuses on outreach, treatment, and research, into trichotillomania.

As a 13-year-old, I remember the numbing, stomach-clenching fear that overcame me as I became convinced I was crazy. I didn't dare tell anyone, but I couldn't hide it either, as it was very obvious something was wrong. With visible bare patches, I felt set apart from everyone else.

At some point, my chronic hair-pulling slowed, but I had developed certain traits that I still have today. I'm hesitant to initiate first contact with people, wary when people speak to me or walk toward me. I prefer to stand on the periphery, even as my TTM is under control. I interact with others, carefully maintaining deliberate, conscious, and measured relationships.

In 2007, I participated in an informal group. Psychiatrist, Jennifer Ragan, MD, encouraged open communication, and with her support, I was able to tell the group about my condition. Everyone was supportive and encouraging, and I soon felt the burden of my secret begin to melt away. Speaking about it, actually telling someone face-to-face, diminished its power over me. I'll always be grateful to Dr. Ragan for providing such a safe and supportive environment. And I used that feeling of liberation to finally tell my brother and sister about what had been a mystery to them for so many years.

I wrote a paper describing my experiences for TLC (Trichotillomania Learning Center) magazine and posted it on allnurses.com, where it generated comments from many people who recognized these symptoms in their own children and had no idea what it was. It's estimated that every teacher will have at least one student with trichotillomania at some point in their career. School nurses, guidance counselors, even barbers and hair stylists should be aware of TTM and be able to recognize the symptoms.

For more information, go to: www.trich.org or allnurses.com.

Cronin receives GEM excellence award for clinical inpatient nursing

The award recognizes nurses who demonstrate superior clinical knowledge and skill and apply them in ways that impact quality of care and patient outcomes.

On October 7, 2013, clinical nurse specialist, Julie Cronin, RN, was named the national recipient of the 2013 GEM Excellence Award for Clinical Inpatient Nursing by Nurse.com. The award recognizes nurses who demonstrate superior clinical knowledge and skill and apply them in ways that impact quality of care and patient outcomes.

In her letter of nomination, nursing director, Adele Keeley, RN, described Cronin as, “a well-rounded, hard-working nurse who is kind and generous in her personal and professional life.”

Cronin co-created the New Graduate Nurse Mentoring Program on her unit where experienced nurses mentor novice nurses and remain a resource to them throughout their careers. The program includes educational sessions on topics such as pain-management, nurse-patient relationships, conflict-management, delegation of responsibilities, and common clinical issues.

Cronin works closely with the Chaplaincy to support staff as they care for complex oncology patients; she organizes memorial services to pay tribute to patients who pass away on the unit.

Phillips House 21 has made measurable improvements in the recent past due to unit-based education in innovation and care re-design led by Cronin. The program, Care Innovations and Transformation, (CIT), sponsored by the American Organization of Nurse Executives, (AONE) has had an impressive impact on the unit’s patient-satisfaction scores with noise-reduction leaping from 50%–86% in less than a year.



Julie Cronin, RN, clinical nurse specialist recipient of the 2013 GEM Nursing Excellence Award for Clinical Inpatient Nursing

Cronin was instrumental in developing an evidence-based, post-discharge phone call program. She’s helped implement more than 20 innovations, including a unit-based SharePoint site to streamline education; a formalized orientation for chemotherapy patients; and changes in medication-administration to give nurses more time to complete assessments and attend daily huddles.

Cronin has made countless presentations and been recognized for outstanding care on numerous occasions. Last year, she participated in a two-week mission to the Dominican Republic to bring nursing care and aid to under-served populations in the area.

The GEM Nursing Excellence Awards are held in nine regions throughout the country, and finalists are selected in six categories for national consideration. Congratulations to Julie Cronin on receiving this prestigious honor and for bringing recognition to herself and MGH with her distinguished service.

Implementation of the Affordable Care Act

and what it means for MGH patients

Most people who already have health-insurance coverage won't experience any changes at all... some individuals with low income who weren't eligible for MassHealth before may be eligible to apply under the new law.

Question: I know 'Obamacare' is scheduled to roll out in 2014. What does that mean for MGH patients?

Jeanette: You're right that the Affordable Care Act (ACA), commonly referred to as Obamacare, will reach some major milestones in 2014. The ACA is based on healthcare reforms enacted in Massachusetts in 2006, so the changes we'll experience won't be as dramatic as in other states. Most people who already have health-insurance coverage won't experience any changes at all. But *some* things will have to change so that Massachusetts is compliant with the new federal law making affordable health-insurance coverage available to more people.

Question: Like what, for example?

Jeanette: One change is that new qualified health plans (QHPs) will be available for individuals to purchase through a state-wide exchange—The Health Connector. Some state plans will be eliminated. Individuals currently covered by Commonwealth Care or the Medical Security Plan (for those receiving unemployment compensation) will either be moved to MassHealth or need to purchase a QHP. State and federal subsidies may be available to assist those with low to moderate incomes.

Another example is the expansion of Medicaid (MassHealth). Under current rules, only certain low-income individuals are eligible, such as children, parents, seniors, and people with disabilities. In states like Massachusetts that have chosen to participate in

Medicaid expansion, low income individuals will be eligible even if they don't fall into one of these categories. So able-bodied, low-income adults with no children may qualify.

Question: What do patients need to know?

Jeanette: Most patients' coverage will not change. Those currently enrolled in insurance plans that will be changing (such as Commonwealth Care) should receive letters and/or phone calls from the state informing them about the steps they need to take to choose new coverage. Remind patients to watch their mail and read this important information.

Individuals who don't have health coverage and who make up to approximately \$46,000 per year (or a family of four making approximately \$94,000 per year) may be eligible for new federal tax subsidies to help pay for health insurance. They can shop for coverage on the Health Connector website: MAhealthconnector.org, until March 31, 2014. As mentioned above, some individuals with low income who weren't eligible for MassHealth before may be eligible to apply under the new law.

Question: Where can patients go to learn more?

Jeanette: Patients who don't have health-insurance coverage can call MGH Patient Financial Services at 617-726-2191. Those who receive calls or letters from the state should respond as instructed.

Announcements

Senior HealthWISE events

Lecture Series

"Atrial Fibrillation of the Heart"
Thursday, November 7, 2013
11:00am–12:00pm
Haber Conference Room
presented by: Nandita Scott, MD
Atrial fibrillation is a condition found in almost 10% of patients over 80. This presentation will review the causes and treatment of this common cardiac rhythm problem.

Special event

Boston Conservatory Cabaret
Enjoy a wonderful theatrical performance by Boston Conservatory musical-theater students performing songs from favorite Broadway musicals

Monday, November 11th
2:00–3:00pm

Thier Conference Room
(RSVPto: 617-724-6756)

Lecture Series

"Swallowing Over Sixty"
Thursday, November 21
11:00am–12:00pm
Haber Conference Room
presented by: Stacey Sullivan, SLP-CCC, speech-language pathologist
Sullivan will discuss normal swallowing changes in aging, signs that you may have a swallowing problem, and evaluations by a speech pathologist. She will give tips for managing common problems such as swallowing pills and some preventative measures.

For more information,
call 4-6756.

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? Wondering about the time line?

To read the latest articles about this work, or if you have a cost-reduction idea or better way to deliver patient care, visit the new MGH/MGPO intranet site:

<http://priorities.massgeneral.org>

Munn Doctoral Fellowship in Nursing Research

Call for Applications

The Yvonne L. Munn Center for Nursing Research is expanding the current Munn Post-Doctoral Fellowship to support pre-doctoral nurses completing dissertations. The Munn Doctoral Fellowship now accepts applications from both pre-doctoral dissertation candidates and post-doctoral nurses actively advancing a program of research. The fellowship provides a buy-out of time and resources to advance the scholar's research agenda.

The fellowship provides added time and resources for pre-doctoral candidates to accelerate completion of their dissertations and post-doctoral applicants to advance their research programs.

Concept papers are due January 19, 2014; final applications are due February 7, 2014.

For more information, contact Diane Carroll, RN, at 617-724-4934 or Amanda Coakley, RN, at 617-726-5334, or visit the Munn Center website at: <http://www.mghpcs.org/munncenter/>.

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

ACLS Classes

Certification:

(Two-day program)

Day one: lecture and review
Day two: stations and testing)

Day one:
November 7, 2013
8:00am–3:00pm

Robbins Conference Room
Founders 2

Day two:
November 8th
8:00am–1:00pm
Robbins Conference Room

For information, contact Jeff Chambers at acls@partners.org

Classes are subject to change; check website for current dates and locations.

To register, go to:
http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf.

NERBNA

(New England Regional Black Nurses Association)

Call for nominations

Consider nominating a colleague who consistently excels in the areas of:

Research
Education/Teaching
Leadership
Nursing Practice

Applications must be submitted by November 15, 2013. Awards will be presented, Friday, February 7, 2014.

For more information, call Gaurdia Banister, RN, at 4-1266.

MGH Institute offers PhD in Rehabilitation Sciences

The PhD in Rehabilitation Sciences at the MGH Institute of Health Professions is designed for clinically certified healthcare professionals wishing to acquire advanced knowledge and skills to conduct clinical research with an emphasis on assessing clinical outcomes in rehabilitation.

Full funding is available for as many as six qualified candidates. For more information, e-mail mlnicholas@mghihp.edu or go to: www.mghihp.edu/phd.

MGH to launch Emergency Alert System

MGH staff can now register for the new Employee Alert System, which officially launched November 1, 2013. The voluntary, subscription-based, alert system gives employees the opportunity to sign up to receive important hospital messages through text messaging, e-mail, and/or phone calls.

“I don’t have to remind the MGH community,” says David Reisman, senior administrative director for Emergency Preparedness, “that we’re often at the center of local and regional emergencies—from natural disasters to terrible acts of violence, even terrorism.” In an effort to enhance communication and ease fear during emergency situations of any kind, the hospital is establishing a new alert system that will allow rapid-cycle communication of essential information.

Reisman is quick to explain that the system is separate from the existing Emergency Notification System that’s initiated by the Hospital Incident Command System. It also doesn’t take the place of traditional communication, such as all-user e-mails or the severe weather hotline. “This is another way to ensure that staff have access to up-to-date information in the event of an emergency,” says Reisman.

Enrollment in the program is now open. Employees are not automatically enrolled; you must initiate the process. To sign up to receive emergency alerts:

- go to www.notifind.net/NF_SUBSCRIBE and click on the ‘Sign up’ link
- fill in the registration form and create a username and password (password must be a minimum of eight characters)
- click ‘Register’
- an e-mail will be sent to the address you provide with further instructions
- click the activation link in the e-mail you receive
- enter your username and password and click ‘Activate account’
- fill in your contact information and click ‘Continue’
- check the locations you’d like to be notified about in the event of an emergency. This refers to notifications about MGH or any other Partners entities
- select how you’d like to receive emergency alerts, including one or all of the following: telephone, e-mail, or text message
- click ‘Finish’

For more information, call David Reisman, at 617-724-4163.

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Submissions

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

Next Publication

November 21, 2013

Inpatient HCAHPS Results 2012–October, 2013

Measure	2012	2013 YTD	Change (2012 - 2013 YTD)
Nurse Communication Composite	81.0	81.5	+0.5
Doctor Communication Composite	81.6	82.2	+0.6
Room Clean	72.9	74.3	+1.4
Quiet at Night	48.5	50.3	+1.8
Cleanliness/Quiet Composite	60.7	62.3	+1.6
Staff Responsiveness Composite	64.9	64.3	-0.6
Pain Management Composite	71.9	71.9	No Change
Communication About Meds Composite	64.0	64.6	+0.6
Discharge Information Composite	91.2	91.3	+0.1
Overall Rating	80.1	80.7	+0.6
Likelihood to Recommend	90.5	90.3	-0.2

MGH continues to perform well on patient-experience metrics, with the most notable increases since last month's report coming in Nurse Communication and Overall Rating of the Hospital. Almost every indicator has increased over last year's results.

Data complete through August 31, 2013
All results reflect Top-Box (or 'Always' response) percentages
Pull date: October 16, 2013



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