Caring Headlines
July 19, 2012

Fulmer is Linda Kelly Visiting Scholar

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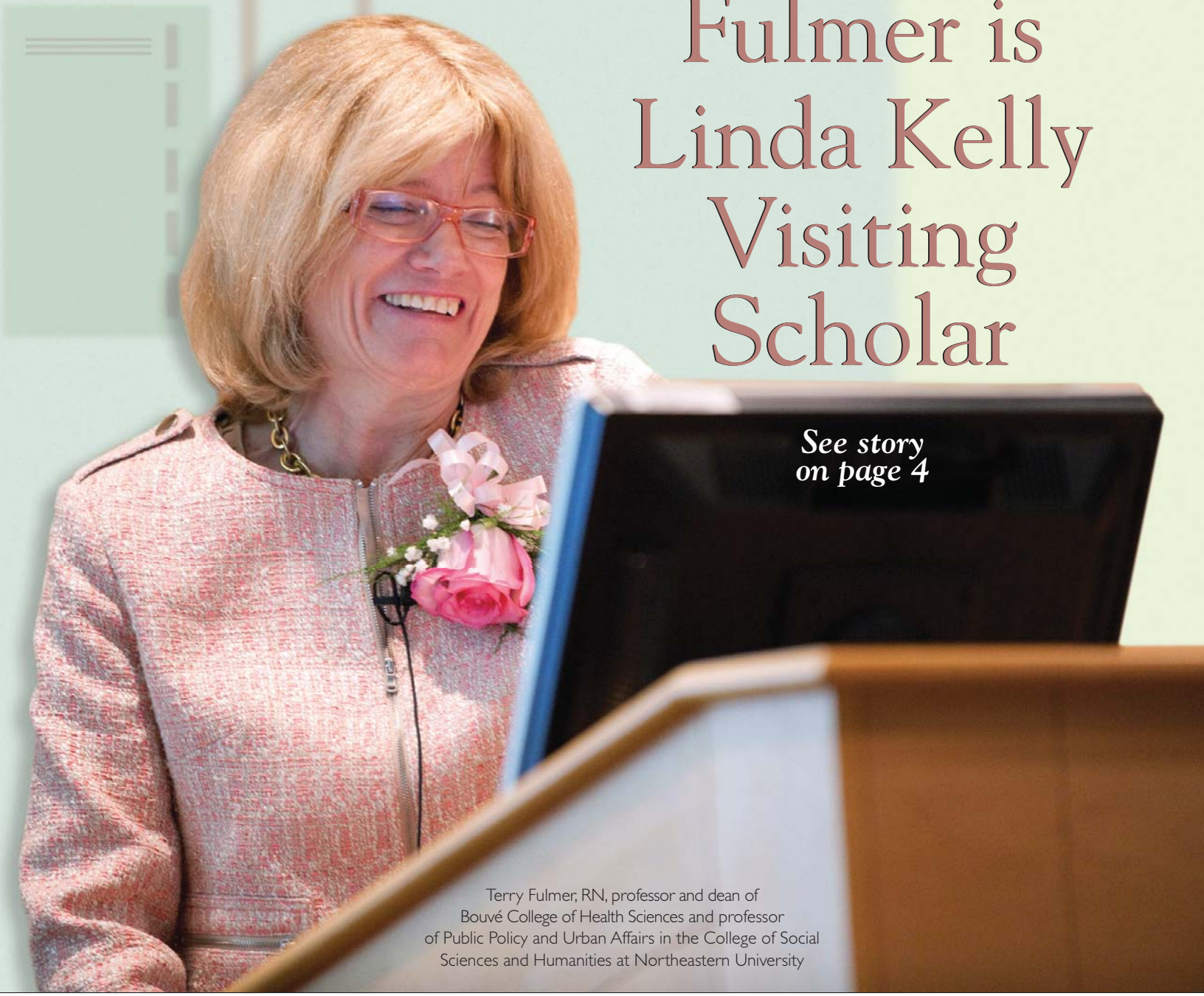

Terry Fulmer, RN, professor and dean of Bouvé College of Health Sciences and professor of Public Policy and Urban Affairs in the College of Social Sciences and Humanities at Northeastern University

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Patient Care Services Strategic Goals 2012–2013

Our mission: To provide the highest quality care to the individuals and communities we serve, near and far; to advance care through excellence in biomedical research; and to educate future academic and practice leaders in the healthcare professions.

If there's one thing we've learned from years of working and planning together, it's that the more challenging the times, the more ambitious our strategic plan needs to be. With the country's volatile political and economic climate combined with the critical need to make health care more efficient and affordable, the leaders of Patient Care Services have crafted a strategic plan that is, indeed, ambitious. After months of thoughtful deliberation, we have identified the following strategic goals for 2012–2013:

1) Develop an efficient and effective patient- and family-centered model of care that advances our relationship-based philosophy
2) Lead patient-affordability and care re-design initiatives
3) Design and implement new programs to improve patient- and family-satisfaction
4) Advance the culture of Excellence Every Day
5) Design and implement clinical and business information systems that support patient care, education, and research

I'd like to share just some of the tactics, programs, and initiatives we're employing to achieve these goals. Perhaps our efforts related to Goal #1 (developing a patient- and family-centered model of care that advances our relationship-based philosophy) are most visible with the recent launch of our 12 innovation units. These special units have introduced a number of interventions, such as the new attending nurse role; use of the SBAR tool (Situation-Background-Assessment-Recommendations) to improve hand-off communication; a new Patient-Family Notebook; inter-disciplinary team rounds, and other care-delivery enhancements to test their impact on clinical outcomes, unit costs, length of stay, and patient- and staff-satisfaction.

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

It's only been four months since we launched the innovation units, but already both anecdotal and HCAHPS feedback has been overwhelmingly positive. We've realized significant gains in most key indicators (nurse and physician communication, cleanliness, night-time quiet, pain-management, and others). And the aggregate length of stay for innovation units (excluding the NICU and ICUs) has come down 3.3%, an improvement that many attribute to the attending nurses' involvement in coordinating care and discharges.

It *appears* that interventions on innovation units are making a difference, but we're employing a robust system of evaluation and analysis to ensure the real data supports the feedback we're receiving. We're planning a retreat for the fall to share best practices and explore ways to roll out (appropriate) interventions on a larger scale.

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We know that health care is in dire need of decisive, demonstrable change, so to deliver anything less would be short-sighted. I'm confident that with our collective wisdom and creativity, we will effect the solutions necessary to continue to provide excellent care to every patient and family every day.

Our tactics for achieving Goal #2 (leading patient-affordability and care re-design) are closely aligned with MGH strategic goals and the Partners Patient Affordability Direct Care initiative. We're focusing primarily on reducing non-salary expenses and ensuring appropriate utilization of resources. Much of this work overlaps Goal #1: looking for ways to reduce length of stay, exploring new processes for safe and efficient transitions of care, and participating on care-re-design teams to translate ideas into practice.

Goal #3 (designing and implementing new programs to improve patient- and family-satisfaction) will require the active participation of every member of the Patient Care Services team. We've conducted a thorough review of the HCAHPS data to identify the most pressing opportunities for improvement. Our efforts will center around noise-reduction, cleanliness, increased communication and support for patients and families, and the development of a cultural competence education program.

I can't think of Goal #4 (advancing the culture of Excellence Every Day) without thinking of our dear friend, Keith Perleberg. He would want us to carry on this important work, and that's exactly what we're going to do. Our Excellence Every Day portal has already become an indispensable resource for staff, and we'll continue to enhance it with information related to Magnet evidence-preparation, Joint Commission readiness, collaborative governance, innovation-unit updates, and other key issues. We're working closely with the PCS Office of Quality & Safety to develop systems to monitor and evaluate patient-centered outcomes, and this information will be broadly shared throughout Patient Care Services.

Goal #5 (designing and implementing information systems that support patient care, education, and research) is crucial to the success of all our other goals. Seamless electronic documentation, safety reporting, and clinical and payroll systems are the underpinnings of our ability to provide high-quality care. Enhancing our information systems and educating the workforce on their use and applications are the mainstays of our strategic plan.

I said it was ambitious. We know that health care is in dire need of decisive, demonstrable change, so to deliver anything less would be short-sighted. I'm confident that with our collective wisdom and creativity, we will effect the solutions necessary to continue to provide excellent care to every patient and family every day.

Updates

I'm pleased to announce the following appointments:

- Jan Filteau as nurse manager in Case Management
- Erika Rosato, RN, as nursing director for the Yawkey 8 Infusion Unit and the Yawkey 7 Henri & Belinda Termeer Center for Targeted Therapies
- Vanessa Gormley, RN, as clinical nurse specialist for the Lunder 7 Neuroscience Unit
- Melissa Donovan, RN, as clinical nurse specialist for the White 8 General Medical Unit
- Meghan McDonald, RN, as clinical nurse specialist in the Emergency Department
- Stephanie Ball, RN, as clinical nurse specialist for the Blake 12 ICU

In this Issue

Linda Kelly, RN, Visiting Scholar Program

advancing inter-disciplinary care for elders

—by Donna Perry, RN, professional development manager

On June 28, 2012, clinicians within Patient Care Services had an opportunity to interact with internationally recognized nursing leader, Terry Fulmer, RN, as part of the third annual Linda Kelly, RN, Visiting Scholar program. Fulmer is a professor and dean of the Bouvé College of Health Sciences and professor of Public Policy and Urban Affairs in the College of Social Sciences and Humanities at Northeastern University. She is an elected member of the Institute of Medicine and currently serves as vice chair of the New York Academy of Medicine. Internationally recognized as an expert in Geriatrics, Fulmer is best known for her research in the area of elder abuse and neglect, funded by the National Institute on Aging and the National Institute for Nursing Research. Most recently, Fulmer served as the Erline Perkins McGriff professor of Nursing and founding dean of the New York University College of Nursing, where she is now dean emerita.

Fulmer packed a lot into her day at MGH, beginning with Obstetrics/Gynecology Grand Rounds, where she presented the results of the landmark IOM report, *The Future of Nursing: Leading Change, Advancing Health*. She touched on the core recommendations

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Below (l-r): visiting scholar, Terry Fulmer, RN; Linda Kelly, RN; Deborah Kelly; Jeanette Ives Erickson, RN; Isaac Schiff, MD; and Debra Burke, RN. At right: Phillips House 21 staff share case study with Fulmer.

(Photos by Brian Feulner)

of the report including the need for nurses to practice to the full scope of their education and be full partners with physicians and other healthcare professionals in re-designing health care. Fulmer emphasized the importance of collaboration with medical colleagues to advance patient outcomes. A rich discussion followed with Fulmer, senior vice president for Patient Care, Jeanette Ives Erickson, RN, and attendees.

Fulmer visited patient care units and engaged staff in dialogue about their practice. She shared how her own research had emerged from her practice with older patients on a general medical unit. She recalled networking with colleagues who had similar interests and concerns, which led to the development of best practices in caring for elders.

Nurses on Phillips House 21 presented a case study of a suspected elder-abuse patient. The issue was discovered through a particularly astute nursing assessment, and an intervention was carried out through collaboration with Case Management, Social Service, and Medicine. Fulmer discussed various types of elder mistreatment, including abuse, neglect, exploitation, and abandonment. Her seminal work in this area includes development of a validated screening tool.

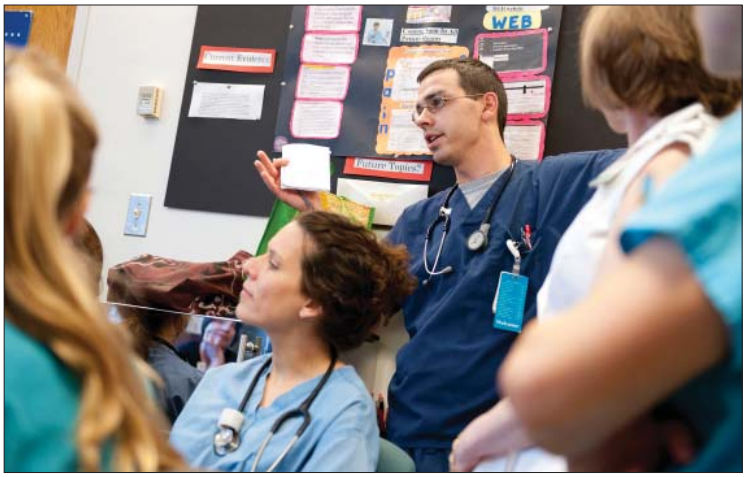
On the Bigelow 11 Medical Unit, Fulmer engaged in discussion with staff around caring for patients with delirium. They talked about practical interventions to rule out factors such as sensory deprivation and medication side-effects. Staff shared successful interventions they've employed, such as normalizing day and night routines and minimizing the number of biomedical devices.

During an inter-disciplinary luncheon, several clinicians from Social Service, the Chaplaincy, Physical Therapy, and Nursing described their practice and care of elder patients. Conversation touched on fall-prevention, skin care, mobilization, 'gaps' in service, and meeting patients' spiritual needs. Several staff commented on the influence Fulmer has had on their practice through her many publications and (SPICES) assessment tool for older adults. Fulmer noted the passion of MGH staff for high-quality elder care and their focus on continuity of care, teamwork, evidence-based-practice, and scholarship.

The day culminated with the annual Linda Kelly Lecture where Fulmer presented her vision for the future of inter-professional education. Emphasizing that research reflects improved patient outcomes from inter-disciplinary care, she sees the next step as shared educational programs. She cited her work at New York University around NYU3T: Teaching, Technology, and Teamwork.

The visiting scholar program was created to honor Linda Kelly, RN, the nursing director for Ambulatory Gynecology for Vincent OB/GYN. Kelly's collaborative leadership style has inspired many patient-safety and patient-satisfaction initiatives. The program is made possible through the generosity of Deborah M. Kelly who has had a long-standing relationship with Linda Kelly and Isaac Schiff, MD, chief of OB/GYN.

For more information about the Linda Kelly, RN, Visiting Scholar Program, call Donna Perry, RN, at 4-0340.



Above: staff of Bigelow 11 General Medical Unit discuss interventions for elder safety with Fulmer.
Below: Fulmer meets with inter-disciplinary staff to share best practices around elder care.

Identifying and managing disruptive behavior

—by Robin Lipkis-Orlando, RN, and Anthony Weiss, MD

Disruptive patient behavior can have a negative impact on many aspects of the healthcare environment, most notably safety. Whether through direct physical assault or verbal threats and abuse, disruptive patient behavior directed toward staff or other patients, at the very least, impedes staffs' ability to provide safe, effective care.

In 2011, hospital leadership formed a Tiger Team, co-chaired by Anthony Weiss, MD, and Robin Lipkis-Orlando, RN, to assess disruptive behavior and make recommendations. The team reviewed the safety reports of the prior year and prepared a survey for staff based on their findings. Nearly 800 responses indicated that several clinical conditions—delirium/confusion, anxiety/irritability, pain, and alcohol withdrawal—along with other factors, such as long wait times, poor communication with medical staff, or inexperienced practitioners, were associated with disruptive patient behavior. Based on these findings, multi-disciplinary teams were formed to develop clinical and operational tools to help identify, reduce, and eventually eliminate disruptive patient behavior, at least in its most severe forms.

Disruptive Patient Behavior Icon
aka 'red-card alert'

The education team, an offshoot of the Disruptive Patient Behavior Tiger Team, offered programs on managing the spectrum of disruptive behaviors. Police & Security offered sessions in Management of Aggressive Behavior. And a pilot program to help staff identify early signs of delirium was initiated on the White 8 Medical Unit. Monthly team huddles now occur to review and learn from safety reports, identify potential areas for improvement, and determine which high-risk patients might fall into a category that could be identified with a special icon in the medical record.

In September, we will introduce a new icon representing patients at risk for disruptive behavior. The icon (aka 'red-card alert') will appear in the patient's record in the same area as MRSA-precaution icons and other clinical alerts. The goal is to improve communication and ensure safe hand-offs for all patients. The icon will be accompanied by a brief care note describing the disruptive behavior along with recommendations for future care and contact information for safety resources. The icon will only be activated by the multi-disciplinary team reviewing safety reports in cases posing the greatest threat to safety.

It's important to file safety reports so we can continue to learn from these events and tailor education to meet specific unit needs. Safety reports should include the name of the staff member and a way to identify the patient.

We are in the process of finalizing a disruptive patient behavior root-cause check-list, which will be piloted on several units. This will help identify additional factors, care-delivery precursors or triggers, patient and staff outcomes, and interventions.

For more information about work related to disruptive patient behavior, or if you'd like to get involved, contact Anthony Weiss, MD, at 6-0519, or Robin Lipkis-Orlando, RN, at 6-3370.

The inaugural Albert H. Brown Visiting Medical Scholar Program

—by Colleen Gonzalez, RN, nursing director

On Tuesday, June 12, 2012, the inaugural Albert H. Brown Visiting Medical Scholar Program welcomed Lucia Wocial, RN, nurse ethicist and program leader in Nursing Ethics at the Fairbanks Center for Medical Ethics at Indiana University. Albert Brown and his wife, MGH trustee, Dorothy Terrell, had been long-time supporters of the hospital even before Brown fell ill in 2010. After months of treatment, Brown succumbed to his illness while in the vigilant care of MGH medical nurses. To honor her husband's life and ensure medical nurses have on-going access to educational opportunities, Terrell established the Visiting Medical Scholar Program in his name.

(Photos by Paul Batista)

Clockwise from top left: Lucia Wocial, RN, nurse ethicist; staff nurse, Alexis Seggalye, RN, reads her clinical narrative; and (l-r) Jill O'Brien, RN; Priscilla McCormack, RN; and Kitman Tsang, RN, share their research.

The day began with medical staff nurse, Erica Tuggey, RN, sharing her clinical narrative chronicling her care in a particularly challenging case. The session, facilitated by Wocial and nursing director, Maria Winne, RN, generated a rich discussion.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, welcomed Brown's family and attendees to the first presentation, "Moral Distress: What is it and What Should We Do about it?" Wocial defined moral distress as that which, "occurs when you believe you know the ethically correct thing to do, but something or someone restricts your ability to take the right course of action." She discussed the impact of moral distress, reviewed current research on methods to detect and measure it, and identified strategies for managing it.

Medical clinical nurse specialist, Cynthia Lasala, RN, facilitated a review of the ANA Code of Ethics for Nurses and a discussion regarding the value of unit-based ethics rounds. Staff nurses, Jennifer Murphy, RN, and Saira Saleem, RN, shared how ethics rounds work on their respective units. Participants were happy to have a framework for how to implement ethics rounds on their own units.

Mary Susan Convery, LICSW, provided the afternoon session, "Caring for the Caregiver," during which she spoke of compassion fatigue and the importance of clinicians caring for themselves as they provide compassionate care to patients and families.

Associate chief nurse, Theresa Gallivan, RN, introduced the final session of the day where staff nurse, Alexis Seggalye, RN, read her clinical narrative which served as a case study for the session. Priscilla McCormack, RN; Jill O'Brien, RN; and Kitman Tsang, RN, shared their research on "Enhancing Nurse-Physician Collaboration in Code Status Discussions." And commentary was provided by Wocial, Ellen Robinson, RN, nurse ethicist; and Susan Wood, RN, clinical nurse specialist.

For more information on the Albert H. Brown Visiting Medical Scholar Program, contact Colleen Gonzalez, RN, at 3-5478.

Patient-education, a key element of discharge planning for diabetic patient

RF worked full-time un-loading trucks... While he had noticed increasing thirst, urination, and fatigue, he didn't seek care until he was brought into the ED by ambulance after losing consciousness.

My name is Kate Fillo, and I am a staff nurse on the Bigelow 11 Medical Unit and the patient education nurse in the Blum Patient & Family Learning Center. The five units that make up the house medicine service are unique in that the patients on this service usually present with complex social, emotional, and physical needs. They often don't have access to primary care so end up using the Emergency Department for their healthcare needs, which are often acute and could have been prevented or managed with more timely intervention.

One patient, RF, is a perfect example. RF worked full-time un-loading trucks, but wasn't eligible for health insurance due to his immigration status. While he had noticed increasing thirst, urination, and fatigue, he didn't seek care until he was brought into the ED by ambulance after losing consciousness.

I met RF on the third day of his admission. When I walked into his room at 7:30am he was already up, sitting in the chair, staring out the window. He greeted me hesitantly in English, and when I responded in Spanish, a wave of relief spilled over his face. He had been admitted to Bigelow 11 for diabetic ketoacidosis, and now a little more than 48 hours later, it was determined that RF would require insulin to manage his diabetes after discharge. And he was likely to be discharged later that day. From reading the progress notes and checking in with the nurse who cared for him the night before, I knew RF had many skills to learn in a short

Katherine Fillo, RN, Bigelow 11 staff nurse and patient education nurse in the Blum Patient & Family Learning Center

period of time. To help him learn, I needed to establish a therapeutic relationship, I needed to find out what was important to him.

As I performed my morning assessment, I asked RF about his family and his work. He lived in a rooming house, and his only family in the United States was his younger sister whom he adored; she lived down the street from him. He worried that he'd missed so much work he wouldn't be paid. I listened as he spoke. I asked RF what he knew about diabetes, and in Spanish he replied, "Diabetes killed my mother." This statement was powerful and shed light on his understanding of the disease. Most of RF's knowledge had come from watching his mother in El Salvador. He could tell me that diabetes had something to do with sugar, but not much more.

RF reported that since coming to the hospital, he 'felt normal.' I explained that insulin had helped make him feel more energetic. I used the teach-back tech-

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nique, having patients use their own words to explain a concept to ensure they comprehend important information, and RF was able to verbalize his understanding of the connection between insulin and his energy level.

I coached RF in the use of a glucometer to check his blood sugar, and soon he successfully pricked his finger and placed a drop of blood onto the reader strip. This was evidence to me that he learned best when given small amounts of information at a time. I explained to RF that he'd need to use a similar device at home to check his blood sugar every morning. He asked how much it would cost, and I realized that his lack of insurance would mean he'd have to pay for his medications and equipment himself.

The plan was for RF to be discharged that afternoon, which meant I had less than eight hours to advocate for RF to receive follow-up services at a clinic near his home. I knew the clinic had bilingual staff and a dedicated diabetes program.

The junior resident and I discussed RF's insulin regimen; I knew it would be important for RF to be able to inject himself using the supplies he'd have available at home. I paged the endocrinologist who'd be making the final dosing decision, and we had a conversation about RF's latest blood sugars and discharge plan. I explained RF's concern about the cost of the glucometer, and she offered to have a sample glucometer brought to the unit. I was excited that we had overcome one hurdle and were that much closer to a safe discharge plan. The junior resident wrote prescriptions for twice daily 70/30 insulin, syringes, testing strips, and lancets. I checked with our unit case manager to see if I could obtain a delayed payment voucher for the prescriptions, and she was happy to provide it.

I returned to RF's room. I needed to ensure that he was in agreement. I explained the plan, and RF said he was motivated to take care of himself, and having 'the machine' would help. I asked how he'd be getting home, and he said his sister was going to pick him up. I asked if she might like to learn how to give insulin injections, too, and RF was receptive to the idea. I called his sister and planned for her to come in for a teaching session.

By noon, RF's new glucometer had arrived. He was quickly able to demonstrate that he could check his blood sugar with minimal coaching. Since his glucose level was over 200, I got a bottle of insulin so he could practice drawing up the medication himself. Again, I used the teach-back/show-back method to walk him through the process of drawing up insulin and injecting himself. After a moment of apprehension, RF successfully injected the needle into his abdomen.

RF's sister arrived later that afternoon. I had printed out some materials on insulin-injection and special diets for diabetics. RF's sister was a petite and outgoing woman; she was eager to learn how to help him, and we quickly established a comfortable rapport. I was surprised at how much more lively RF was with his sister present. She seemed to bring out his true character.

I encouraged RF to show his sister what he'd learned about the glucometer and blood-sugar monitoring. This enabled me to gauge what RF had retained from earlier in the day. I beamed with pride as I watched RF show his sister how to prick his finger for a blood sample, then allowed her to do the same. When the glucometer read 145, RF was able to interpret the results. "It's okay, not too much sugar."

I had them both practice drawing up the evening dose of insulin from the bottle I'd obtained earlier. Satisfied that both RF and his sister were competent, I transitioned to teaching injection technique. They engaged in some classic sibling horseplay with the sister pretending to be excited at the prospect of injecting him with a needle. But when the moment arrived, RF's sister was completely focused and took the task very seriously. She performed the injection perfectly.

RF and his sister left the hospital a half hour later. They were both grateful for the time I'd spent with them, and I was thrilled at their willingness to learn. I'm confident RF returned home and to work without any complications. I know I met RF and his family's needs to the best of my abilities. And most importantly, I'll incorporate the lessons I learned from RF about involving family in discharge-teaching into my care of future patients.

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

Kate needed to convey a lot of information in a very short time in order to ensure RF was discharged safely. And she managed it all with RF's well-being as her primary focus. She collaborated with other members of the team to ensure continuity; she used the evidence-based, teach-back technique to ensure RF knew how to use the glucometer and self-administer insulin. She built on his close relationship with his sister to make sure he had the support he needed. And she did it all as efficiently as humanly possible.

Thank-you, Kate.

Mind body medicine

empowering patients to help alleviate medical symptoms and conditions

—by Katie Horne, Benson-Henry Institute for Mind Body Medicine

At the Benson-Henry Institute, nurses and clinical staff help patients discover their own innate ability to heal.

Mind body medicine is an evidence-based, multidisciplinary field that draws on the teachings of medicine, nursing, psychology, neuroscience, genomics, nutrition, and exercise physiology to enhance the body's natural healing capacities. Mind body medicine adopts the perspective that health is optimized when mind body approaches are used in combination with conventional medicine, surgery and/or pharmacology.

The field of mind body medicine was pioneered by Herbert Benson, MD, director emeritus of the Benson-Henry Institute (BHI) for Mind Body Medicine. In the 1970s, he coined the phrase, "relaxation response," which is the body's innate mechanism for reducing stress. Learning techniques to elicit this physiologic state can help buffer the harmful effects of a stress response, and this is the cornerstone of clinical practice and research at BHI. According to Gregory Fricchione, MD, director of the Institute, "Mind body medicine provides scientifically based, self-care education that serves as an important link between clinical care and public health."

(Photos provided by Benson-Henry Institute)

Herbert Benson, MD, speaks with patient after leading her through a relaxation-response exercise.

At the Benson-Henry Institute for Mind Body Medicine, clinicians pride themselves on providing patient-centered, compassionate care with the intention of empowering patients to make informed decisions. Through individual and group services, patients learn different skills to evoke the relaxation response and thereby reduce stress. Programs incorporate cognitive and behavioral skills to enhance resiliency and reinforce the importance of positive lifestyle behaviors, such as healthy eating, regular physical activity, and restorative sleep.

In this article, we will discuss three of BHI's most popular programs, and how they've impacted patients' lives.

Relaxation Response Resiliency Program (3RP)

Also known as the medical symptom reduction program, 3RP was established in 1979 for adults suffering from a wide variety of symptoms, including insomnia, fatigue, GI disorders, depression, anxiety, and chronic pain. The program is directed by nurse practitioners, Peg Baim, RN, and Leslee Kagan, RN, and meets weekly for eight weeks.

Donna Rubenoff attended 3RP in 2009 at the suggestion of a friend; she was looking for relief from

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chronic stress and medical problems. Says Rubenoff, "I learned to elicit the relaxation response after not having meditated a day in my life. I learned how to re-structure my negative thoughts. After meditating daily, I felt a difference in my world view."

Rubenoff has maintained her meditation practice and credits the program with relieving her medical symptoms. She has since decided to change careers and help others learn to meditate. For the past two years, Rubenoff has led a meditation group at her temple and conducts meditation groups at senior residence communities in the Greater Boston area. She also teaches at the Brookline Adult & Community Education Center.

Mind Body Program for Women

The Benson-Henry Institute offers a medical symptom-reduction program specifically for women. The eight-week program provides a setting where women can comfortably learn skills for coping with symptoms and connect with and support one another. Since its inception, the group has helped thousands of women, including Patty Charette, who completed the program in 2005 and returned to be a peer counselor at the Institute.

Charette was initially looking for help with anxiety, job stress, insomnia, tinnitus, and a GI disorder. From the start, she felt a connection to program director, Leslee Kagan. Says Charette, "Leslee is a powerful healer. No doctor was able to fully help me, but she did." Charette consulted with Kagan to help find specialists to identify and treat her ailments. But since completing the program, many of her symptoms have improved or disappeared altogether.

"I'm more resilient and less reliant on medication," says Charette. While she couldn't control everything in her life, Charette realized she could influence her reactions to stressors. "This change in thinking made me feel less like a victim. I can consciously make a change within myself to achieve wellness."

The Cardiac Wellness Program

The Cardiac Wellness Program helps participants make heart-healthy lifestyle changes to lower their risk of heart disease, stroke, obesity, smoking, and stress-related health issues. Patients with heart disease and those at risk for heart disease are eligible to participate. Each session includes on-site, monitored exercise, individual nutrition counseling, yoga or relaxation exercises, and stress-management techniques. Held at MGH West in Waltham, this program is led by Aggie Casey, RN, and runs for 13 weeks.

70-year-old, Josephine Carbonaro, participated in the program last year. Under severe stress, she was referred by her MGH provider for elevated blood pressure and cholesterol.

"I loved the one-on-one attention and positive feedback," says Carbonaro. For her, cognitive re-structuring and nutrition counseling were the most beneficial parts of the program. "They teach you to notice when you feel stressed, stop, breathe, reflect, and choose. Learning to cook healthy meals was the greatest benefit. I lost twenty-five pounds and my cholesterol went down forty points."

Carbonaro felt so strongly about the program she enrolled her husband. "Mind body medicine works," she says. "It helped us achieve a significant life change."

(L-r): Peg Baim, RN, nurse practitioner; Aggie Casey, RN, clinical nurse specialist; and Leslee Kagan, RN, nurse practitioner

At the Benson-Henry Institute, nurses and clinical staff help patients discover their own innate ability to heal. Darshan Mehta, MD, medical director, sums it up this way: "Our goal is to teach skills. We want patients to be in the driver's seat of their own health."

For more information, visit: www.massgeneral.org/bhi, or call Sue Clough at 617-643-6054. For the Cardiac Wellness Program at MGH West, call Lauren Lortie at 781-487-6100.

MGH healthcare providers can refer patients to the Benson-Henry Institute via the CRMS application or download a referral form from: www.massgeneral.org/bhi/services/referral.aspx.

The Carol A. Ghiloni, RN, Oncology Nursing Fellowship

—by Mandi Coakley, RN, staff specialist

Carol Ghiloni, RN, (center front) with fellows, Colin Cullitan (front left) and Rebecca Lindmark (front right), along with (l-r): Debra Burke, RN, associate chief nurse, Adele Keeley, RN, nursing director; former Ghiloni fellows, Julie Cronin, RN, and Jane D'Addario, RN; Hannah Lyons, RN, clinical nurse specialist; and fellowship coordinator, Mandi Coakley, RN.

For the 12th consecutive year the Carol A. Ghiloni, RN, Oncology Nursing Fellowship is sponsoring two student-nurse oncology fellows for a ten-week, hands-on, learning experience in the Oncology Nursing Service. During that time, this year's fellows, Colin Cullitan, a student at Creighton University in Nebraska, and Rebecca Lindmark, a student at Saint Anselm College in New Hampshire, have had an opportunity to observe the many different roles nurses play and the career opportunities available to them upon graduation. The Oncology Nursing Fellowship was developed in 2001 to offer nursing students an opportunity to learn about oncology nursing with the hope of hiring them into oncology nursing positions upon graduation.

Cullitan and Lindmark began their ten-week fellowship on different inpatient units with assigned preceptors. For the first four weeks, Cullitan spent time with preceptor, Jane D'Addario, RN, on Phillips House 21, while Lindmark worked with preceptor, Jesse MacKinnon, RN, on Lunder 9. Halfway through the fellowship, they switched.

In addition to hands-on experience on inpatient units, fellows were able to observe procedures in Radiation Oncology, the Infusion Unit, and outpatient care areas in the Yawkey Building. They attended Schwartz Center rounds, HOPES programs, spent time in the Blood Transfusion Service, Interventional Radiology, and took advantage of other learning opportunities within the Cancer Center.

The Carol A. Ghiloni, RN, Oncology Nursing Fellowship receives funding from the Hahnemann Hospital Foundation. For more information, call Mandi Coakley, RN, at 6-5334.

Teamwork, commitment, and the wedding of a lifetime

—by Todd Rinehart, LICSW

I have been a social worker with the Palliative Care Service for six years, and during that time I've had the privilege of working with many colleagues in a variety of settings and circumstances. Recently, I was involved in a case that beautifully illustrates the impact collaboration can have on patients and families.

On March 30, 2012, my colleague, Lorie Smith, MD, asked me to accompany her to a family meeting where she had the sad task of informing her patient, Mr. H, that he had only a short time to live. After receiving the news, Mr. H expressed his desire to attend his daughter's wedding, which was scheduled to take place a month later. Dr. Smith knew he wouldn't survive long enough to attend the wedding. So Mr. H's daughter and her fiancé decided to move the wedding up to the following Sunday, just two days away. They hoped to be married in the Healing Garden on Yawkey 8, where Mr. H had felt tranquil and at peace while undergoing treatment.

(Photo provided by family)

Patient, Ed Hayes (front) with (l-r): Chris Mcgilvary (son-in-law); Jackie Hayes (wife); and daughter, Diana Mcgilvary, the bride.

I was determined to assist Mr. H in fulfilling his last wish. I set about reserving the Healing Garden, which, at this late date and for a Sunday, was wrought with challenges. I enlisted the aid of Debbie Burke, RN, associate chief nurse, and her immediate response was, "Yes, we need to make this happen." Within a half hour, she had spoken to Antonio Campos in Police & Security, and weekend access to the Healing Garden for Mr. H and his family was granted.

Meanwhile, clinical nurse specialist, Jacqui Collins, RN, coordinated the behind-the-scenes details to arrange a reception in the solarium on Mr. H's unit. Marybeth Hogan, RN, would assist Mr. H in dressing for the occasion and transport him to and from the Healing Garden. Erin Gillis, RD, nutritionist, heard about the event and took it upon herself to arrange for refreshments.

I left the hospital Friday evening confident the wedding would be a memorable event for Mr. H and his family.

On Monday, I received an e-mail from Mrs. H informing me that the wedding had been a success; there wasn't a dry eye in the house. Come to find out—not only did Mr. H's daughter get married, but Mr. and Mrs. H renewed their vows, too. The entire H family expressed their deep appreciation for the help they received in making Mr. H's wish a reality. A local news station covered the story, and as we all watched the segment at our inter-disciplinary, palliative-care team meeting, we were moved to silence.

I felt such pride working alongside my colleagues to honor Mr. H's last wish and create this memory for his family. We may not always realize the impact we have on patients and families, but in this case, it couldn't have been more obvious. Many of the people who assisted in the wedding planning were unknown to me, but their commitment to carry out a dying man's wish, a man unknown to many of *them*, is truly inspiring. I'm honored to have been part of that team. Mr. H died peacefully two weeks later.

National certification for medical interpreters

—by Anabela Nunes, director, Interpreter Services

The profession of medical interpreter is a relatively new one, and national certification has only recently become available. Over the last 20 years, much has been done to advance the field with the formation of professional organizations, national professional standards, and a national code of ethics.

Being able to communicate effectively with patients of limited English proficiency is a state and federal law. In the US today, 47 million individuals speak a language other than English; and of those, 23 million have limited English proficiency. Studies show that language barriers impact patient safety and quality of care, and partnering with professional medical interpreters can reduce re-admission rates and lower lengths of stay. Patients with limited English proficiency are almost twice as likely as English-speaking patients to suffer from adverse events resulting in temporary harm or death.

Congratulations (l-r): Felix Duran, Alma McDonald, Lisbeth Rodriguez, Elizabeth Ramirez, and Andrew Beggs, the first MGH staff medical interpreters to become nationally certified.

Felix Duran, Alma McDonald, Lisbeth Rodriguez, Elizabeth Ramirez, and Andrew Beggs, were the first MGH staff medical interpreters to become nationally certified, and Rosario Flores and Jennifer Beauchamp-Ankeny, members of our freelance pool, have also become certified.

National certification ensures a consistently high standard of medical interpretation and goes a long way toward ensuring that patients receive care in a language they understand.

Says medical interpreter, Lisbeth Rodriguez, CMI, "Before certification became available, hospitals may have used individuals with minimal fluency to interpret, which can have negative consequences for patients and providers. As certification becomes the gold standard, hopefully we'll see increased awareness of language and cultural disparities in hospitals across the country."

Creating a national certification program took years of work and perseverance by interpreters, administrators, and clinicians who helped develop competencies. MGH is committed to supporting interpreters in pursuing certification. Interpreter Services has developed study guides and workshops and provided access to webinars to help prepare staff for the exams. Certification requires applicants to pass a written and oral exam, both of which cover a wide range of medical, cultural, legal, and linguistic topics.

Says Andy Beggs, CMI, "MGH maintains high standards for its medical interpreters. Certification means that we meet or exceed national standards. This gives me great confidence that we're serving our patients with the highest-quality medical interpretation possible."

For more information about this new certification, call Anabela Nunes, director of Medical Interpreter Services, at 6-3298.

Affordable Care Act survives landmark Supreme Court decision

Question: I heard about the decision to uphold the Accountable Care Act. What does that mean for patients?

Jeanette: Many in the healthcare community were relieved to hear that the Supreme Court of the United States upheld the Affordable Care Act, the national healthcare-reform legislation. Under the Affordable Care Act, more than 30 million un-insured Americans will have coverage and access to health care. The ruling ensures that patients with pre-existing conditions cannot be denied coverage; more seniors will be eligible for discounts on prescription drugs; young adults (up to age 26) may be covered by their parents' insurance; and there are no more lifetime or annual limits on coverage.

Question: What does it mean for MGH?

Jeanette: The decision reinforces our belief that payment reform is here to stay. That means our efforts to re-design care and make systems more efficient are right on target. If millions of previously un-insured Americans are going to be accessing healthcare services, providers are going to be called upon to find ways to deliver care more efficiently, effectively, and affordably.

The nation's aging population may pose the biggest threat to hospitals' efforts to contain costs. Over the next decade, as baby boomers phase into Medicare, publicly insured patients—the segment of our patient population that uses the greatest percentage of reimbursed services—will increase dramatically. Cutting costs alone will not be enough to meet this challenge.

Question: What are we doing to help make care more affordable and efficient?

Jeanette: We have embarked on a number of projects under the umbrella of the Partners Patient Affordability Direct Care initiative. Patient Care Services launched 12 innovation units specifically for the purpose of testing new ideas, creating new care-delivery models, and determining whether innovative ideas should be adopted hospital-wide.

Partners HealthCare was selected by CMS to be one of 32 inaugural Pioneer Accountable Care Organizations, an initiative aimed at making the care of Medicare patients more coordinated and efficient. We're working with payers to develop alternative care contracts, participate in global payments, and develop new incentive structures. We have teams looking at ways to re-design care to be more efficient and affordable. We're exploring all avenues to ensure that the public is able to reap the benefits of the Supreme Court ruling with affordable access to high-quality care.

Question: Is there anything we can do to help?

Jeanette: The Supreme Court decision basically affirms that health care is a right for everyone, not a privilege for those who can afford it. Massachusetts has led the way on health care reform, serving as a model for the law the Supreme Court just upheld. That means we're ahead of other states in implementing many aspects of the law. But if you have thoughts on how to make care more effective and affordable, I'm interested in hearing about it. Talk to your managers or supervisors, or call me directly at 6-3100.

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Announcements

One-stop intranet site for strategic priorities

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

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

http://priorities.massgeneral.org.

Collaborative Governance

Applications are now being accepted for collaborative governance committees. Collaborative Governance is the multi-disciplinary decision-making structure of Patient Care Services. Applications are due by October 5, 2012.

For more information about collaborative governance or to obtain an application, go to: http://www.mghpcs.org/IPC/Programs/Governance.asp, or call Mary Ellin Smith, RN, at 4-5801.

New MGPO website

The new MGPO website is now available. The look matches the *Fruit Street Physician,* the content has been rewritten, and the layout is more intuitive and user-friendly. Check it out at: http://mgpo.partners.org.

Clinical Ethics Residency for Nurses

Applications now being accepted

Applications for year three of the Clinical Ethics Residency for Nurses (CERN), are now being accepted. The program begins in September; applications should be submitted by July 16, 2012.

Applicants will be notified of their acceptance during the week of August 6th.

Participants attend 10 eight-hour sessions from September, 2012, through May, 2013. To obtain an application or learn more, e-mail Rosemarie Lemole (rlemole@partners.org).

Make your practice visible: submit a clinical narrative

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

Blum Center Events

Shared Decision Making: "Understanding the Prostate Specific Antigen (PSA) Test"

Wednesday, August 22, 2012
12:00–1:00pm
presented by
Mary McNaughton-Collins, MD
Learn what a PSA tes is; the pros and cons of PSA testing; and the newest recommendations for being tested

Program is free and open to MGH staff and patients. No registration required. Sessions held in the Blum Patient & Family Learning Center.

For more information, call 4-3823.

ACLS Classes

Certification:
(Two-day program
Day one: lecture and review
Day two: stations and testing)

Day one:
September 10, 2012
8:00am–3:00pm
O'Keeffe Auditorium

Day two:
September 24
8:00am–12:00pm
Their Conference Room

Re-certification (one-day class):

September 29th
8:00am–1:00pm
Founders Training Room 130

October 10th
5:30–10:00pm
Founders Training Room 130

For information, call 6-3905 or go to: http://www.mgh.harvard.edu/emergencymedicine/education/acls.aspx

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

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