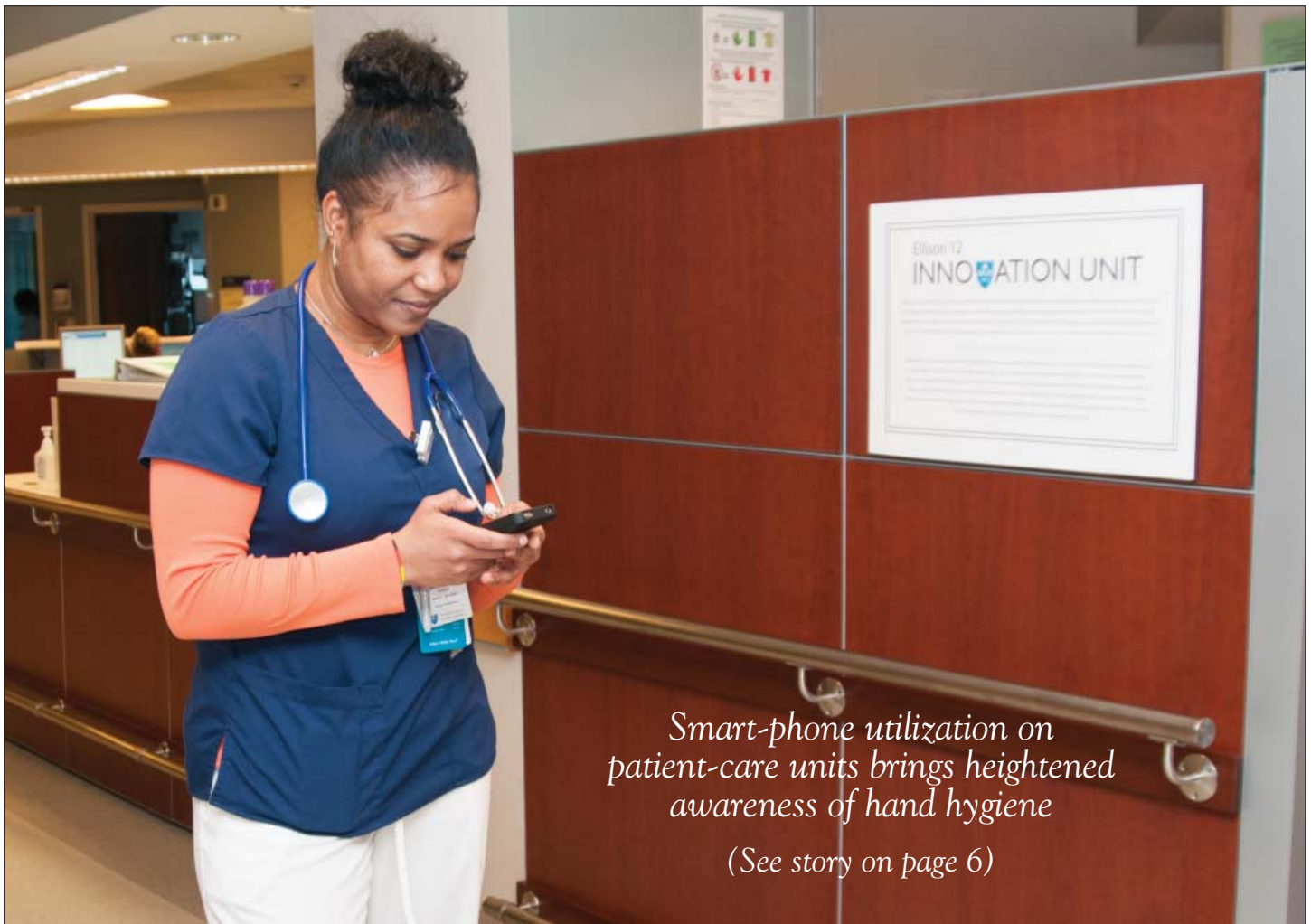


Caring

Headlines

March 20, 2014

Hand hygiene and mobile devices



*Smart-phone utilization on
patient-care units brings heightened
awareness of hand hygiene*

(See story on page 6)

On Ellison 12 Medical Unit, staff nurse, Venice Scott, RN, uses smart phone to text a colleague. Data shows that smart-phone utilization has improved communication on Innovation Units.

PCS goals align with MGH Strategic Plan

I think you'll agree that our PCS goals are well aligned with the MGH strategic plan and that both our agendas seek to improve the patient experience, enhance the quality of care, and ensure equitable access for all.

In the January 9, 2014, issue of *Caring Headlines*, I shared the goals and tactics of Patient Care Service's strategic plan for the coming year. The culmination of a comprehensive strategic planning process, numerous retreats and discussions, and informed by our mission, vision, and values, the broad goals we set for ourselves include:

- Goal #1:** Optimize the patient experience ensuring a coordinated, standardized, evidence-based model of care-delivery throughout the entire Patient Journey
- Goal #2:** Implement and evaluate consistent use of standardized documentation tools to support the processes that optimize the patient experience and outcomes
- Goal #3:** Create a welcoming, accessible environment that attracts, retains, and develops a culturally competent workforce while embracing the diversity of our patients, their families, our employees, and the communities we serve

In a parallel effort, after almost two-years of deliberation, the MGH/MGPO recently approved their strategic plan for the coming year and the coming decade. The plan recognizes the need to deliver the highest quality care, control costs, and enhance all aspects of our mission, including clinical care, education, research and service to our local and global communities. It's an ambitious plan that supports our work with population health-management; enhanced access to care; coordinated, team-based care through



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

multi-disciplinary care centers, and several new initiatives, as well.

I think you'll agree that our PCS goals are well aligned with the MGH strategic plan and that both our agendas seek to improve the patient experience, enhance the quality of care, and ensure equitable access for all.

The MGH Strategic Plan:

- **Re-design the model of care.** Building on care re-design, Innovation Units, and other initiatives, optimize the patient experience and increase efficiency, including focusing on length of stay, re-admissions, appropriateness of care, and access
- **Optimize center-based care.** Multi-disciplinary centers will use care re-design to enhance quality and efficiency to offset risk contracting and bundled payments
- **Optimize population health management.** Ensure better quality of care and a reduction in medical expenses with specific strategies tailored to primary

continued on next page

As members of the MGH community, PCS clinicians and support staff play a vital role in the execution and success of both strategic plans... I know I can count on your continued leadership and engagement as we strive ever harder to ensure the best possible care for our patients and families.

- care, specialty care, post-acute care, and patient-engagement
- *Transform chronic disease care.* Develop and introduce new treatments to reduce the prevalence of diabetes, obesity, substance-use disorders, and tobacco use, which represent some of the greatest factors contributing to health burdens and costs
 - *Expand strategic services and network-development.* Create a new center, tasked with growing patient volume from more distant locations for specialized services such as enhanced primary care, executive health, and international health
 - *Establish an MGH research institute.* Create a ‘front door’ to research to attract and engage industry and philanthropy, facilitate enhanced support for researchers, and guide MGH science
 - *Facilitate translational research.* Collaborate with industry to move discoveries from research to clinical therapy
 - *Develop new models for medical education.* Develop a core group of clinician educators to help prepare future clinicians to provide high-quality, efficient, team-based care in our re-designed care-delivery model
 - *Leverage MGH patient data.* Develop central registry support to facilitate robust measurement and evaluation of specific conditions and populations

- to ensure success under new payment models and leverage MGH biobank to help monitor and evaluate clinical outcomes
- *Re-energize workforce development.* Focus on education across all career stages and disciplines by piloting and expanding new models of practice, continuing education, and inter-professional education.
 - *Intensify diversity efforts.* Develop and set institution-wide expectations around diversity to enable better and faster decisions and to better serve our increasingly diverse patient population
 - *Strengthen internal governance.* Coordinate population-health and episodic-care agendas, re-structure the Executive Committee on Teaching and Education, and create a new executive committee to oversee all aspects of the MGH community mission

As members of the MGH community, PCS clinicians and support staff play a vital role in the execution and success of both strategic plans. These goals have been carefully crafted to position MGH to meet the financial and healthcare challenges of the next decade and beyond. I know I can count on your continued leadership and engagement as we strive ever harder to ensure the best possible care for our patients and families.

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A celebration of mentoring

Hausman mentor, Raymond Hawkins, honored in ceremony 'fit for a king'

—by Erick Erius and Deborah Washington, RN

Guest of honor, Ray Hawkins in the attire of an African king, because in African culture, elders are revered as kings.

Black History Month took on special meaning this year. On February 25, 2014, the MGH community came together to celebrate the importance of mentoring, and they did so by paying tribute to one of MGH's most prolific mentors, cardio-pulmonary perfusionist, Raymond Hawkins. Hawkins, known by many as, 'Hawk,' began his career at MGH in 1963 after finishing a stint

in the US Navy. Military service was a great opportunity for a young man who had grown up on a tobacco farm in North Carolina; and even more impressive when you consider that Hawkins had never learned to swim.

As a Hausman mentor, Hawkins frequently tells his story to young people as an example of how progress can be made when opportunity and hard work come together. Hawkins' primary job in the Navy was as a boilerman tender engineer. He also excelled in track and field and boxing where he became USA international service champion for three consecutive years in both sports.

After leaving the Navy, Hawkins came to Boston and was hired by MGH as a window washer. He only intended to stay in Boston for a few months, but he enjoyed the work and his co-workers and decided to stay. With the help of an acquaintance from a stint at the National Institutes of Health, Hawkins rose to the position of cardiac surgical operating room technician, a role he held for 11 years. He learned to take down, clean, and reassemble the equipment. He assisted cardiac perfusionists during open-heart surgery. And in 1974, says Hawkins, "They offered me the job of cardio-pulmonary perfusionist. I accepted the position, and I still hold it today."

As part of his mentoring, Hawkins points out the importance of being noticed, especially when you set goals for yourself and know what direction you want your career to take. Challenging opportunities are sought by those who have overcome challenges in the past. Professionalism, strong working relationships, providing guidance to others, and demonstrating a genuine desire to 'give back' are qualities that people notice.

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Black History Month (continued)

During Black History Month it is especially important to acknowledge what is unique about being an African American who mentors other African Americans. The intention to help, being passionate about giving and receiving wisdom, and building mutually rewarding relationships are all part of the African culture. It's challenging to find ways to be noticed in an organization as large as MGH if there's no infrastructure to support the achievements of a diverse workforce. Building a career from scratch is a complex endeavor that involves finances, work schedules, social support, and academic excellence.

It makes you appreciate how a young African American man can go from a tobacco farm to the US Navy; from window washer to nationally recognized cardio-pulmonary perfusionist.

In his remarks, keynote speaker, Erick Erilus, noted, "I was invited to share my thoughts about Mr. Hawkins not only out of a desire to honor him, but because I know why mentoring is so important. In my position with my faith organization, I work with black youth. I teach those I mentor the importance of a covenant relationship with the Heavenly Father. I teach them to love, respect one another, and obey the commandments. These principles are important in African American culture and play a part in how young people approach challenges and hold onto hope for the future.

"Mr. Hawkins is known for his willingness to lend a hand to everyone. He advocates for the future of minorities interested in the field in which he excels. He makes it clear that he does not want to be the first and last African American cardio-pulmonary perfusionist at MGH. Mr. Hawkins teaches others to never give up on their dreams. In February, 2009, Mr. Hawkins was honored with the John H. Gibbon, Jr. award by the American Society of Extracorporeal Technology, the highest honor in the field of Perfusion. This annual award honors candidates who make a significant contribution to the cardio-pulmonary discipline juxtaposed with extracorporeal circulation.

"If there is a formula for mentoring young African Americans it would be this:

- Remind yourself how easy it is to miss the chance to make a difference in the life of someone who does not share your background, your identity, or your position in life
- Remind yourself to look at your network of friends, co-workers and employees, and the cultural backgrounds of those who make it up and see if there is someone there who needs an opportunity that you can provide
- Remind yourself that mentoring ethnic minorities is a call to action and a way to open or close a door to possibilities. You may be the key to that door.

"I know I speak for all who came today to honor this man when I say, 'God bless you Mr. Hawkins.'"

For more information about this year's Black History Month event, call Deborah Washington, RN, at 617-724-7469.

Clockwise from top: Hawkins with PCS director of Diversity, Deborah Washington, RN; keynote speaker, Pierre 'Erick' Erilus; attendees line up to pay their respects to Hawkins; performer/educator, Ukumbwa Sauti.



(Photos by Michelle Rose)



Smart phones call for smart handling

Hand hygiene and the introduction of smart phones on patient care units

According to a report issued recently by Partners Information Systems, 644,451 text messages were sent by staff using hospital-issued Voalte smart phones during the month of January. And that doesn't include phone calls, which usually account for about 5% of smart-phone utilization. Data tells us that smart phones are improving communication and helping to reduce noise on patient-care units. But along with those benefits, smart phones can increase the risk of transmitting pathogens.

To educate staff about proper smart-phone, hand-hygiene practices and to help limit the spread of pathogens, Nursing and Infection Control collaborated to create the *Mobile Devices and Infection Control* poster (at right), which is being widely circulated throughout the hospital. The poster contains clear and simple guidelines for managing mobile devices in the healthcare setting.

To augment the information contained in the poster, the following photos show how staff can minimize contamination and prevent transmission of pathogens from patient to patient. These

practices apply to all hand-held devices, not just smart phones. As a best practice, staff should start their shift with a clean device. Always Cal Stat before touching devices. And store devices in a clean place.

For more information about hand hygiene and mobile devices, call Infection Control at 617-726-2036.



Retrieving device from docking station



Retrieve your phone from the docking station



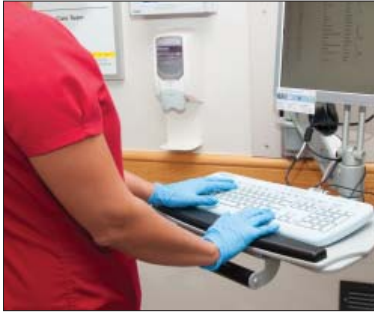
Don gloves.



Clean phone with Super Sani-Cloth.

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Retrieving device from pocket while working



Your device activates while working in a patient's room.



If wearing gloves, remove them.



Perform hand hygiene. (For Contact Precautions Plus, wash hands first, then use Cal Stat.)



Retrieve phone with clean hands.

Retrieving device from nearby clean surface while providing care



Place device on clean paper towel with clean hands if you need to see messages while providing care.



If device activates, view message without touching phone.



If you're wearing gloves and need to respond, remove gloves.



Perform hand hygiene. (For Contact Precautions Plus, wash hands first, then use Cal Stat.)



Handle phone with clean hands.

Cleaning a contaminated device

If your phone becomes contaminated (e.g., touched with unclean hands or gloves, or placed on a surface in a patient's room) it must be cleaned.



If wearing gloves, remove them.



Perform hand hygiene. (For Contact Precautions Plus, wash hands first, then use Cal Stat.)



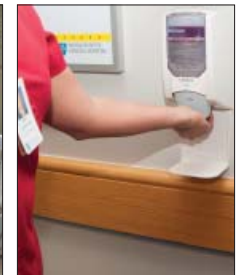
Don clean gloves.



Clean phone with Super Sani-Cloth and store in a clean place.



Remove gloves.



Perform hand hygiene. (For Contact Precautions Plus, wash hands first, then use Cal Stat.)

Special thanks to staff nurse, Inese Kudeja, RN, for demonstrating the hand-hygiene practices highlighted in this spread.

‘Therapeutic alliance’ helps alleviate fear for patient at the end of life

‘Michelle’ was brought emergently to MGH after an acute myocardial infarction, which led to a long and complicated stay in the Cardiac Surgical ICU.

My name is Susie Essig, and I’ve been a clinical social worker in the Cardiac Surgical Intensive Care Unit and Cardiac Surgical Step-Down Unit for two years. Critically ill patients in the Cardiac Surgical ICU are in a vulnerable place, facing issues beyond their experience. I feel privileged to have had the opportunity to support one such patient as she faced the end of her life. ‘Michelle’ was brought emergently to MGH after an acute myocardial infarction, which led to a long and complicated stay in the Cardiac Surgical ICU. Michelle was placed on extra-corporeal membrane oxygenation (ECMO) in the Operating Room and remained critically ill throughout her hospitalization.

During my initial visits with Michelle, she would lie in bed with the covers up to her chin and stare at the ceiling. She would briefly acknowledge my presence and express feeling thankful that she had survived. With further exploration, Michelle shared that she didn’t feel ready to, “face this reality.” I validated those feelings and tried to focus on building rapport and trust. To develop our therapeutic alliance, I met with Michelle on a regular basis; she felt comfortable enough with me to vent her feelings and fears.



Susie Essig, LICSW
social worker

When I asked how she had coped with challenges in the past, she just looked at me and said, “I pushed it all away.” Then she shook her head and began to sob.

I sat with her as she cried and created a space where she could begin to explore her feelings and allow herself to be vulnerable. I wanted her to know that I would remain present, supportive, and open as she went through this challenging time.

As our rapport grew stronger, my work with Michelle began to focus on developing her ability to cope with her serious and progressive health issues. She had a history of detaching and internalizing her feelings, but due to the acuity of this situation, she felt forced to face the reality of her physical illness. She began to share details of her social history, opening up to me about her 19-year-old daughter and her daughter’s struggle with a severe learning disability;

continued on next page

My work with Michelle helped me realize the power of being present and open to a person's fears and anxieties at the end of life. As a new social worker, working with Michelle helped me focus on the therapeutic alliance and showed me how a strong foundation can present opportunities for self-exploration, both for the patient and the social worker.

her boyfriend, who was dependent on her financially and emotionally; and the distant relationships she had with her brother and sister.

During the time I spent with Michelle, many of her interpersonal struggles and feelings of guilt at not being able to continue in these relationships began to emerge. Michelle's lack of control became a common theme. Her acute illness and complex family dynamics became an emotionally draining and time-consuming situation both for Michelle and for staff involved in her care.

I helped Michelle articulate her needs and wishes. Over time, with Michelle's input, the inter-disciplinary team and I found creative ways to increase her sense of control. A schedule was created that her nurses updated regularly with her goals for the day. This helped Michelle track her progress and empowered her to be part of her care-planning.

Michelle experienced great anxiety, which became more debilitating over time, ultimately impacting her ability to sleep and tolerate daily interventions. At times, her anxiety escalated to where she described tightness in her chest and difficulty breathing. When it passed, I'd ask Michelle how I could support her during those times, to which she replied, "Just being present." I consulted with the psychiatric clinical nurse specialist about the impact of Michelle's anxiety on her care, and she began to meet with Michelle to teach her how to practice relaxation techniques.

As Michelle continued to physically deteriorate, opportunities arose for us to discuss her fears and struggles related to her mortality. The Cardiac Surgery and Palliative Care teams shared with Michelle that her prognosis was increasingly poor, which led to discussions about goals of care. After these conversations, Michelle would openly express her fears about dying. To help her manage her anxiety, I asked her to let me know if she began to feel overwhelmed. This helped inform how to safely increase her distress tolerance and gave her a sense of control over the direction of our time together.

She shared her concerns about whether her daughter and boyfriend would be able to manage if she didn't survive or was unable to be active in their lives. Michelle wanted to work on her relationships with her brother and sister. With her guidance, we engaged in conversations with her siblings where she expressed her hopes that they would be more involved with her daughter and boyfriend. She shared

with them her fears about the future. These discussions were difficult for Michelle, but therapeutic in being able to join together as a family to prepare and address these concerns.

Michelle struggled with the idea of leaving her daughter.

The question for me became, "What does it mean to Michelle to say good-bye?" Her focus was on sorting out her daughter and boyfriend's social and financial needs. She wanted to know they'd be taken care of if she didn't survive. Michelle spoke with her brother and sister about coordinating services, such as disability income and housing for her daughter, which she had intended to do herself. Her siblings assured her that these matters would be taken care of, and I provided them with information about these resources. Michelle's sister invited her daughter to move in with her until she could find an apartment, and Michelle's boyfriend moved in with a close friend who could share expenses.

Michelle passed away after suffering a stroke almost two months after being admitted. My hope is that Michelle felt her voice was heard at the end of her life. She was able to explore the prospect of leaving her child and seize the opportunity to make arrangements for her ongoing safety and well-being. My work with Michelle helped me realize the power of being present and open to a person's fears and anxieties at the end of life. As a new social worker, working with Michelle helped me focus on the therapeutic alliance and showed me how a strong foundation can present opportunities for self-exploration, both for the patient and the social worker. The most rewarding aspect of my job is being able to have an impact on patients' lives during their most vulnerable and challenging times.

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

Michelle may have dealt with life's challenges by 'pushing them away,' but Susie recognized that that strategy would not bring her peace as she faced the final days of her life. With gentle guidance and encouragement, Susie helped Michelle face her fears, which in turn, gave her a sense of much-needed control. Through presence, compassion, and empathy Susie and the team gave Michelle the courage to take the actions she wanted and needed to take — for herself and her family.

Thank-you, Susie.

Connell nursing research mentor comes to MGH

—by Stephanie Ball, RN, clinical nurse specialist

Critical care nurses are known to go to extremes to protect their patients, and Mary Lou Sole, RN, interim dean and Orlando Health distinguished professor at the University of Central Florida College of Nursing, is not exception. Despite sub-freezing temperatures on Thursday, February 27, 2014, Sole honored her commitment to come to MGH to speak with Connell nursing research scholars about their post-doctoral research programs.

An accomplished nurse scientist, Sole holds the highest honor of Pegasus professor at the university. She authored the introduction to *Critical Care Nursing* and is the principal investigator for several NIH grants. Most recently, Sole was the American Association of Critical Care Nurses distinguished research lecturer and was named Researcher of the Year by the National Association of Clinical Nurse Specialists.

Sole is mentoring, Stephanie Ball, RN, clinical nurse specialist in the Blake 12 Surgical Intensive Care Unit and Connell nursing research scholar in the Munn Center for Nursing Research. Ball met Sole at the National Teaching Institute of the American Association of Critical Care Nurses where they struck up a conversation about their mutual interest in oral-care practices for critically ill patients. Following that

meeting, Sole agreed to formally become Ball's mentor and has been a strong guiding influence in Ball's program of research in critical care.

Sole presented, "An A-B-C approach to developing a program of research in critical care," at MGH on February 28th. Her presentation outlined her more than 20 years as a critical-care nurse researcher and the challenges she faced along the way. Sole's practical approach and tips on how to survive the ebb and flow of research were well received by MGH nurses. Sole also had an opportunity to meet with the Doctoral Forum and staff nurses on Blake 12.

For more information about Sole's visit, contact Stephanie Ball at 617-724-9976.

At right: Mary Lou Sole, RN, interim dean and Orlando Health distinguished professor at the University of Central Florida College of Nursing (right), and Stephanie Ball, RN, clinical nurse specialist in the Blake 12 Surgical Intensive Care Unit and Connell nursing research scholar



More than just a Journal Club presentation

—by Christina Jewell, RN, and Emily Pelletier, RN, co-chairs of the More than Just a Journal Club Sub-Committee of the Research and Evidence-Based Practice Committee

On February 10, 2014, first author, Erica Edwards, RN, attending nurse in the Cardiac Intensive Care Unit, presented her recently published study, “Changes in Provider Perception of Family Presence during Resuscitation,” at More than Just a Journal Club. The presentation was co-sponsored by the Research and Evidence-Based Practice Committee and the Cardiac Intensive Care Unit. Published in 2013, in *Clinical Nurse Specialist*, along with co-authors, Lisa Davies Despotopoulos, RN, and Diane L. Carroll, RN, the study was supported by the Munn Center for Nursing Research and the American Association of Critical Care Nurses.

A growing number of family members are requesting proximity to patients during resuscitation and invasive procedures. This practice, which is a regular occurrence in the ED and on pediatric units, has raised interest among providers in adult intensive care units. This study was conducted to measure changes in perceptions of healthcare providers in the Cardiac ICU before and after implementation of an educational program that included discussions, presentations, and unit-based guidelines for family presence during resuscitation and invasive procedures.

The study used a descriptive design. Healthcare providers completed family presence scales for confidence and risk-benefit pre- and post-implementation of the family presence education program.

Family presence scales were completed by 43 staff members before and 40 after the family presence educational program. There was improvement in family presence risk-benefit for resuscitation ($p < .01$) though no change was noted in perceptions for invasive procedures. There was no significant change in confidence for family presence for resuscitation or invasive procedures, but there was a trend toward improved scores. A significant increase was seen in the number of invi-



Erica Edwards, RN attending nurse, Cardiac ICU

tations for family members to be present during resuscitation after the educational program ($p < .02$).

The family presence educational program and approval of unit-based guidelines helped improve staff perceptions of risk and benefit of family presence during resuscitation and of actual invitations for family presence during resuscitation. The study provided an infrastructure for family presence and support for enhanced patient-centered care. Edwards shared strategies for implementation of family presence, which led to further discussion.

The article can be accessed through the Treadwell library.

The next More than Just a Journal Club will be held in April, when Peggy Settle, RN, will present her study, “Nurse activism in the Newborn Intensive Care Unit: actions in response to an ethical dilemma.” For more information, e-mail Chrissy Jewell, RN, at cjewell1@partners.org.

Preventing catheter-associated urinary-tract infections

CAUTIs are highly correlated with extended length of stay and prolonged duration of catheterization. Every day that a catheter is in place there is risk of infection. The most effective means of preventing CAUTIs is removing the catheter altogether.

Catheter-associated urinary-tract infections (CAUTIs) account for 40% of hospital-acquired infections in US hospitals each year. CAUTIs are highly correlated with extended length of stay and prolonged duration of catheterization. Every day that a catheter is in place there is risk of infection. The most effective means of preventing CAUTIs is removing the catheter altogether.

A simple mnemonic device to help reduce the incidence of CAUTIs is: **ARM**:

- **Avoid** the use of catheters. Consider alternatives such as bedside urinals, urinary pouches, bed pans, frequent toileting, and other options
- **Reduce** the number of days a catheter is in place by regularly assessing the need for a catheter. Remember the most effective means of preventing CAUTIs is to remove the catheter as soon as possible
- **Maintain** the catheter below the level of the bladder and avoid dependent loops. Perform daily catheter care using warm soap and water. Maintain a closed system and avoid disconnecting the catheter from the drainage bag. Use only the sterile port to obtain urine specimens. Secure the catheter to prevent urethral trauma and traction. Insert catheters using aseptic technique

Beginning in 2011, representatives from Infection Control, Patient Care Services, Partners IS, the Center for Quality & Safety, and the Surgical Care Improvement Project began meeting as the CAUTI Prevention Working Group to design an interven-

tion to encourage appropriate use of in-dwelling urinary catheters, ensure documentation of reason for continued use of catheter, and foster timely removal.

The Working Group developed a Provider Order Entry (POE) system with the following elements:

- When ordering an in-dwelling urinary catheter, providers must choose from a list of acceptable indications derived from national guidelines and approved by appropriate specialties at MGH, including General Surgery, Adult Urology, Pediatric Urology, Pediatric Quality & Safety, and the Acute Pain Service
- Based on the indications chosen, providers will receive timed reminders prompting them to re-evaluate the need for continuing in-dwelling urinary catheter

Since implementation of the template in July, 2012, compliance with the urinary-catheter quality measure as part of the Surgical Care Improvement Project has increased dramatically. Efforts that have contributed to increased compliance include implementation of concurrent record reviews for surgical patients, the POE intervention requiring documentation of the indication for all urinary catheters, and broad educational efforts throughout the hospital raising awareness about CAUTI quality-improvement efforts.

For more information about CAUTI improvement strategies, consult with your clinical nurse specialist; call Infection Control at 617-726-2036; or visit the Excellence Every Day portal page to review the CAUTI Toolkit.

Ambulatory Practice of the Future

*enhancing primary care through improved
communication, teamwork, and smart technology*

The belief is that engaging patients in their own health, wellness, and disease-management means spending time with them, being proactive, and focusing on their personal health goals using innovative tools and programs to help drive better clinical outcomes.

Question: Some of my colleagues see caregivers at the Ambulatory Practice of the Future. What is that?

Jeanette: The Ambulatory Practice of the Future (APF) is an innovative, primary-care clinic that was created specifically for MGH employees and those covered under their health-insurance plans. The model was conceptualized about ten years ago, and the practice officially opened in 2010. Its mission is to, “inspire, empower, and engage patients and care-providers to partner in their journey to better health and wellness.” The APF strives to provide a unique, team-based, patient-centered, care experience that will result in improved health outcomes and lower cost of care.

Question: How is it different from other primary care practices?

Jeanette: The hospital has invested in dedicated space to provide an engaging setting for patients and a team approach to primary care that includes physicians, nurses, nurse practitioners, medical assistants, and non-traditional caregivers, such as health coaches. The belief is that engaging patients in their own health, wellness, and disease-management means spending time with them, being proactive, and focusing on their personal health goals using innovative tools and programs to help drive better clinical outcomes.

Question: How does it work?

Jeanette: Patients are encouraged to communicate freely with their care-providers. They can follow up via office visits, electronic messaging, telephone, or video hook-up. This minimizes the inconvenience often associated with contacting members of the care team. Chronic conditions can be managed remotely using innovative technology that keeps patients connected to their team and care plan. And health coaching provides an opportunity for patients to explore their own motivation for maintaining wellness and break down any barriers that might be preventing effective health-management.

Question: Who is the current patient population?

Jeanette: The APF cares for MGH employees and those covered under their insurance plans in an MGH-sponsored health-insurance model.

Question: What’s next for the APF?

Jeanette: The APF plans to continue its pioneering work with innovations in team-design, clinic workflow, and the application of smart technology to engage patients in their own health and wellness while simultaneously providing an appealing work environment for the care team.

For more information about the Ambulatory Practice of the future, call 617-724-1100.

Announcements

Special Schwartz Center Rounds®

"Boston Marathon Caregivers One Year Later: Moving Forward with Healing and Renewed Compassion"

Exclusively for hospital staff, first responders and medical-tent volunteers.

These confidential sessions will bring together caregivers who treated patients following the Marathon bombings to discuss how they're coping.

Sessions will be held:

Friday, March 28th
8:00–9:30am

Thier Conference Room
Register by March 21st

Thursday, April 3rd
8:00–9:30am

Inn at Longwood Medical, The Fenway Room
342 Longwood Avenue, Boston
Register by March 27th

Wednesday, April 9th
6:00–7:30pm

Boston Park Plaza Hotel, Terrace Room
50 Park Plaza at Arlington Street, Boston
Register by April 2nd

Registration is required
Please e-mail schwartzcenter@partners.org with your: name; e-mail address; organization; and session(s) you plan to attend.

Your contact information will be used for registration purposes only.

Education in ExtraCorporeal Membrane Oxygenation

Save the date

24th annual SEECMO (Specialist Education for ExtraCorporeal Membrane Oxygenation) conference.

April 4–6, 2014
Omni Hotel

Providence Rhode Island

For ECMO specialists, respiratory therapists, nurses, perfusionists, and physicians who have an interest in the clinical application, research, and continuing development of ECLS.

Jointly sponsored by MGH, Rhode Island Hospital, and Yale New Haven Hospital.

For more information, or to register, go to: http://www.rhodeislandhospital.org/SEECMO_2014.html.

Blum Center Events

Book Talk
Almost Anorexic
Tuesday, March 25th
12:00–1:00pm

Join Jennifer J. Thomas, co-author of *Almost Anorexic* for a discussion on different types of eating disorders.

Programs are free and open to MGH staff and patients.
No registration required.

All sessions held in the Blum Patient & Family Learning Center.

For more information, call 4-3823.

Senior HealthWISE events

All events are free for seniors 60 and older

"Aging with a strong body"
Thursday, April 3, 2014
11:00am–12:00pm

Haber Conference Room
speaker: Jacobo Hincapie Echeverri, MD, geriatric fellow

"Protect yourself from financial frauds and common scams that target seniors"

Thursday, April 17th
11:00am–12:00pm

Haber Conference Room
speaker: Betsey Crimmons, senior attorney, Elder Abuse Prevention Project of Greater Boston Legal Services

"Careful, Careful, Don't Fall"
Thursday, May 1st
11:00am–12:00pm

Haber Conference Room
speaker: Bernardo Reyes, MD, geriatric fellow

For more information, call 4-6756.

Clinical Pastoral Education

Fellowships for Healthcare Providers

Three Schwartz Center fellowships are available for the fall, 2014, Clinical Pastoral Education Program.

This opportunity is available to clinicians from any discipline who work directly with patients and families and who wish to integrate spiritual caregiving into their professional practice.

Group sessions meet Mondays from 8:00am–5:00pm.

Clinical hours are negotiated.

Applications are due by April 18, 2014.

For more information call Reverend Angelika Zollfrank at 724-3227 or go to: MGHChaplaincyCPE.org

PhD in Rehabilitation Sciences

Fellowship funding for qualified students

The PhD in Rehabilitation Sciences program at the MGH Institute of Health Professions is designed for clinically certified/licensed healthcare professionals in Physical Therapy, Occupational Therapy, Speech-Language Pathology, Rehabilitation Nursing, and Physical Medicine and Rehabilitation who wish to acquire advanced knowledge and skills to conduct clinical research with an emphasis on assessing clinical outcomes in rehabilitation. Partial 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.

E. Lorraine Baugh Visiting Faculty Scholars Series

Candi Castleberry Singleton, chief inclusion and diversity officer at University of Pittsburgh Medical Center, will present "Making the World a Better Place for All to Live—with All Our Differences"

Monday, March 24, 2014
4:00–5:00pm
MGH Institute of Health Professions,
Shouse Building, Room 305

Singleton's recent efforts include the nationally recognized Dignity & Respect Campaign, Cultural Competency Initiative, and Healthy Community, Healthy You. She serves as co-chair of the Regional Health Literacy Coalition. Event is open to the public. Reception to follow.

For more information, e-mail: provost@mghihp.edu.

Professional Achievements

Lanckton appointed

Rabbi Ben Lanckton, staff chaplain, was appointed secretary of the Executive Board of the Neshama: Association of Jewish Chaplains in Whippany, New Jersey, January 14, 2014.

Termezy appointed

Tara Termezy, OTR/L, occupational therapist, was appointed a member of the AOTA Leadership Development Program of the American Occupational Therapy Association, in Bethesda, Maryland, January 28, 2014.

Benacchio certified

Catherine Benacchio, RN, clinician nurse specialist, Cardiac Step-Down Unit, became certified as an adult clinical nurse specialist by the American Nurses Credentialing Center, in January, 2014.

Botelho certified

Andrea Botelho, RN, thoracic staff nurse, became certified in Medical Surgical Nursing by the American Nurses Credentialing Center, in December, 2013.

Gallagher certified

Shannon Gallagher, RN, thoracic staff nurse, became certified in Medical Surgical Nursing by the American Nurses Credentialing Center, in December, 2013.

Kasper certified

Hallie Kasper, RN, clinical research nurse practitioner, Radiation Oncology, became certified in Pediatric Hematology/Oncology by the Association of Pediatric Hematology/Oncology Nurses, in December, 2013.

Burchill presents

Gae Burchill, OTR/L, occupational therapist, presented, "Flexor and Extensor Tendons: Anatomy and Physiology," at Tufts University, January 27, 2014.

Team publishes

David Hwang, MD; Daniel Yagoda; Hilary Perry; Tara Tehan, RN; Mary McKenna Guanci, RN; Lillian Ananian, RN; Paul Currier, MD; J. Perren Cobb, MD; and Jonathan Rosand, MD, authored the article, "Consistency of Communication Among Intensive Care Unit Staff as Perceived by Family Members of Patients Surviving to Discharge," in the *Journal of Critical Care*.

Clinical Recognition Program

Clinicians recognized
October 1, 2013–February 1, 2014

Advanced Clinicians:

- Jane D'Addario, RN, GYN-Oncology
- Bridget Lyons, RN, Medicine
- Elizabeth Costigan, RN, Infusion Center
- Emily Shell, RN, Medical Intensive Care Unit
- Emilia Comerford, RN, Main Operating Room
- Christen Auvil, RN, Neuroscience
- Valerie McCarthy, RN, Medicine
- Meghan Crann, RN, Medicine
- Caitlin Laidlaw, LICSW, Social Work

Clinical Scholar:

- Mary Pomerleau, RN, Newborn Family Unit

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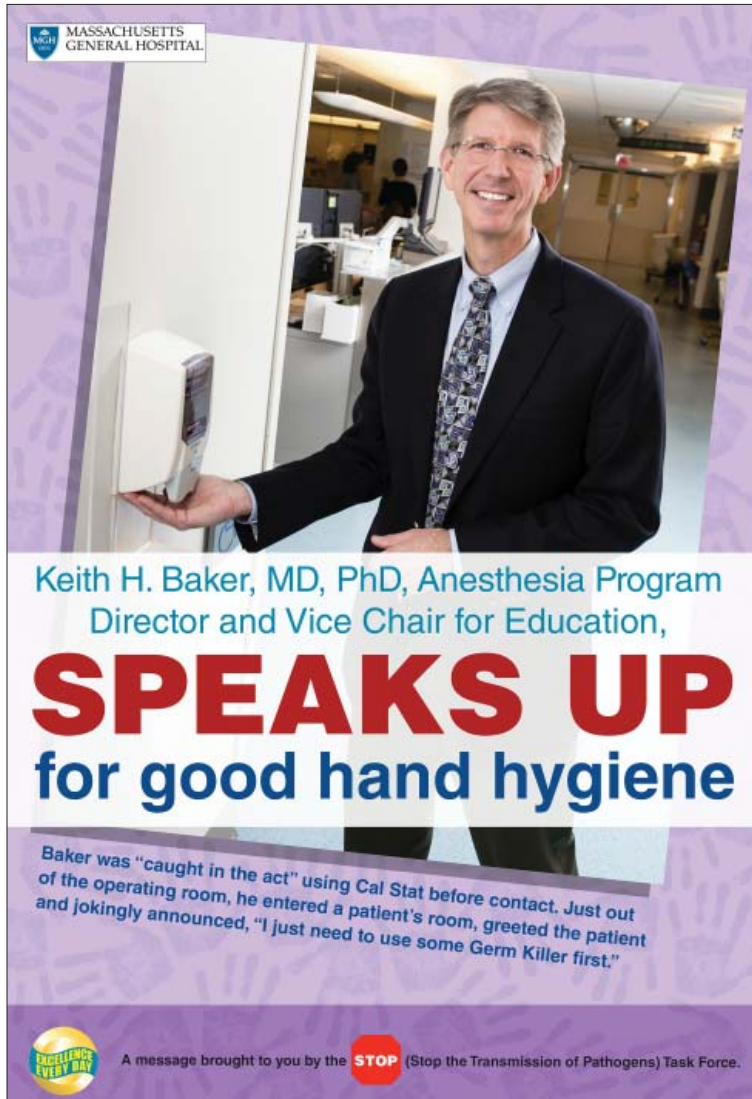
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Submissions

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

Next Publication

April 3, 2014



MASSACHUSETTS GENERAL HOSPITAL

Keith H. Baker, MD, PhD, Anesthesia Program Director and Vice Chair for Education,
SPEAKS UP
for good hand hygiene

Baker was "caught in the act" using Cal Stat before contact. Just out of the operating room, he entered a patient's room, greeted the patient and jokingly announced, "I just need to use some Germ Killer first."

EXCELLENCE EVERY DAY

A message brought to you by the **STOP** (Stop the Transmission of Pathogens) Task Force.

Speak Up!

See something, say something

Clean hands can help stop the spread of germs and reduce the risk of infection. Clean hands are especially important in the hospital setting. MGH is committed to achieving excellence in hand hygiene through vigilance and collaborative practice.

At MGH, healthcare workers are required to use Cal Stat, an alcohol-based hand sanitizer, before and after contact with patients or patients' environments. Patients, families, and visitors are encouraged to do the same, and sometimes a polite reminder is appreciated.

Help spread the message. Speak up for hand hygiene and promote Excellence Every Day.

Keith Baker, MD, vice chair of Education and Residency program director, recently checked his cell phone before entering a patient's room. That could have been the preamble for a hand-hygiene failure, but he remembered to Cal Stat before approaching the patient, saying, "It's standard practice."

(See related story on page 6)

Caring Headlines

March 20, 2014

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