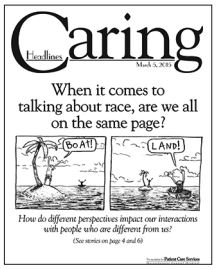
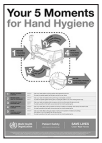
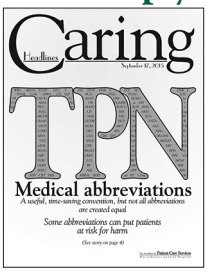
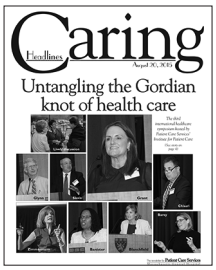
Headlines Caring

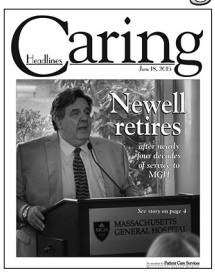
January 21, 2016

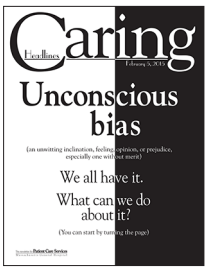












Celebrating Everyday Heroes

Diversity & Disabilities

Chaplaincy

ellucid

access

Ebola

Global health

hand hygiene

Future thinking

Innovation

simulation

Therapy

staffing ratios

Scrub the Hub!

MOLST

healthcare proxies

Leadership

Quality & Safety

Physical

mattresses

Unconscious bias

Speech-Language Pathology

Orthotics

Transgender patients

inclusion

gender identity

autism awareness

GEM Awards

Cognitive assumptions Dissonance

Cultural communication style

Metavision

Gordian Knot

CAUTIs

Autonomy

Joint Commission

Service excellence

Fall-prevention

Social Work

2015

We're #1

SNOW!

another storm update

Record-breaking 110.6 inches

Resiliency!

Blizzard of 2015

MGH Military Veteran Partners Employee Group

Lets talk about race!

I-PASS

communication

Safe Patient

Respiratory Care

Transfer

Strategic Plan

equitable care

Paul Erickson

LOS

ownership

All hands on deck!

eCare

Epic, Epic, Epic, Epic, Epic, Epic, Epic, Epic, Epic

suicide-prevention

Volunteers

Patient Safety Culture Survey

LGBTQ

Research

Nurse Residency

patient progression

Acuity

tableau dashboard

HCAHPS

Interpreter Services

Learning

Humanitarian aid

Dialogue on Race

Occupational Therapy

Staff Perceptions of the Professional Practice Environment Survey (SPPPE)

15 seconds

READI

eCare

Pressure Ulcers

guardianship

Nursing

CLABSIs

baby-friendly certification

Estimated Date of Discharge (EDD)

The newsletter for Patient Care Services
Massachusetts General Hospital

2015

Jeanette Ives Erickson

A look back at 2015

innovation, improvement, our journey toward an integrated health-information system, and so much more…

Working on this annual-report issue of *Caring* reminded me of what a great supporter Paul was of MGH and especially Patient Care Services. He was always so proud of your good work and accomplishments.

The Blizzard of 2015. The Patriots won the Super Bowl. Marathon-bombing suspect, Dzhokhar Tsarnaev, was found guilty and sentenced to death. The Supreme Court upheld marriage equality, and the Confederate flag was removed from the state capitol in South Carolina. We saw incidents of racial unrest and gun violence. Caitlyn Jenner taught us something about courage and gender-identity, and the stunning American Pharoah won the triple crown for the first time in 37 years.

It's amazing how just those few references can bring back a whole year's worth of memories. For me personally, 2015 was a year I will never forget. With the sudden death of my husband, Paul, I learned so much about grief, kindness, resilience, and the comfort that comes from being part of this incredible MGH community. I want to take this opportunity to once again thank everyone who took the time to reach out to me with support and condolences. Working on this annual-report issue of *Caring* reminded me of what a great supporter Paul was of MGH and especially Patient Care Services. He was always so proud of your good work and accomplishments. Even I, as I read this issue, marveled at what we were able to accomplish together.

We were once again named the #1 hospital in the country by *US News and World Report*. We had a successful Joint Commission visit; surveyors were impressed with our implementation of National Patient Safety Goals, our inter-disciplinary approach to care, and the degree to which our practice is driven by knowing the patient.

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

We saw a change in leadership with David Torchiana, MD, replacing Gary Gottlieb, MD, as president and chief executive officer of Partners HealthCare. And within Patient Care Services, we welcomed a new director of Nursing Research & Innovation, Meg Bourbonniere, RN, and a new director of Volunteer Services, Jacqueline Nolan. Both wasted no time getting acclimated to their new roles and identifying strategic priorities for their departments.

Social Service continued to support patients and families in inpatient and outpatient settings. Clinical social workers offered crisis intervention in the ED, assessed patients for organ transplant, assisted patients at the end of life, and provided exceptional care to patient and families throughout the continuum. The department integrated its Violence Intervention Advocacy Program with HAVEN, our domestic violence program, to better assist victims of violence, providing them with skills and opportunities to safely return to the community. Through collaborations with local police departments, courts,

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Jeanette Ives Erickson (continued)

criminal-justice agencies, the Boston Medical Center Streetworker Program, the Louis Brown Institute of Peace, Chelsea's HUB Team, and others, Social Service helped provide comprehensive care to patients and families in an attempt to reduce community violence.

Clinical Support Services (CSS) staff were major, behind-the-scenes heroes during last year's never-ending snow storms. USAs and OAs overcame untold obstacles to get to work, many staying over multiple nights to ensure continuous support for patients, families, and staff. CSS led a multi-departmental effort to decrease hallway clutter and underwent a substantial re-organization to increase the number of OAs providing front-desk support.

Physical and Occupational Therapy had a busy year. Occupational therapists introduced innovative sensory strategies, environmental modifications, and behavior-management techniques to help patients with acute illness or developmental issues cope with being hospitalized. As part of the Inter-professional Dedicated Education Unit initiative on the Bigelow 11 Medical Unit and the Ellison 8 Cardiac Surgical Step-Down Unit, physical and occupational therapists worked with dyads of students to train and expose them to inter-professional teamwork in actual clinical situations.

Medical Interpreters focused on process-improvement to increase capacity, enhance the care of limited English-proficient patients, and decrease disparities. Re-routing VPOP and IPOP calls to the vendor during business hours enabled the department to increase the number of patients, families, and clinicians served by medical interpreters, enhancing both safety and the patient experience.

Respiratory Care worked with NICU and Labor & Delivery staff to ensure new neonatal resuscitation equipment is available in delivery rooms and modified the protocol for delivery of surfactant to high-risk infants. Together with SICU staff, they developed bi-weekly Complex Respiratory Care Rounds to enhance the knowledge of therapists, nurses, and residents around new approaches to respiratory care for SICU patients. And they introduced high-flow nasal cannulas, replacing non-invasive ventilation for the management of hypoxemic respiratory failure.

Speech, Language and Swallowing Disorders, in partnership with IHP Communication Sciences and Disorders students, successfully piloted an intensive group program focused on cognitive intervention. Historically, they've not been able to share video-fluoroscopic images with referring providers or the care team, but thanks to the efforts of the department, video-fluoroscopic swallow studies are now viewable on PACS, the Picture Archiving and Communication system where all Radiology images are stored.

Chaplaincy offered workshops to help staff cope with challenging situations and Resiliency Rounds to help staff manage stress. 2015 saw the completion of MGH's first Clinical Pastoral Education residency program. The Field Education program tripled in size, and a monthly Buddhist service was added to the Chapel schedule. Chaplaincy now provides a full-time Emergency Medicine chaplain and is collaborating with the Islamic Society of Boston Cultural Center to initiate a Muslim patient visitation program.

The Volunteer Department saw 1,440 volunteers contribute more than 100,000 hours of service. The Beacon Program grew 6.8%, the Gray Family Waiting Area served some 25,000 families, and the Pet Therapy program brought joy to nearly 6,000 patients and staff. The department launched the Transplant Clinic Hospitality program and the MGH Eat Street Café Volunteer program to assist patients with disabilities.

The Norman Knight Center for Clinical & Professional Development introduced the Success Pays program as part of our annual Certified Nurses Day celebration and led the educational effort to implement I-PASS as the preferred communication format for patient hand-overs.

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The Annual Report Issue

Jeanette Ives Erickson (continued)

The Munn Center for Nursing Research and *The Center for Innovation in Care Delivery* completed an evaluation of our Innovation Unit initiative. The Munn Center helped reinvigorate our Evidence-Based Practice initiative and disseminated the results of the 2015 Staff Perceptions of the Professional Practice Environment survey.

The Maxwell and Eleanor Blum Patient & Family Learning Center expanded its support of health literacy and plain language to many departments and now offers editing of video as well as printed materials. Blum Center staff helped train staff in the skills necessary to effectively teach patients about health and illness.

The Knight Simulation Program helped meet the learning needs of staff in Medicine, Psychiatry, Palliative Care, Chaplaincy, Oncology, and the Center for Community Health Improvement.

The Institute for Patient Care oversaw the credentialing or re-credentialing of nearly 600 nurses in various specialties; hosted more than 2,000 nursing students for clinical placements; and coordinated the Health Care and the Gordian Knot: Preparing to Lead through Unprecedented Change, Challenge, and Complexity Symposium.

Orthotics and Prosthetics saw a change in leadership as manager, Mark Tlumacki, retired after more than 30 years of service. His successor, James Krupa, joined our team this summer, and we look forward to a long and productive relationship with him.

The Ladies Visiting Committee Retail Shops installed new fixtures and re-organized their spaces to be more wheelchair friendly. The Flower Shop designed the floral arrangements for the Boston Marathon event in April. The Images Oncology Boutique collaborated with Botswana Oncology Global Outreach to provide breast prostheses, garments, and specialty bras to women in Botswana.

Nursing worked in collaboration with many other disciplines and departments in their efforts to make care more effective and affordable. Nurses and support staff participated in the selection and roll-out of new mattresses on general care units; updated and disseminated educational materials regarding physiologic monitor alarms; established the new Blake 7 Biothreat Unit and Anticoagulation Management Services Nurse On-Call Program.

The Ellison 18 Pediatric Unit held its first multi-disciplinary, pediatric Cross Cultural Teamwork and Communication Training; Ellison 13 Obstetrics hired two human milk specialists and purchased bedside refrigerators for new moms. MGH was designated a Baby Friendly hospital by Baby Friendly USA, Inc., a global initiative of the World Health Organization and the United Nations Children's Fund.

A new job description was created for the Bulfinch temp observer role expanding its parameters to better serve the patient and the care team. The role was implemented in July. Now, under the direction of a nurse, observers can engage patients in diversional activities, assist with ambulation, and position food trays for easier access by patients.

In the perioperative setting, operating rooms continued to work on supply-cost reduction. GI-Endoscopy installed Omnicell units in procedure rooms to enhance practice related to the control of narcotics. And a number of changes were made to accommodate the Perioperative Master Renovation Plan, including the Pre-Admission Testing Area's phone program re-locating to Nashua Street, and the Electroconvulsive Therapy program moving to the Center for Perioperative Care.

> I am in awe of this great organization and the people who make it the #1 hospital in the country... Something magical happens in this hospital every day, and I feel blessed to be part of it.

Adult surgical units convened a group of staff nurses, clinical nurse specialists, and PCS quality and safety representatives to create a plan to help decrease device-related pressure ulcers. With the introduction of new products and interventions, device-related pressure ulcers have been significantly reduced.

To improve the progression of care, Lunder 7 and 8, rescheduled their inter-disciplinary neurology rounds from 1:30pm to 7:30am so that all clinical staff could attend.

We were fortunate to host a number of visiting scholars this year, including Lynn Kelso, RN, assistant professor from the University of Kentucky College of Nursing as our Albert H. Brown Medical Nursing visiting scholar. And Diane Carroll, RN, nurse scientist, was this year's Cardiac Nursing visiting scholar.

Linda Kelly, RN, of the MGH department of Vincent Obstetrics and Gynecology, was named the inaugural incumbent of the Sonja and Deborah Kelly Endowed Scholar. The scholar was established through the generosity of Edmund 'Ted' and Deborah Kelly and will allow Linda Kelly to pursue research in women's health to advance gynecological care.

I am in awe of this great organization and the people who make it the #1 hospital in the country. I'm in awe of your kindness and generosity as individuals and your commitment and compassion as healthcare professionals. Something magical happens in this hospital every day, and I feel blessed to be part of it. Thank-you for everything you do for patients and families; for your loyalty and contributions to MGH; and for making this a safe and welcoming place for all.

Enjoy this annual-report issue of *Caring Headlines*.

The PCS Strategic Plan:

reflecting on 2015; looking ahead to 2016

—by Marianne Ditomassi, RN, executive director for PCS Operations

The process is informed by feedback from leadership across Patient Care Services, the Staff Perceptions of the Professional Practice Environment Survey, the hospital's Culture of Safety Survey, input from collaborative governance and advisory committees, and feedback from patients and families.

Every fall since 1996, the Patient Care Services Executive Committee has come together in a series of strategic planning retreats to outline priorities for the coming year (see diagram below). The planning process begins months prior to the retreats as the Executive Committee reviews the goals and tactics from the prior year. The process is informed by feedback from leadership across Patient Care Services, the Staff Perceptions of the Professional Practice Environment Survey, the hospital's Culture of Safety Survey, input from collaborative governance and advisory committees, and feedback from patients and families. Attention is paid to aligning the work of Patient Care Services with the hospital's overall strategic plan, the greater healthcare landscape, and local, national, and international factors affecting the current environment.

The PCS Executive Team, with input from staff and leadership, regularly reviews the PCS Professional Practice Model (see diagram on next page) to ensure it reflects current practice and the key components that drive inter-disciplinary care. The PCS Professional Practice Model remained unchanged this year.

The 2015 PCS Strategic Plan

Goal 1: Excellence Every Day

Optimize the patient experience by providing the highest quality, safest, most efficient care that meets or exceeds standards set by patients and families, the hospital, and external organizations

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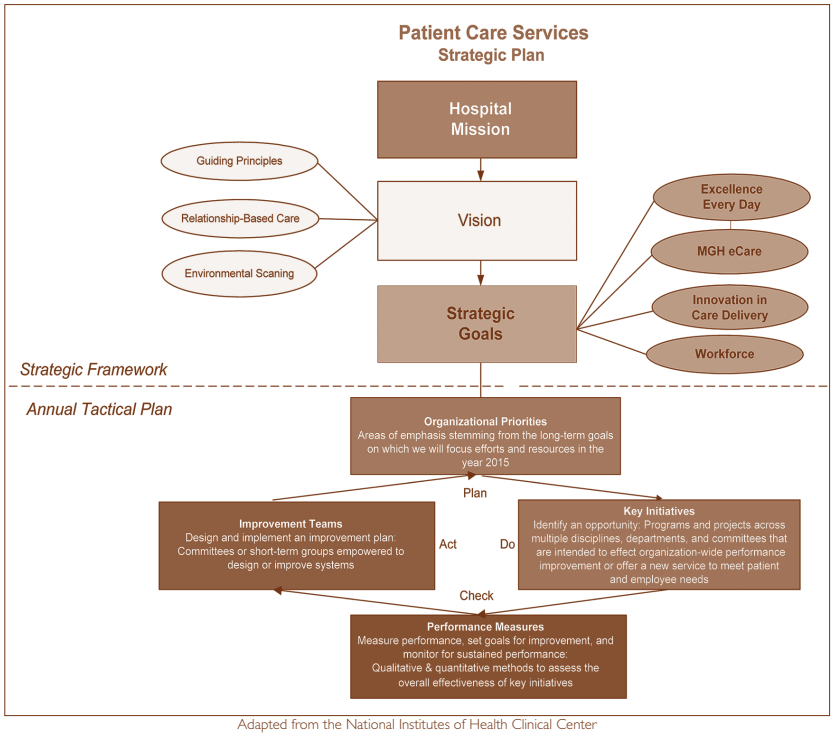


Adapted from the National Institutes of Health Clinical Center

Safe patient hand-overs was a big focus of our Excellence Every Day work. I-PASS training was rolled out to all nurses and health professionals in Patient Care Services.

Our work around Goal #1 was significant, including a successful Joint Commission survey in mid-April. It's re-affirming to receive external validation of the excellent care we provide to patients and families. We also saw favorable trends in our nurse-sensitive indicators, including catheter-associated urinary-tract-infection (CAUTI) rates and central-line-associated bloodstream infection rates. This was due in part to the development of new evidenced-based protocols and the introduction of new equipment. And patient-satisfaction scores met or exceeded targets in the categories of Pain Management, Responsiveness, and Quiet at Night.

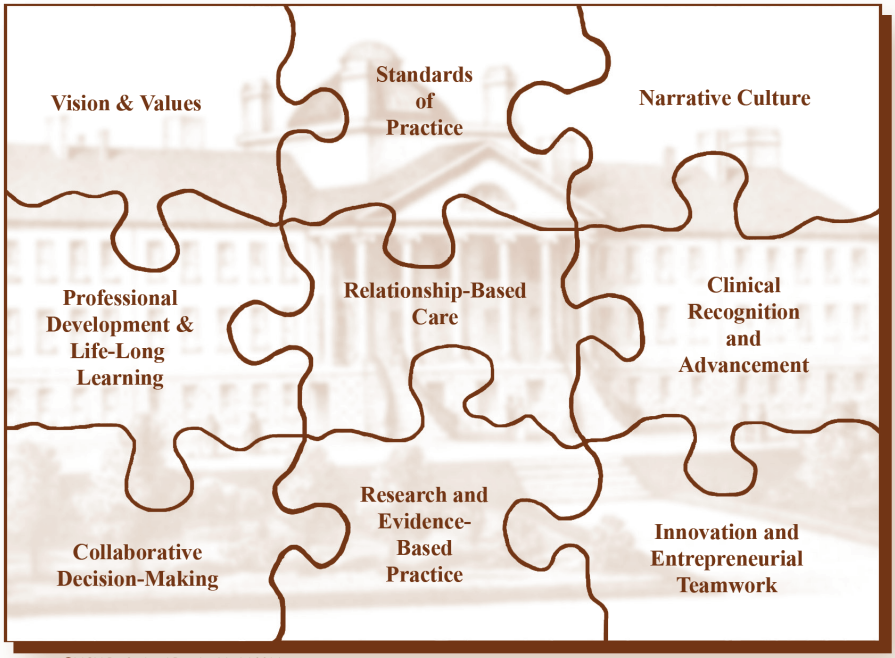
During Nurse Recognition Week in a session entitled, "The Wisdom of Experience," four clinical nurses, Sarah Molway Ballard, RN; Christen Auvil, RN; Carolyn LaMonica Velez, RN; and Amy Mawn, RN, shared safety narratives chronicling the lessons they learned from errors or near-misses identified while caring for patients.

We were fortunate to host professor and associate dean of Academic Affairs at the University of North Carolina's School of Nursing at Chapel Hill, Gwen Sherwood, RN, as the keynote speaker for the 2nd annual Barbara A. Dunderdale, RN, Lecture on the Future of Nursing. Sherwood was joined by Helen Haskell, founder and president of the non-profit organization, Mothers Against Medical Error, for their presentation on the importance of fostering a just culture, where reporting adverse events is encouraged.

Safe patient hand-overs was a big focus of our Excellence Every Day work. As an organization, we identified I-PASS as our preferred hand-over format, and I-PASS training was rolled out to all nurses and health professionals in Patient Care Services.

We made great progress in translating the idea of a PCS data warehouse into reality. Led by Annabaker Garber, RN, director of PCS Informatics, and Antigone Grasso, RN, director of PCS Management Systems and Financial Performance, specifications for the data warehouse have been articulated and are currently being designed.

PCS Professional Practice Model



Goal 2: MGH *e*Care

Implement and evaluate the use of standardized documentation tools to support the processes for optimizing patient experience and outcomes

Implementation of MGH *e*Care has been one of our highest priorities for both 2015 and 2016. Careful attention has been paid to ensuring that adequate resources are available to clinicians and support staff throughout the hospital so they could familiarize themselves with the new electronic documentation system well before we go live. In preparation for the April 2, 2016, implementation date, a novel approach was employed. More than 300 new graduate nurses, *e*Care nurse residents, were brought on board for a specified time to provide 'backfill' allowing staff nurses to attend classroom training on the new *e*Care system. Ideally, as nursing positions become available in the future, *e*Care nurse residents will be hired permanently.

To ensure readiness, direct-care staff, unit and department leadership, patients, and families have been instrumental in conducting, testing, and mapping intra-departmental work-flows.

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Work is underway to finalize the areas of focus for the 2016 PCS Strategic Plan. The four areas identified as priorities include: Capacity, MGH eCare, Patient care affordability, and Workforce. Work-groups are currently meeting to articulate the language, tactics, and outcomes for each goal. The final plan will be vetted among leadership and staff in the coming weeks.

In November, the departments of Physical Therapy, Occupational Therapy, Social Work, and Speech-Language Pathology successfully launched the clinical portion of Partners *e*Care.

Goal 3: Innovation in Care Delivery

Enhance the patient experience ensuring a coordinated, standardized, and evidence-based model of care-delivery throughout the Patient Journey

Tactics for this goal focused on evaluating the work on Innovation Units and advancing efforts to meet the length-of-stay targets set by the MGH Patient Progression Team. Details about Innovation Unit Evaluation can be found on the next page, and more information about the Patient Progression Team can be found on page 10.

Goal 4: Workforce

To be an employer of choice, known for being diverse, inclusive, and engaged, resulting in an informed, self-sustaining, creative workforce

To gain greater understanding of workforce satisfaction, the 2015 Staff Perceptions of the Professional Practice Environment Survey was conducted this fall, and the results were shared with staff and leadership in a number of forums. Of the PCS clinicians who responded to the survey, 84% reported being somewhat satisfied, satisfied, or very satisfied with their work environment. A similar survey was administered to patient care associates, the results of which will be shared in early 2016. This feedback from clinicians and support staff provides valuable insights that are used to set priorities for the coming year.

The MGH Institute for Patient Care led a collaborative governance re-design effort to better align the committees' work, decision-making, and communication with Patient Care Services' priorities (see page 14 for a more complete look at the work of collaborative governance committees this past year).

To further advance our diversity agenda, hiring managers within Patient Care Services were supported in efforts to recruit more leaders from diverse backgrounds. And representation for staff with disabilities was added to the hospital's new Diversity Committee and to the PCS Diversity Committee to ensure that patients and staff with disabilities have a voice at the table.

The 2016 PCS Strategic Plan

As a result of our most recent planning sessions, work is currently underway to finalize the areas of focus for the 2016 PCS Strategic Plan. The four areas identified as priorities include:

- Capacity
- MGH *e*Care
- Patient care affordability
- Workforce

Work-groups are currently meeting to articulate the language, tactics, and outcomes for each goal. The final plan will be vetted among leadership and staff in the coming weeks. Look for details in a future issue of *Caring Headlines*.

I-PASS
BETTER HANDOFFS. SAFER CARE.

I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Time line and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

Innovation Unit evaluation

—by Meg Bourbonniere, RN, director, Nursing Research & Innovation

Work on Innovation Units centered around the patient journey... Interventions were designed to fill the gaps between phases of care and standardize care when appropriate to achieve the highest level of consistency, continuity, and efficiency.

The MGH Innovation Unit Program, launched in 2012 on 12 inpatient units, was a strategic initiative designed to improve patient care by creating opportunities to trial new ideas and interventions. In 2013, 29 more inpatient units, the Emergency Department, and perioperative services became part of the program for a total of 41 Innovation Units.

Work on Innovation Units centered around the patient journey, from pre-admission to post-discharge care, and included 15 evidence-based interventions. Interventions were designed to fill the gaps between phases of care and standardize care when appropriate to achieve the highest level of consistency, continuity, and efficiency.

Final evaluation of the Innovation Unit Program, overseen by Gaurdia Banister, RN, and Marianne Ditomassi, RN, was conducted in late 2015 with research support from Jeff Adams, RN, Dorothy Jones, RN, and Meg Bourbonniere, RN. Data was obtained from multiple sources and included quantitative data from eight patient-experience indicators (HCAHPS), four quality indicators, seven operational-efficiency measures, surveys of implementation and impact, and qualitative data from focus groups and open-ended questions. Baseline data was collected on all Innovation Units for the 2011 calendar year.

- Nearly all patient-experience measures showed an improvement from baseline. Room Cleanliness, RN Communication, Quiet at Night, and Staff Responsiveness showed statistically significant improvement on adult units in Phase 1; no significant difference on pediatric units during Phase 1 or Phase 2

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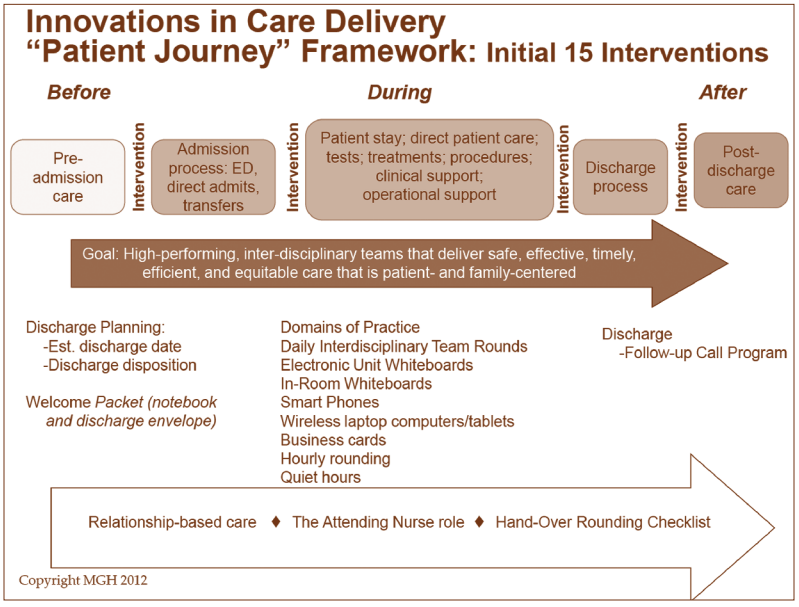

Innovation Units (continued)

Participating in the Innovation Unit 'experiment' gave staff the opportunity to effect real change by engaging in evidence-based decision-making, reflecting on practice, and contributing to evidence-based solutions.

- Phase 1 units saw a decreases in CLABSIs and Falls with Injury; Phases 2 and 3 (combined) saw a decrease in Pressure Ulcers ≥ Stage 2 and Restraints
- In Phase 1, Direct Care Shifts per 24-hours, Total Expenditures, and Total Acuity showed a statistically significant increase. Hours per Workload Index and Direct Costs increased moderately. Results showed a slight decrease in Hospital Inpatient length of stay (LOS), important given the increased acuity and medical complexity of the patient population
- All operational efficiency measures in Phase 2 showed a significant differences between pre- and post-intervention. Note: the long lag time between baseline 2011 and data-collection in late 2013 may have influenced these results
- As the acuity and medical complexity of patients has risen, a higher level of nursing resources and supplies have been required to care for this patient population

During Phases 2 and 3 of the program, a sustainability and impact survey was administered to Phase 1 nurses and PCS staff. Results of the survey indicated that cell phones, in-room white boards, and the newly introduced attending nurse role were the most widely adopted of the 15 interventions. Interventions that had the greatest impact on staff satisfaction were inter-disciplinary rounds, in-room white boards, and cell phones. Staff perceived that post-discharge phone calls, in-room white boards, hourly safety rounds, inter-disciplinary rounds and the attending nurse role had the greatest impact on patient satisfaction. In terms of safe, high-quality care, the interventions perceived to have had the greatest impact were inter-disciplinary rounds, cell phones, and hourly safety rounds. Cell phones, the attending nurse role, and inter-disciplinary rounds were most frequently identified as having the greatest impact on cost.

Teamwork and collaboration emerged as dominant themes in focus groups and surveys. It was thought that opportunities for creative practice within the Innovation-Unit experience promoted collaboration across disciplines in rounds and during meetings. Collaborative spirit impacted care outcomes and increased patient-, provider-, and family-satisfaction. The presence of white boards in patients' rooms provided staff with insight into patients' and families' goals and care preferences, which improved overall communication.

The impact of the Innovation Unit Program has been far-reaching. More than 40 units participated, and countless patients and staff were impacted. The Innovation Unit Program was a catalyst for change throughout MGH that fostered 'outside-the-box' thinking. The process of implementing the Innovation Unit Program and outcomes derived from the experience have fostered new strategies and ways of thinking about care-delivery. With its focus on improving care, standardizing processes, and reducing costs, the Innovation Unit Program contributed greatly to organizational efforts to re-design care.

Participating in the Innovation Unit 'experiment' gave staff the opportunity to effect real change by engaging in evidence-based decision-making. It gave staff a chance to reflect on practice, which led to creative, experience-based solutions to improve care and streamline systems. The Innovation Unit model motivates staff and promotes professional autonomy. The ultimate outcome of the Innovation Unit Program could be seen as increased overall satisfaction with the patient-care environment.

Innovation Unit Evaluation Indicators

Patient Experience Measures (HCAHPS)	Quality Indicators (NDNQI)	Operational Efficiency Measures (MGH)
Room Cleanliness	CLABSI	Hours per Workload Index (HPWI)
Discharge Information	Falls with Injury	Direct Care Shifts per 24-Hours
MD Communication	Pressure Ulcers ≥ Stage 2	Hospital Inpatient LOS
RN Communication	Restraints	Direct Costs
Overall Rating		Total Expenses per Equivalent Patient Day
Pain Controlled		RN Turnover Rate
Quiet at Night		Total Acuity
Staff Responsiveness		

The attending nurse role moving forward

—by Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development

2015 saw the roll-out of the new Attending Nurse Leadership-Development curriculum, encompassing: team dynamics, communication, conflict-resolution, motivation, strategic planning, leadership vs. management, and giving and receiving feedback.

It's hard to believe that this month marks four years since Innovation Units were first introduced to the MGH community. One of the interventions embedded in this new approach to patient care was the role of the attending nurse (ARN). What began as a group of 12 pioneer clinicians has grown to a roster of 105 nurses across all inpatient units, the Emergency Department, and the ED Observation Unit. From the beginning, attending nurses have met as a group with Gino Chisari, RN, director of The Norman Knight Nursing Center, to explore the many facets and dimensions of their new role. As time went on, these meetings became more of a clearinghouse for ideas and an opportunity to welcome and support new attending nurses as they came on board during Phases 2, 3, and 4 of the Innovation Unit launch.

In early 2015, The Knight Center rolled out an Attending Nurse Leadership-Development curriculum, encompassing: team dynamics, communication, conflict-resolution, motivation, strategic planning, leadership vs. management, and giving and receiving feedback. Attending nurses acted as a focus group providing feedback on several hospital initiatives, attended a series of special presentations, and continued to maintain a protected space to share lessons learned and support one another.

In 2016, for the first time, attending nurses will have defined strategic goals based on an environmental scan and SWOT (strength-weakness-opportunity-threat) analysis conducted in the fall. At their December meeting, attending nurses reached consensus on two goals:

- *Internal structure: attending nurses will develop a meeting structure to engage or re-engage more nurses with the group.* Attending nurses remain highly committed to the role and draw enormous energy from the meetings. They recognize the importance of meeting formally but understand that staffing challenges, census, patient acuity, and other factors prevent nurses from attending meetings. To stimulate greater attendance, the group will pilot a series of tactics, adopting, adapting, or abandoning them as appropriate until the goal of a 25% increase in attendance is achieved
- *Value to the organization: attending nurses will continue to contribute to the achievement of organizational goals and initiatives during 2016.* The attending nurses' view of patient care and the patient-care experience is different from other roles. It is this difference that allows attending nurses to contribute to the plan of care in a way that is complementary to the primary nurse, that is in collaboration with the inter-disciplinary team, and that is aligned with organizational priorities related to length of stay, the patient experience, quality, and safety. By leveraging this vantage point and their growing experience, attending nurses are confident they can contribute in a meaningful way to advancing organizational goals and initiatives

There is much to look forward to in 2016 as attending nurses work with the rest of the inter-disciplinary team to achieve their own, Patient Care Services', and the hospital's strategic goals in the new year.

Record-breaking improvement in patient-experience scores

—by Richard Evans, former chief of Service Excellence

What a year. In 2015, we received the highest ratings ever in nearly every category of our HCAHPS survey. After a challenging 2014, due to the launch of the Partners *e*Care revenue cycle and the Ebola scare, we saw renewed advances in our metrics this past year. And perhaps more impressive, we've been able to sustain the advances in our ratings since launching the Innovation Unit initiative in 2012. In the world of service improvement, that is a significant accomplishment. Not only did we improve the patient experience, we maintained the positive changes we introduced.

With all disciplines working together, we strengthened our commitment to ensure quiet times on inpatient units. We worked hard to respond to call bells in a timely fashion and proactively meet patients' needs so they wouldn't have to use call bells at all. These are important issues to patients and families.

In 2015, our quiet time rating improved 1.7 points. Not only is that a huge improvement from last year, it's over and above the significant improvement we achieved since 2011. Patients are starting to mention quiet times in their comments—they appreciate our efforts to make the hospital a more restful place.

Responding to call bells has been an ongoing challenge. In a hospital as complex as MGH, patients have significant needs. Call-bell response is critical. We've worked diligently to improve our response to call bells with innovations like smart phones and hourly safety rounds. In 2015, we focused on mobilizing the entire team to *prevent* call bells by enlisting the aid of departments like Chaplaincy, Pharmacy, Social Work, Physical and Occupational Therapy, Buildings & Grounds, Nutrition & Food Services, Respiratory Care, and others. The message was that we could prevent call bells if everyone proactively checked on patients while in their rooms. The result was incredibly positive. Patients noticed. Our rating in this domain rose 2 full points this year to the highest level ever.

Our ratings continue to compare favorably with peer institutions across the country. Our scores for Discharge Information are the highest of any academic medical center in the nation. Our scores for Overall Rating and Likelihood to Recommend MGH are also among the highest in the country. And our Nursing Care scores remain in the top quartile compared to our peers.

It's tempting when talking about the patient experience to focus on the scores and the metrics. And while it's important to achieve those numbers, it's imperative to remember that those numbers are just a reflection of the quality of care delivered by our staff to patients and families. Treating patients with dignity and compassion, doing everything we can to ensure their comfort and safety—that's what those numbers really mean.

Our HCAHPS scores are a credit to the commitment and dedication of the entire workforce. Congratulations on a job well done.

Inpatient HCAHPS Results – 2015 YTD

2015 Calendar Year

Measure	2014	2015 Year to Date	2014-2015 Change
Nurse Communication Composite	82.1	83.1	**1**
Doctor Communication Composite	81.6	83.4	**1.8**
Room Clean	72.2	72.6	**0.4**
Quiet at Night	49.7	51.3	**1.6**
Cleanliness/Quiet Composite	60.9	62.0	**1.1**
Staff Responsiveness Composite	63.8	65.8	**2**
Pain Management Composite	71.7	73.2	**1.5**
Communication about Meds Composite	65.8	66.6	**0.8**
Discharge Information Composite	91.6	91.2	**-0.4**
Overall Rating	79.8	81.1	**1.3**
Likelihood to Recommend	90	90.6	**0.6**

SERVICE EXCELLENCE
Dedicated to the Patient Experience

2015 Data locked through August 2015
All Scores reflect Top-Box %
Date Pull: 10/30/2015

Nearly every indicator is favorable compared to last year; 2015 was our best year yet for patient experience—a tribute to the hard work and commitment of the entire MGH team.

Optimizing patient flow

a look at the work of the Patient Progression Improvement Team

—by Amy Giuliano and Janet Madden, RN, Nursing Department

The Patient Progression Improvement Team identifies ways to alleviate bottlenecks. The departments of Medicine, Surgery, Neurology, and Neurosurgery were selected as the team's focus based on their potential to lower the number of avoidable inpatient days and reduce overall average length of stay.

Optimizing patient flow is a hospital-wide initiative designed to enhance care-delivery, improve access, and ensure timely patient progression while maintaining optimal quality, safety, and service. MGH functions at high capacity every day. When bottlenecks occur, they impede patient progress, keep patients from being discharged in a timely manner, and prevent us from accepting new admissions.

For more than a year, the Patient Progression Improvement Team, chaired by senior vice president for Patient Care, Jeanette Ives Erickson, RN, and medical director of the Vascular Center, Michael Jaff, DO, has been meeting to identify ways to alleviate bottlenecks in the system. Four services were selected as the team's focus based on their potential to lower the number of avoidable inpatient days and reduce overall average length of stay. Those departments were Medicine, Surgery, Neurology, and Neurosurgery. The Patient Progression Improvement Team is comprised of nursing and physician leaders from the four focus areas as well as representatives from Case Management, Social Work, Physical Therapy, and other departments.

The Patient Progression Improvement Team reviews data, develops plans, and holds teams accountable for ensuring that patients receive the right care in the right place at the right time.

The work of the Patient Progression Improvement Team:

- allows us to provide services to more patients who need our care
- helps decompress the chronically overcrowded Emergency Department
- helps advance our Population Health Management strategy

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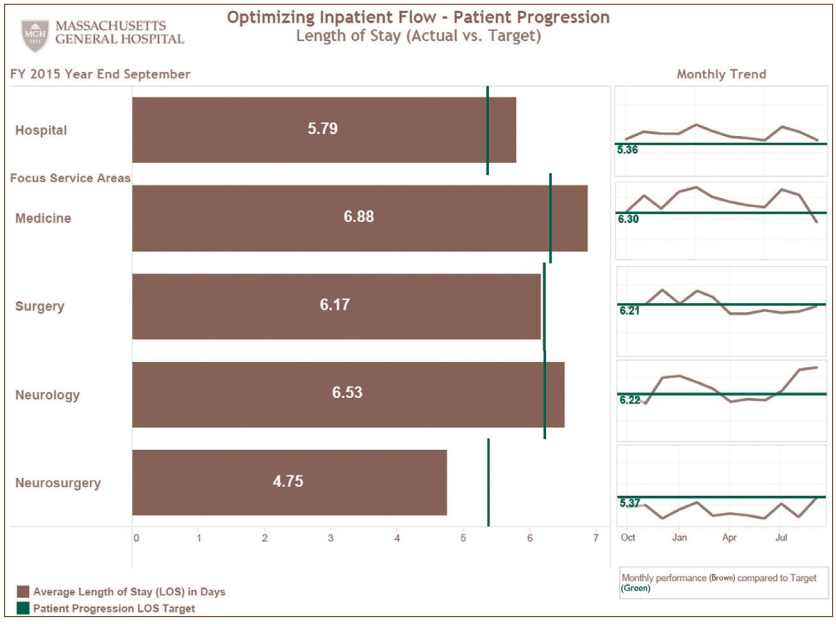


- provides capacity for growth in inpatient care (including international patients and patients outside of our immediate area)
- improves efficiency and value for patients and families

Measuring Outcomes: Average Length of Stay

Measurement is a key component of the Patient Progression Improvement Team's work. Achieving a sustained reduction in average length of stay has been a prime focus over the past year. The dashboard on the previous page shows the 2015 fiscal year-end average length of stay compared to the patient progression target (0.5 days less than the 2014 fiscal year-end length of stay). Key findings:

- Hospital-wide average length of stay was favorable (5.79 days in FY 2015 versus 5.82 in FY 2014)
- Average length of stay for Medicine increased (6.88 days in FY 2015 versus 6.84 in FY 2014)
- Surgery, Neurology, and Neurosurgery all showed improved length of stay compared to FY 2014
- Surgery and Neurosurgery exceeded length of stay targets for FY 2015
- Neurology ended the year at 6.53 days average length of stay, 0.19 days below budget but greater than Patient Progression targets
- Average length of stay in Medicine remained (0.08 days) higher than budget and Patient Progression targets. It's worth noting that 1,332 more patients were discharged from Medicine compared to last year

Guardianship

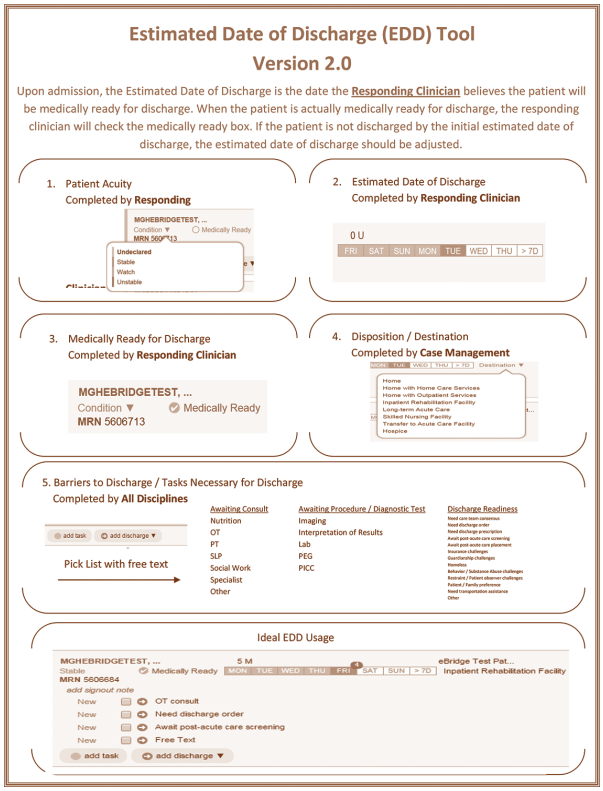
In August, 2014, an advanced practice nurse was added to the Guardianship Team to partner with the guardianship social worker to create a front-line team of two dedicated professionals. The team initially focused on guardianship cases in the Neurosciences. But once the approach was deemed successful in early identification of guardianship cases, reducing processing time, and decreasing avoidable days and length of stay, the team's efforts were made available to all services (in December of 2014).

Since that time, all aspects of internal processing for guardianship cases have been reduced in all services except the time from admission to case-initiation in Medicine. Length of stay and guardianship-related avoidable days have decreased in all services. The guardianship advanced practice nurse and social worker have worked with families and staff to assist patients in appointing health care proxies or locating pre-existing health care proxies, which has helped avert guardianship in 38% of potential cases. They recently developed a 'guardianship roadshow,' which along with an attending neuroscience nurse, they take to units to improve staff's understanding of best practices related to guardianship-prevention and early identification of guardianship cases.

Estimated Date of Discharge Tool

A new on-line tool was developed to ensure documentation and communication of the estimated discharge date among patients, families, and clinicians. The Estimated Date of Discharge (EDD) tool is intended for use by all members of the inter-disciplinary team. The tool provides real-time access to updates on the estimated date of discharge, anticipated discharge disposition, barriers to discharges, and tasks necessary to ensure impending discharges.

The tool was rolled out a little more than a year ago. Utilization statistics are available on the Length of Stay portal page. It is hoped that continued focus on communication and awareness around date of discharge will foster more efficient care-delivery, improved patient experience, and shorter overall length of stay.



Levels of Care Education

To facilitate optimal patient flow and ensure that patients' needs are fully met after discharge, all members of the healthcare team, including patients and families, should have a working understanding of post-acute care options. Post-acute care choices should be based on:

- individual patient needs
- plans for ongoing treatment
- input from the team, the family, and the patient
- availability of care options
- insurance considerations

A discharge plan that places the patient in the most appropriate care setting can greatly affect clinical outcomes and minimize the possibility of

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Collaborative

promoting Excellence knowledge and

—by Gaurdia Banister, RN, executive director, and Mary Ellin Smith, RN, professional

2015 was a year of growth and accomplishment for collaborative governance and our more than 300 collaborative governance champions whose commitment to excellence is the driving force behind this PCS decision-making body. Following is a brief summary of the work of collaborative governance committees this past year.

The Diversity Committee continued to educate champions and the MGH community around the importance of cultivating a culturally skilled workforce and fostering a culture that embraces diversity. Champions shared stories from their own backgrounds and traditions and had an opportunity to meet with Verna Myers, author, speaker, and cultural activist, about unconscious bias and how it affects our everyday practice and relationships.

The Ethics in Clinical Practice Committee continued to increase awareness and understanding of the importance of advance directives. Champions hosted an educational booth in the Main Corridor for National Healthcare Decision Day, educating patients, families, and clinicians about the MOLST (Medical Orders for Life Sustaining Treatment) initiative, which became law in 2014. They presented case studies, reviewed journal articles, and hosted a book club.

The Patient Education Committee continued its work to ensure patients are able to obtain, read, understand, and use healthcare information in making appropriate decisions and complying with treatment instructions. Champions provided consultation to other committees about existing educational resources and those that will be available through Partners *e*Care. Champions published articles in *Caring Headlines* and hosted a health literacy booth as part of Health Literacy Month.

The Fall Prevention Committee continued its work to raise awareness about the importance of identifying patients at risk for falling and shared strategies to prevent falls. The committee shed light on concerns that young adults are also at risk for falling, recognizing that fall risk is not a factor of age. The committee continued to monitor data from the PCS Office of Quality & Safety and served as a consulting resource for areas with high fall rates.

The Research and Evidence-Based Practice Committee continued to lead efforts to ensure care-delivery is evidence-based through a review of research articles and Journal Club presentations, including one on the *e*Care Nurse Residency Program. *Did You Know* posters focused on oral care and breastfeeding.

The Informatics Committee continued to give voice to the concerns and suggestions of clinicians in preparation for the transition to Partners *e*Care. Champions reviewed data screens and processes and provided feedback on their potential impact to current workflows. The committee also developed a new treatment sheet that eliminates duplication and ensures regulatory compliance.

The Pain Management Committee continued to provide leadership in ensuring clinicians have the knowledge and skill to assess and manage pain as part of the multi-disciplinary team. Champions reviewed and provided feedback on procedures and educational plans related to the administration of Ketamine on general care units. The committee hosted an informational booth as part of Pain Awareness Month.

The Restraint Solutions in Clinical Practice Committee continued to focus on reducing the use of restraints not only with new products (blue sensory mitts) but by assisting staff in recognizing cues for escalating behavior and sharing interventions to help keep patients and staff safe.

governance

Every Day through compassion

The Institute for Patient Care development manager

The Policy, Procedure, and Products Committee brought their clinical knowledge and expertise to bear, reviewing more than 100 procedures in 2015. Champions continued to identify questions and concerns at the bedside and bring them to the attention of accountable individuals and departments. They provided feedback on monitor alarms, practice alerts, and medication administration.

The Skin Care Committee continued to provide consultation on products and challenging skin-care issues. Champions reviewed the results of the pressure-ulcer surveillance survey and created a journal club to discuss evidence-based findings. Champions participated in case studies of patients with complex, skin-care issues.

The Staff Nurse Advisory Committee and *PCS Inter-Disciplinary Staff Advisory Committees* continued to bring their ideas and expertise forward in meetings with the Patient Care Services Executive Committee. Champions contributed to a successful Joint Commission survey, identified opportunities for cost savings and opportunities to improve HCAHPS scores, and made recommendations on how to implement National Patient Safety Goals.

This past year, a group led by Gaurdia Banister, RN, executive director of The Institute for Patient Care, and Mary Ellin Smith, RN, professional development manager, determined that in order to make the best use of time and resources and remain an effective decision-making body, the work of some committees would be consolidated while the work of others would be discontinued. As a result, the Fall Prevention, Pain Management, Skin Care, and Restraint Solutions committees ended their work on December 31, 2015. Improved HCAHPS scores, safety reports, skin breakdown surveys, and a decrease in the use of restraints speak to the success of their efforts.

And to ensure that collaborative governance continues to focus on the most relevant priorities in our current practice environment, two new committees were formed, effective January 1, 2016:

- The Patient Experience Committee
- The Quality & Safety Committee

All disciplines within Patient Care Services benefit from the input of staff advisory committees. These committees provide feedback on practice issues and concerns; review pertinent clinical indicators of care; and serve as a forum for communication. (See revised committee structure at left.)

As we look forward to 2016, collaborative governance will continue to be a critical part of our Professional Practice Model, placing the authority, responsibility, and accountability for patient care with clinicians at the bedside.

PCS Diversity Program reaches beyond the walls of MGH

—by Deborah Washington, RN, director PCS Diversity Program

2015 marked the five-year anniversary of the report on the Future of Nursing. The IOM released an evaluation of the progress made in the past five years and recommends that Nursing make diversity a priority. That recommendation is in alignment with our own strategic plan and diversity initiative.

This past year, the PCS Diversity Program focused on national, state, and organizational issues in our efforts to advance our diversity and inclusion agenda. The program expanded to include a new dimension of diversity: the health literacy of patients and families in the context of how their lives are impacted by their local neighborhoods and communities. We saw broader participation on our Patient and Family Advisory Committees (PFACs) with a boost in the diversity of their membership. And value continued to be placed on bringing the voice of *all* patients to the healthcare table.

We continued to be involved with the Future of Nursing campaign and mindful of the Institute of Medicine's (IOM) recommendations related to diversity in nursing leadership, practice, and education. Through webinars on topics such as mentoring and diversity, we were able to benchmark our efforts against those of other states. 2015 marked the five-year anniversary of the report on the Future of Nursing. In December, the IOM released an evaluation of the progress made in the past five years and recommends that Nursing make diversity a priority. That recommendation is in alignment with our own strategic plan and diversity initiative.

In 2015, we strengthened our relationship with the Future of Nursing's Massachusetts State Action Coalition through the work of its Diversity Advisory Committee. We hope that the next five years will see greater diversity in the workplace and an increase in the enrollment of diverse students in nursing schools. We continue to assist local schools of nursing in overcoming challenges they may encounter in recruiting and retaining diverse students.

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Some scenes from the February 18, 2015, "Let's Talk about Race" open-table discussion.

2015

Diversity (continued)

The newly created MGH Diversity Committee, co-led by Jeanette Ives Erickson, RN, senior vice president for Patient Care, is bringing renewed interest to our diversity agenda. Two important open-table discussions were held during Black History Month confirming that staff want to talk about issues in the news that impact us all. Health equity and quality will be priorities as this committee clarifies its future work.

Through our association with AARP Massachusetts, we've connected to initiatives like Age Friendly Boston, The Department of Health's Falls-Prevention Commission, and Life Re-Imagined, a program that embraces reflection and appreciation for personal values and accomplishments. This type of community engagement provides opportunities to expand our perspective on the meaning of continuum of care.

New language is currently being crafted by the Robert Wood Johnson Foundation and the Institute of Medicine around what they call, "the culture of health." This will add to our understanding of the social determinants of health, diversity, and cultural sensitivity as we take on the challenges of population health.

The Association for Size Diversity and Health reminds us of the stigma that is still associated with weight in our society. From their website, this statement describes the programmatic approach to addressing this important issue. "Our approach is a continuously evolving alternative to the weight-centered approach to treating clients and patients. It is a movement to promote size-acceptance, end weight discrimination, and lessen the cultural obsession with weight-loss and thinness. The approach promotes balanced eating, life-enhancing physical activity, and respect for the diversity of body shapes and sizes.

Requests for unit-based Cultural Rounds have increased, bringing this unique learning experience to more areas throughout the hospital. Topics focus on team dynamics and how to respond to remarks with racial undertones.

Career counseling, continuing education, recruitment and retention, mentoring, and cultural consultations are just a few of the activities of our diversity program. For more information, contact Deborah Washington, RN, director, PCS Diversity Program, at 617-724-7469.

Members of the Patient Care Services Executive Team

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

Shelley Amira, associate director, Administration, MGH Center for Global Health and Disaster Response

Gaurdia Banister, RN, executive director, The Institute for Patient Care

Debra Burke, RN, associate chief nurse

Leila Carbunari, RN, director, International Programs, International Patient Center

Mary Cramer, senior director, Process Improvement, Ambulatory Management & Performance

Jana Deen, RN, senior director, Patient Safety

Marianne Ditomassi, RN, executive director, PCS Operations and Magnet Recognition

Theresa Gallivan, RN, associate chief nurse

Annabaker Garber, RN, former director, PCS Informatics

Marie Elena Gioiella, LICSW, director, Social Services

Antigone Grasso, director, PCS Management Systems and Financial Performance

Van Hardison, RN, interim director, PCS Informatics

Misty Hathaway, senior director, Center for Specialized Services, MGPO

Bob Kacmarek, RRT, director, Respiratory Care

Robin Lipkis-Orlando, RN, director, Office of Patient Advocacy

Labrini Nelligan, executive director, Lunder-Dineen Health Education Alliance

Jacqueline Nolan, director, Volunteer Services

Anabela Nunes, director, Medical Interpreters

Reverend John Polk, director, Chaplaincy

George Reardon, director, Clinical Support Services, Orthotics & Prosthetics

Susan Sabia, managing editor, *Caring Headlines*

Colleen Snydeman, RN, director, PCS Office of Quality & Safety

Michael Sullivan, PT, director, Physical and Occupational Therapy

Nancy Sullivan, director, Case Management

Steve Taranto, director, Human Resources

Dawn Tenney, RN, associate chief nurse

Carmen Vega-Barachowitz, CCC-SLP, director, Speech, Language & Swallowing Disorders and Reading Disabilities

Deborah Washington, RN, director, PCS Diversity

Kevin Whitney, RN, associate chief nurse

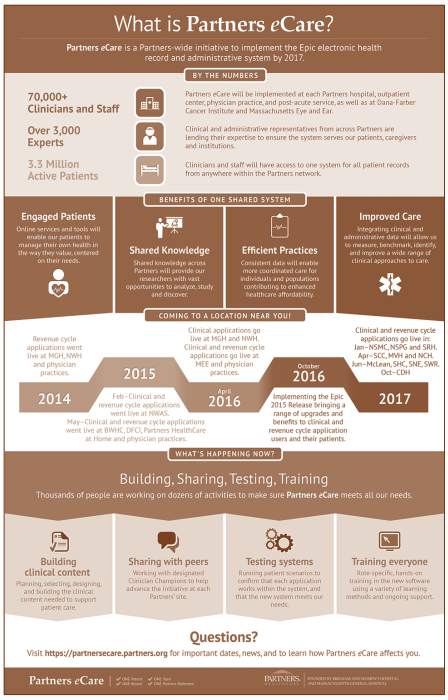
Partners *e*Care

a year of intense planning, preparation, and practice

—by Annabaker Garber, RN, director, PCS Clinical Informatics

We made incredible strides this past year toward making Partners *e*Care a reality. Our first clinical go-live, December 10th, was a resounding success. Our health-profession colleagues, Dermatology, and Behavioral Health were the first groups to adopt the clinical capabilities of the new system, and more ambulatory sites followed in January. The remaining ambulatory sites and inpatient areas will go live April 2, 2016, bringing us completely on-line with a Partners-wide, integrated health information system. The year was characterized by planning, preparation, and practice.

The MGH *e*Care team recruited 28 front-line staff to act as informatics analysts. This group, representing Nursing, the health professions, Case Management, and Nutrition, worked for MGH *e*Care on a part-time basis covering a diverse range of departments throughout the hospital. Their work included documenting current work flows and sequencing the order in which we perform and document our work. This was necessary in order to fully predict the impact of the new system on information-capturing practices. Informatics analysts became experts in the new *e*Care functions and have supported super users and departments in preparation for the transition. Going forward, this group will comprise the core of our 'uber user' team, providing support and assistance to super users and front-line leaders during the critical go live period and beyond.



MGH supported the work of 38 organizational-readiness work-groups, each led by clinical and administrative leaders. Work-groups were tasked with predicting the impact of *e*Care on their areas and creating plans to use the new system effectively, or what we called, 'impact mitigation.' This is a critical step in ensuring we're fully prepared to go live.

We enlisted more than 1,300 super users across all departments, 660 in Patient Care Services alone. Super users will act as front-line support for staff. Super users undergo extra training to become adept in the new functionality so they can support end-users before and during transition. As we go live, super users will be 'at the elbows' of staff, answering questions and identifying issues that need to be addressed. They'll reinforce new work flows, and after go-live, they'll continue to provide input to ensure a seamless transition.

MGH has engaged almost 60 staff members as credentialed trainers. Credentialed trainers are vital links in helping new users make the connection between how *e*Care works and how they'll be collecting, entering, and retrieving health information going forward. We're already hearing from those who've gone through training that having credentialed trainers who understand their work and their practice has made training more meaningful and more enjoyable. It will be extremely helpful to have this wealth of expertise to support users during go-live.

2015 was an important year in our Partners *e*Care journey. Because of the hard work and dedication of our entire workforce, we're poised for a very successful transition.

Global health and emergency preparedness

—by Maryfran Hughes, RN, nursing director, Emergency Department

Ever ready to deliver the highest quality care, our Emergency Preparedness Team, supported by Infection Control, implemented a detailed plan to safely care for Ebola patients in the Emergency Department and Medical and Pediatric ICUs.

In 2015, the MGH community had many opportunities to feel the impact of our extensive emergency-preparedness activities. In January and February, unprecedented snow storms and blizzards wrought havoc on the city creating all manner of transportation challenges, but MGH employees still managed to get to work to care for patients and families.

That same spirit that buoyed staff through one of the worst winters in Boston history prevailed as we dealt with the threat of an Ebola epidemic. Ever ready to deliver the highest quality care to those in need of our services, leaders from almost every department came together to develop a plan to safely care for Ebola patients. Led by our Emergency Preparedness Team and supported by Infection Control, a detailed management plan was implemented in the Emergency Department and Medical and Pediatric ICUs. Staff became champions, training their colleagues in donning and doffing personal protective equipment (PPEs). All departments supported the Ebola planning effort with front-line staff engaging in drills to simulate patient arrival, transport, transfer of care, lab safety, management of waste, and other Ebola-specific precautions. Drills were conducted to test the needs of pediatric patients, and special construction in the ED and MICU ensured a safe environment for any Ebola patients we might receive. Due to the intense commitment and readiness planning of staff and leadership throughout the hospital, MGH was designated as one of ten national NETEC Ebola Treatment Centers. And that level of collaboration continues as we work with state and federal agencies on our on-going preparation and response plans.

ED pediatric nurse, Paige Fox, RN, volunteered at an Ebola treatment center in Sierra Leone for ten weeks, caring for children critically ill with Ebola. Her experience was recounted in the September 3, 2015, issue of *Caring Headlines*.

MGH has a long history of supporting the global community. Pat Daoust, RN, associate director of Nursing for the MGH Center for Global Health, reports that MGH is connected to more than 50 programs in 42 countries around the world, developing and training teams of nurses and physicians to respond to global crises. This past April, more than 25 MGH staff members responded to the Nepal earthquake, treating more than 2,000 patients, many in rural, hard-to-reach areas. The MGH Global Health Disaster Response teams continue to train in preparation for deployment.

Education and training are a critical part of being able to support the global community. Sponsored by generous donors, MGH Global Health offers a number of fellowships that allow MGH nurses to work for up to three months in places like Uganda, Tanzania, and Malawi. They also make it possible for local counterparts to attain master's degrees in Nursing or Medicine to help foster access to better health care through local providers.

For more information about the work of our Emergency Preparedness Team, contact Maryfran Hughes, RN, at 617-724-4127. For information about the work of the MGH Center for Global Health, contact Pat Daoust, RN, at pdaoust@mgh.harvard.edu.

The Lunder-Dineen Health Education Alliance of Maine

—by Labrini Nelligan; Denise O'Connell, LCSW; and Carole MacKenzie, RN

The Lunder-Dineen Health Education Alliance of Maine, based at MGH, is a one-of-a-kind, interactive, health-education program that links an academic medical center with a neighboring state. The program has been charged with improving the health and well-being of the residents of Maine by advancing the skill and expertise of their healthcare professionals. The idea is that on-going, high-quality education empowers health professionals to provide the best possible care.

"The inspiration for this partnership can be credited to the Peter and Paula Lunder family (generous supporters of the Lunder Building) and MGH leadership," says Labrini Nelligan, executive director of the Lunder-Dineen Alliance. Maine has some unique challenges—it is geographically large, predominately rural, and it's the least densely populated state east of the Mississippi. The Lunders were confident that this innovative, Maine-MGH collaboration would help overcome those challenges.

Back row (l-r): Carole MacKenzie, RN; Robert Birnbaum, MD; Denise O'Connell, LCSW; and Gino Chisari, RN. Seated: Labrini Nelligan; James Dineen, MD; and Jeanette Ives Erickson, RN.

Says Denise O'Connell, LCSW, Lunder-Dineen senior program manager, "We've met with officials from every hospital in Maine, and hundreds of thought leaders in academia, community-based practices, advocacy groups, government, and professional organizations."

This relationship-based approach helped identify several areas of critical need in the areas of education (mental and behavioral health), substance-use disorders, nursing leadership, older adult health, oral health, and veterans' health. The program has forged critical partnerships that help ensure our efforts are tailored to meet the needs of the great state of Maine and its healthcare professionals.

Three strategic initiatives are being employed to address these needs, each with a clear methodology incorporating best practices to enhance learning. We've convened state-wide advisory groups to guide the work of each initiative, with subject-matter experts from Maine and MGH.

The Maine Nursing Preceptor Education Program

Fifty-three percent of nurses in Maine are age 50 or older; 52% are not planning to remain in the workforce beyond five years. And the retirement cliff for nursing faculty is expected to be even steeper. To help support, retain, and transition nurses, we launched a state-wide nursing preceptor education program informed by academic and clinical leaders from both Maine and MGH. This free educational program advances and strengthens the knowledge, skills, and practice of nurse preceptors.

MOTIVATE

To improve oral health care, Lunder-Dineen is in the process of developing the MOTIVATE program. The goal is to improve the quality of oral health care and preserve the dignity and quality of life for older adults in long-term care settings. MOTIVATE provides a 21st-century, educational model that will expand oral-health knowledge, skills, and practice for healthcare providers in the long-term-care setting.

Says O'Connell, "We're conducting a needs assessment in collaboration with Maine Veterans' Homes, the pilot site for this program. Based on the assessment, we'll work closely with the advisory team to develop a blended learning model to address the gaps in oral-health education."

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Time to Ask

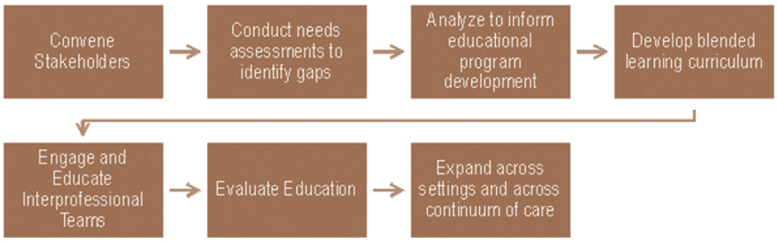
Alcohol is the number one mis-used substance in Maine and Massachusetts. Exploring alcohol use with patients and families and connecting unhealthy alcohol use to its short-and long-term consequences is a crucial public-health need in Maine.

Most healthcare professionals receive very little education in alcohol use, despite its prevalence. The Time to Ask initiative strives to help the primary care team properly identify, assess, and recommend treatment for patients affected by unhealthy alcohol use.

The Lunder-Dineen Alliance recently launched our first interactive, on-line, alcohol education program featuring MGH expert, John Kelly, associate director of the Center for Addiction Medicine. To view the learning tool, go to: http://www.lunderdineen.org/impacts-unhealthy-alcohol-use.

MGH has committed significant resources to this work, including the expertise and/or participation of MGH senior leadership, full- and part-time employees and volunteers, and an inter-disciplinary team of executives who advise the program. Co-chairs are Maine native, Jeanette Ives Erickson, RN, senior vice president for Patient Care; Maine native, James Dineen, MD, internist; and Robert Birnbaum, MD, vice president of Continuing Professional Development at Partners HealthCare. Rounding out the team are: Nelligan; O'Connell; Gino Chisari, RN, director of The Norman Knight Nursing Center and Lunder-Dineen chief learning officer; and Carole MacKenzie, RN, professional development specialist.

Lunder-Dineen Educational Framework



The goal is to develop a sustainable, state-wide program that can be expanded across settings and throughout the continuum of care by:

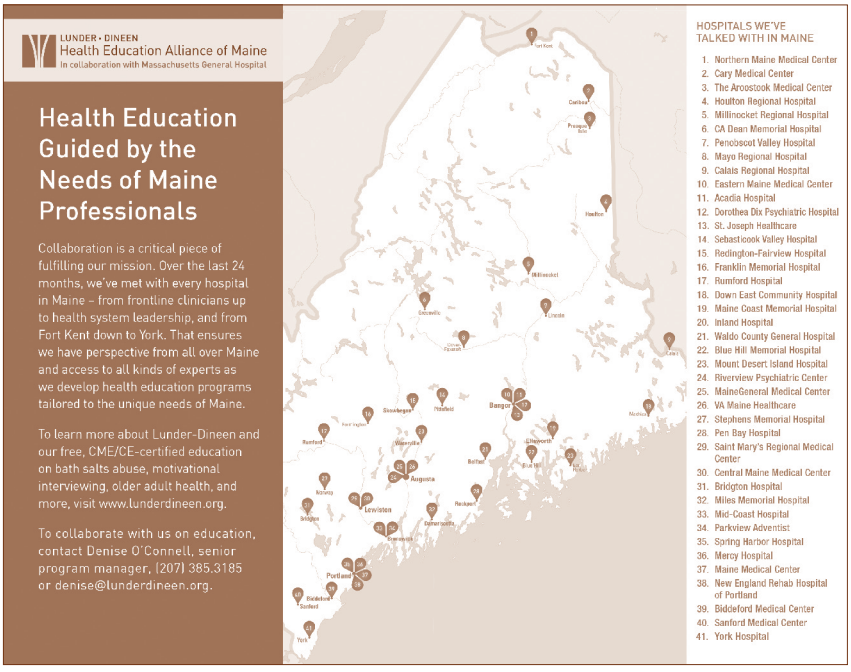
- convening and collaborating with stakeholders
- creating evidence-informed education tailored to Maine healthcare professionals
- engaging inter-professional teams
- offering education at no cost to learners

Says Ives Erickson, "I'm very pleased to see how far we've come in such a short time from our initial concept to this full-fledged, health-education program advancing these important initiatives. I know my home state of Maine is benefiting greatly from these efforts."

Members of the Lunder-Dineen team have been invited to present regionally and nationally on the strategic initiatives and share the success of the program. They've reported on their progress at the nursing summit of the Organization of Maine Nurse Executives, the national Gathering of the DentaQuest Foundation, and the annual convention of the Association for Nursing Professional Development. The alliance has received supplemental, philanthropic support from the DentaQuest Foundation, Northeast Delta Dental, the Sam L. Cohen Foundation, and others.

The Lunder-Dineen Alliance will continue to collaborate with The Norman Knight Nursing Center, the Yvonne Munn Center for Nursing Research, the Maxwell & Eleanor Blum Patient and Family Learning Center, the Red Sox Foundation and MGH Home Base Program, the Benson-Henry Institute for Mind-Body Medicine, Partners HealthCare Office of Continuing Professional Development, and the MGH Development Office.

For more information about the work of the Lunder-Dineen Alliance go to: www.lunderdineen.org, or call 617-724-6435.

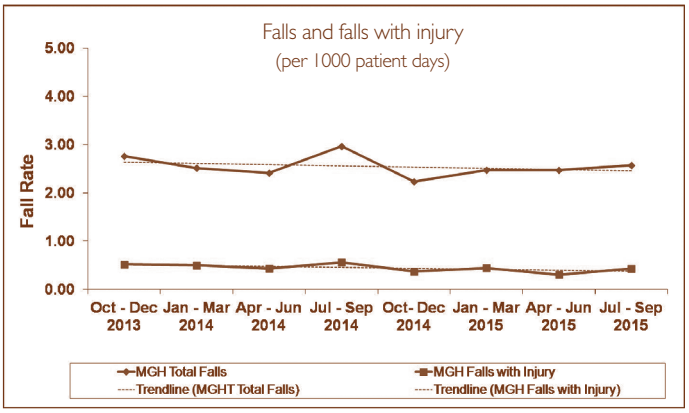


Tracking quality with nurse-sensitive indicators

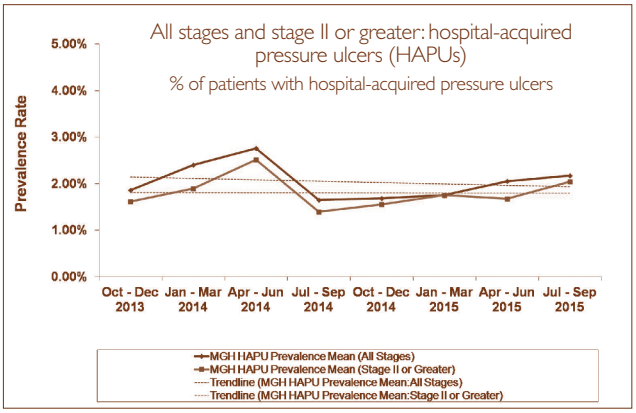
—by Colleen Snydeman, RN, director, PCS Office of Quality & Safety

Quality

Clinical-quality, nurse-sensitive indicators help us track aspects of patient care known to be associated with nursing interventions. We use this data to guide decisions about performance-improvement, research, and innovative solutions. Specific tactics are determined by unit leadership and staff to improve unit-level performance. Best practices are reflected in positive trends. The following graphs illustrate our performance for each indicator. More information is available on the specific Excellence Every Day portal page referenced with each graph.



- Portal Page: www.mghpcs.org/eed_portal/EED_fallprevention.asp
- PCS Falls Committee collaborated with the MGH Falls Task Force to promote the MGH LEAF Program (Let's Eliminate All Falls)
- The role of Bulfinch observer (sitter program) was revised to include hands-on care
- A revised Fall Communication Tool was distributed to better reflect risk assessment and interventions
- Patient fall data is now being collected and disseminated for select ambulatory settings
- Ongoing efforts:
  - Fall-prevention equipment continues to be provided to patients at high risk for falls
  - Fall-education materials (pamphlet and videos) are available for patients and families
  - Staff education programs (Nursing Grand Rounds and annual falls display table) to raise awareness around fall prevention



- Portal Page: www.mghpcs.org/eed_portal/EED_skin.asp
- Using an established algorithm, we are ensuring the appropriate use of specialty mattresses for patients at risk for pressure ulcers during quarterly pressure-ulcer prevalence days
- Partnering with MGH surgeons to reduce tracheotomy-site pressure ulcers in trauma patients through the elimination of sutures
- Real-time reporting and monitoring of pressure ulcers through the safety reporting system, promoting assessment of skin- and pressure-ulcer rate deduction
- Pre-admission skin assessment performed in the Emergency Department and communicated in hand-overs and on admission
- Expert wound consultation
- Ongoing efforts:
  - Skin Care Committee
  - Clinical Nurse Specialist Wound Care Task Force
  - Continued use of the SKIN Bundle

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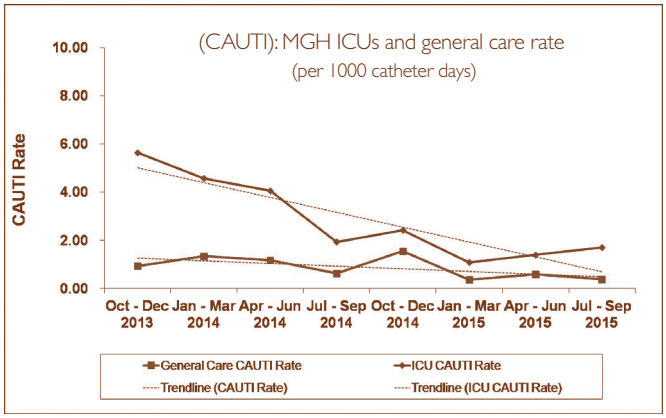
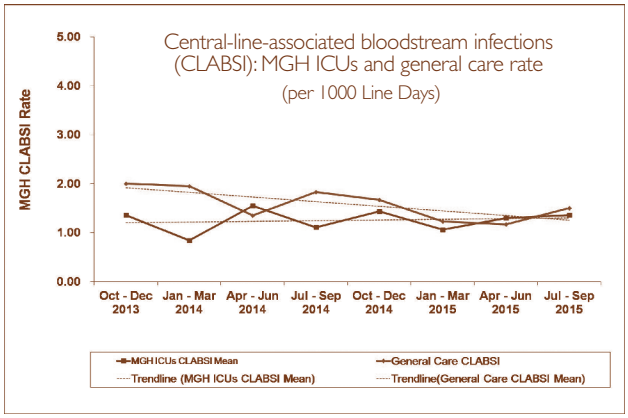


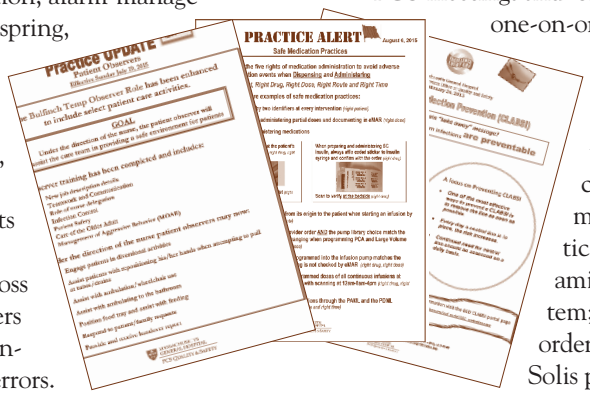


- Portal Page: www.mghpcs.org/eed_portal/EED_CAUTI.asp
- Successful reduction in CAUTI rates
- CAUTI reduction efforts recognized by the first annual Partners Quality Symposium
- Nurse Driven Protocol for Foley Catheter Removal was developed and is ready for implementation with 2016 eCare roll-out
- Implementation of the new National Healthcare Safety Network/ Center for Disease Control guidelines for CAUTI surveillance
- Ongoing strategies:
  - Quarterly monitoring of compliance with 'securing catheter'
  - Monthly CAUTI task force meetings
  - Performance-improvement planning sessions for unit-based improvement plans
  - Real-time feedback to unit leadership as CAUTI cases are identified

- Portal Page: www.mghpcs.org/eed_portal/EED_centrallines.asp
- Port protection cap (Curos) implemented on all catheter ports for patients with central venous catheters (CVCs)
- IV Task Force convened in July, 2015
  - Addresses opportunities and concerns related to IV practice
  - Staff input sought through surveys to assess educational opportunities related to staff knowledge and practice regarding needleless connector and IV access and maintenance
- Critical Care Quality & Safety Committee inter-disciplinary group promoting CLABSI improvement
- Ongoing efforts:
  - Use of CVC-insertion checklist
  - Daily assessment for removal of CVCs
  - Use of biopatch as part of CVC dressings
  - Chlorhexidine bathing for ICU patients
  - Scrub the Hub awareness

Safety

We began the year preparing for the Joint Commission visit, focusing on National Patient Safety Goals and showcasing our best practices around blood transfusion, patient identification, medication-safety, infection-prevention, alarm-management, and critical lab results. In the spring, staff spoke up in record numbers completing the hospital-wide safety culture survey; we heard safety narratives during Nurse Week, and saw the nomination of safety stars. Our safety-culture-survey results exceeded national benchmarks in many areas, especially teamwork across units. We need to work on hand-overs and transitions, communication openness, and non-punitive response to errors.



PCS leadership collaborated with leaders throughout MGH and the PCS Office of Quality & Safety reviewing safety events and near misses to determine the plans for improvement, which may include education, system updates, and/or revisions to policies, practices, or procedures. Patient safety and quality-improvement are ongoing priorities at PCS meetings and forums, in HealthStream courses, in one-on-one training, in Practice Alerts and Updates, articles in *Caring Headlines*, and Tuesday Take-Aways.

An abbreviated list of *some* of the topics we addressed this past year includes: mislabeled specimens; tubing mis-connections; safe medication practices; naso-gastric tubes; continuous ketamine infusion; fecal management system; patient observers; cardiac monitoring orders; critical-result pathways; CADD-Solis pumps; blood-transfusion documentation; and new arterial blood-gas syringes.

For more information on the work of the PCS Office of Quality & Safety, call 617-643-0435.

How understanding the data drives decision-making

—by Antigone Grasso, RN, director, PCS Management Systems and Financial Performance

These graphs show the impressive work we're doing to keep care affordable and to ensure we have an engaged, empowered, highly-educated workforce. This is what drives our Magnet designation and helps drive the work we're doing to make care more effective and efficient.

The September, 2015, Center for Health Information and Analysis' annual report on the, "Performance of the Massachusetts Heath Care System," found that health-care spending in Massachusetts increased in 2014 by 4.8%, slightly more than the national increase of 4.7% for the same time period. The increase in Massachusetts is beyond the benchmark of 3.6% and reflects an acceleration over past years, though several factors contributed to this increase, including significant member growth in MassHealth, the state health care program. Even with these qualifiers, national healthcare costs still account for 17.5% of the Gross Domestic Product and are projected to grow at a rate of 4.9% per year through 2024. Everyone would agree that this rate is unsustainable.

We must all be mindful of and contribute to the fiscal success of the hospital while remaining true to our mission to deliver, "the very best health care in a safe and compassionate environment."

The following graphs show the impressive work we're doing to keep care affordable and to ensure we have an engaged, empowered, highly-educated workforce. This is what drives our Magnet designation and helps drive the work we're doing to make care more effective and efficient.

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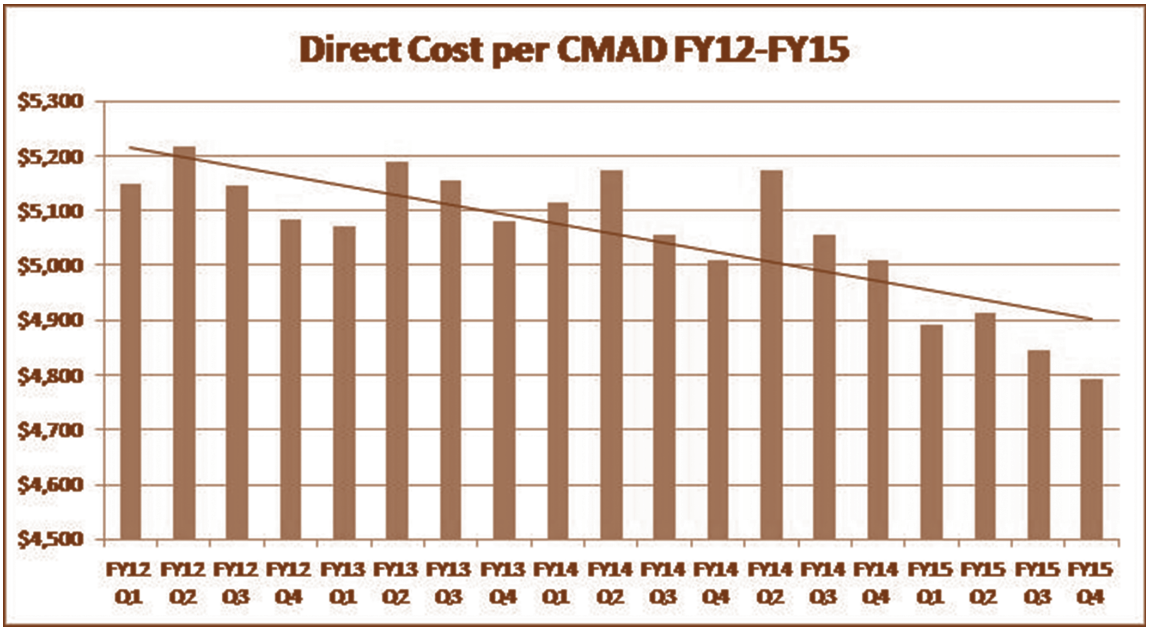
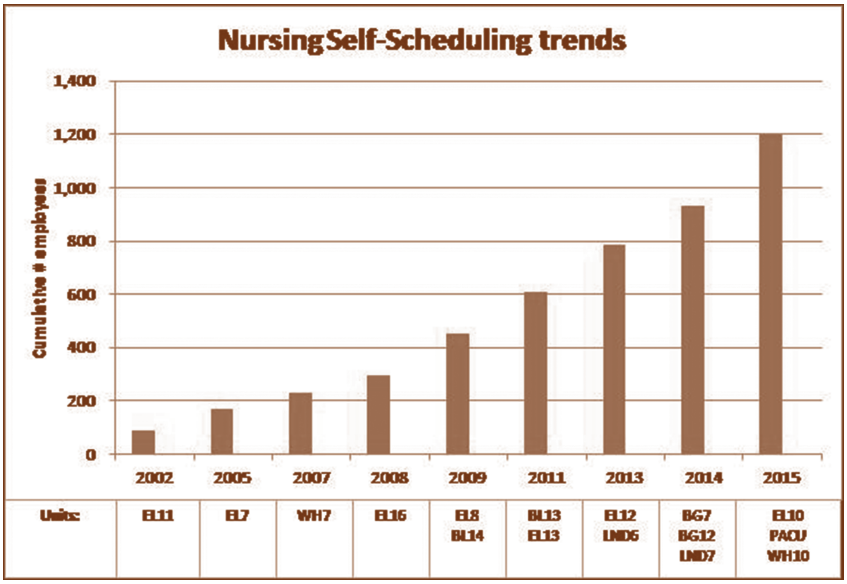
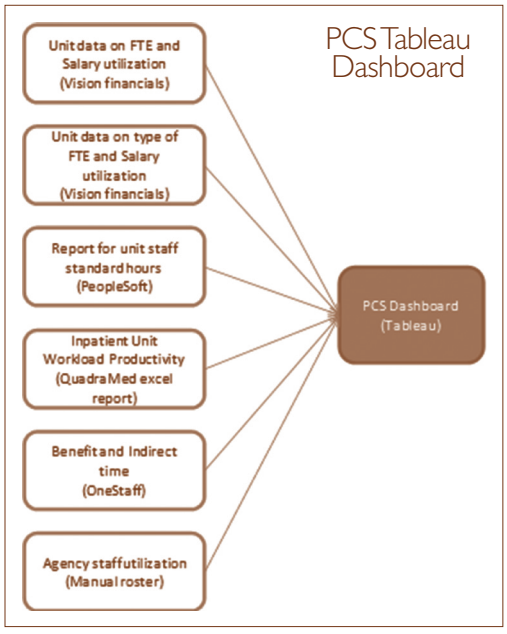


The Data (continued)



The Direct Cost per Case Mix Adjusted Discharge (CMAD) on the opposite page applies costs from direct sources (excluding overhead/indirect sources) to hospital discharges adjusted for patient complexity. The downward trend between fiscal years 2012 and 2015 reflects the improvement in expense-management.

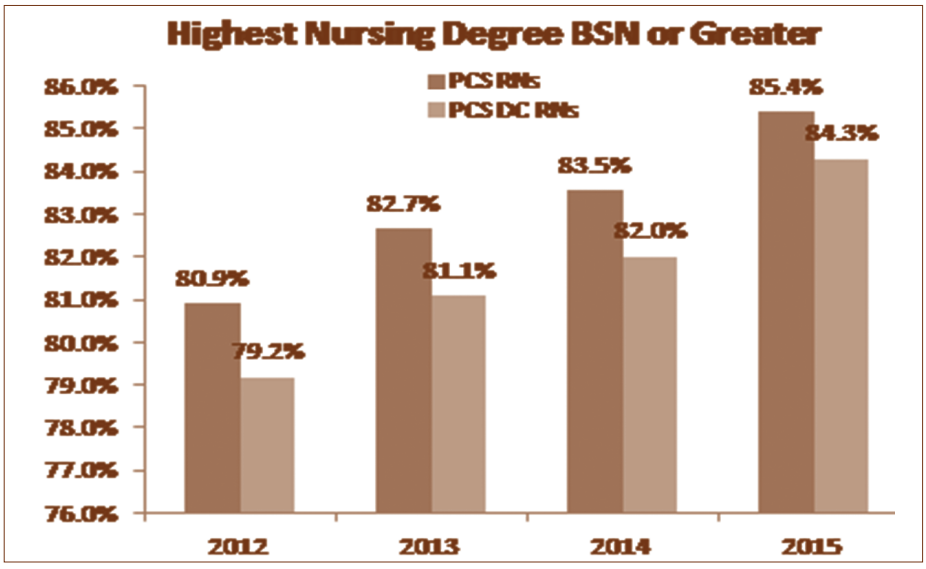
Self-scheduling is one of the tools we use to ensure staff have a voice in their work life, and it's one piece of our Magnet evidence. Since going live with the One-Staff scheduling system in 1997, more than 20% of direct-care staff now participate in self-scheduling (see above).



We are constantly exploring ways to improve efficiency. Historically, it has been cumbersome for PCS leadership to obtain quick snapshots of key financial metrics for their areas. With the implementation of a new PCS dashboard using a business-intelligence tool called, Tableau, leaders have been given the gift of time: now they only need to access one data source instead of six (with manual compilation), a time reduction of 83% (see diagram below, left).

We continue to see a year-over-year increase in the percentage of nurses educated at the baccalaureate level or higher. This increase points to the impact of the decision made in 2006 to require BSN preparation for new graduate nurses. This metric reflects our alignment with recommendations from the Institute of Medicine and The Future of Nursing report that calls for at least 80% of nurses to be educated at the baccalaureate level or higher by 2020. The graph below includes *e*Care nurse residents; if we exclude them, the 2015 PCS nurse and PCS direct-care nurse amounts decrease to 84.5% and 83.2%, respectively.

For more information, contact Antigone Grasso, RN, at 617-724-1649.



International nursing in 2015

—by Gino Chisari RN, director, The Knight Nursing Center, and Marianne Ditomassi, RN, executive director for PCS Operations

MGH Nursing is guided by the four-pronged mission of MGH, serving patients and families through practice, education, research, and community outreach. In support of that mission, MGH Nursing has forged twinning relationships with the international community to foster advances in health care among their counterparts in other parts of the world.

Huashan Hospital Nursing

The Huashan Hospital-MGH Twinning Nurse Leader Fellowship, created in 2009, is built on three pillars of the Professional Practice Model: Practice, Education, and Research, with Leadership, Life-Long Learning, and Quality & Safety weaved throughout the curriculum. Since its creation, the fellowship has hosted 31 nurse leaders from Huashan Hospital in Shanghai, China.

Nursing director and twinning preceptor, Joanne Empoliti, RN (left), with her preceptee, Huashan head nurse, Jing 'Anna' Zhang, RN.

Each Huashan nurse is paired with a preceptor and twinning team and assigned a 'home unit' for a 10-week learning experience. Preceptors provide mentorship to visiting nurses, helping them integrate their new knowledge into practice. This past fall, four MGH nurse leaders traveled to Shanghai to conduct an assessment as Huashan nurses began to strategize about next steps in becoming a Magnet hospital. The MGH team was comprised of nursing directors, Ann Kennedy, RN; Barbara Cashavelly, RN; and Vivian Donahue, RN; and administrative director of the Charlestown HealthCare Center, Jean Bernhardt, RN.

Global Nursing Education Program

Jane Keefe, RN, professional development manager and coordinator of the Global Nursing Education Program, reports that in 2015, MGH Nursing hosted 40 international nurse visitors. Visits ranged from one-day to 10-week stays with nurses from Australia, Iceland, Botswana, England, India, South Korea, Japan, and China, among other countries.

Jiahui International Hospital

In July, a team of MGH nurses met with nurses from Jiahui International Hospital (JIH) in Shanghai. This was followed by several teleconferences, a site visit to conduct a gap analysis, and a week-long retreat in December. Initial goals for this twinning relationship are to assist in creating a competency-development model, a JIH nursing professional practice model, and other operational and educational preparations in anticipation of opening three ambulatory care clinics in 2016 and a new hospital in 2017.

For more information about international nursing at MGH, contact Gino Chisari, RN, at 617-643-6530.

re-admission. Understanding what level of post-acute care best meets the patients' needs is critical to optimal patient progression.

Toward that end, an inter-disciplinary team created a series of educational materials to clearly delineate the various levels of post-acute care according to Medicare guidelines (see diagram below). The materials help families and caregivers understand and communicate about appropriate options for patients after they're discharged. The goal is to maximize patient functionality and independence by determining placement locations that are best suited to meet the needs of patients and families. Special badges containing information about levels of care were made available to staff, and the Length of Stay portal page contains key references.

Next Steps/New Opportunities

Select initiatives have been identified as high priority and will continue to be a focus of the Patient Progression Improvement Team in the coming year. The Optimizing Patient Flow Team with leadership from Physical Therapy, Social Work, and Case Management, has been meeting regularly with leadership at Partners Continuing Care, Spaulding, and Partners Home Care to advance efforts to improve patient progression and minimize delays in discharge to the next level of care. Other high-priority efforts include:

- working with Partners Continuing Care
- maximizing the use of home-care services together with Partners Healthcare at Home, including focusing on special populations (patients requiring wound care, etc.)
- simplifying discharge and transfer for appropriate patients through the Spaulding Bed Placement initiative

High-priority efforts geared at making care-delivery more seamless include:

- exploring opportunities to use tele-health technology
- exploring direct-admit opportunities in Medicine
- reviewing admission criteria and processes
- continuing to identify and minimize operational barriers
- enhancing/promoting a culture of planning for discharge before or upon admission

Opportunities are being explored to introduce discharge preparation and incentives for patients to be discharged early in the day, scheduling modifications in Surgery, and efforts specific to particular patient populations, such as transfer patients, behavioral- and delirium-management patients, and others.

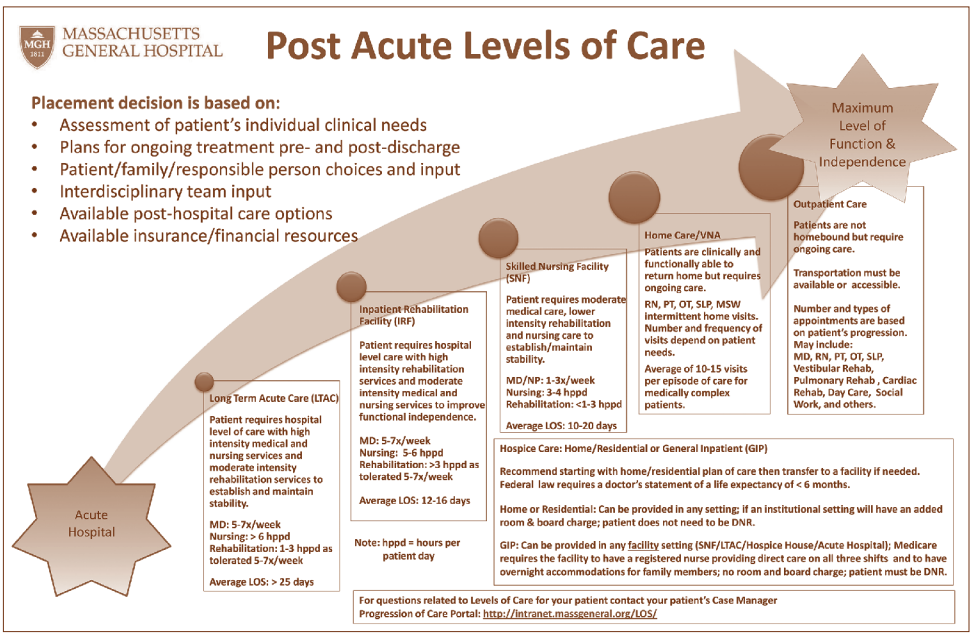
Looking ahead, MGH president, Peter Slavin, MD, has convened a Capacity Task Force to align strategic initiatives across the institution and focus efforts on those that will have the most significant impact on capacity to improve access, care-delivery, and patient flow.

What else...?

The Patient Progression Improvement Team plans to expand their work to include patient expectation-setting, timely identification of patients for early discharge, a routine review of long length-of-stay cases, and ways to make certain tests and procedures more transparent, including weekend testing (Interventional Radiology, Pathology, Percutaneous Endoscopic Gastrostomy or PEG procedures).

Information about the Optimizing Patient Flow initiative and the work of the Patient Progression Improvement Team, including a complete summary of Patient Progression Improvement Team initiatives, can be found on the Length of Stay portal page on the MGH intranet at: http://intranet.massgeneral.org/LOS/.

For more information about this work, e-mail: MGHLOS@partners.org.



2015 PCS Scholarships

—by Julie Goldman, RN, professional development manager

Through the generosity of our donors and supporters, a record 25 scholarships were presented this year:

The Norman Knight Doctoral Nursing Scholarship

- Debra Burke, RN
- Carol Casey, RN
- Jennifer Clair, RN
- Julie Cronin, RN

The Charlotte and Gil Minor Nursing and Health Professions Scholarship to Advance Workforce Diversity in Patient Care

- Melissa Joseph, RN
- Michael Grasso, RN
- Rai Singh, RRT
- Jane Martell, RN

The Cathy Gouzoule Oncology Scholarship

- Michele Golden, RN

The Norman Knight Nursing Scholarship

- Alicia Shulman, RN
- Jessica Robertson, RN
- Charlene Badolato, RN
- Jessie MacKinnon, RN
- Linda Caruso, RN
- Alexa O'Toole, RN
- Tara Belisle
- Scott Farren, RN
- Amira Hamzic, RN
- Karin Rallo, RN

The Pat Olson, RN, Memorial Scholarship

- Michele Alvarez

For information about the Patient Care Services Scholarships program, contact Julie Goldman, RN, at 617-724-2295. To support Nursing or Patient Care Services, contact Mary Hanifin at 617-643-0468.

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January 21, 2016

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