

Caring

Headlines

February 17, 2011

A closer look at the Clinical Recognition Program

A Celebration of Excellence in Clinical Practice



Clinical scholar, Christine McCarthy, RN, Medical ICU (left) 'unbundles' her clinical narrative with nursing director and member of the CRP Review Board, Vivian Donahue, RN.

A generous couple, a brand new building, and the great state of Maine

The James J. Dineen, MD, Maine–MGH Health Education Partnership, an ambitious initiative to partner with the Maine healthcare community to establish innovative, educational programs to enhance and promote health care and health education in both communities.

When Peter and Paula Lunder and the Lunder Foundation made their incredibly generous gift to support construction of the Building for the Third Century, they did more than help finance

a new, state-of-the-art, medical facility. You may recall when MGH president, Peter Slavin, MD, announced the formal naming of the Lunder Building in October of last year following the Lunders' extraordinary donation—a donation they made in honor of Drs. James Dineen, Bruce Rosengard, David Miller, and Roman DeSanctis, and in recognition of our exceptional nursing staff. Their gift also supports the James J. Dineen, MD, Maine–MGH Health Education Partnership, an ambitious initiative to partner with the Maine healthcare community to establish innovative, educational programs to enhance and promote health care and health education in both communities.

As many of you know, Maine is my home state, so I'm thrilled to co-lead this initiative along with Dr. Dineen, a fellow Maine native; Robert Birnbaum, MD, leader of the MGH Academy; and Gino Chisari, RN, director of The Norman Knight Nursing Center for Clinical & Professional Development. This MGH leadership team will work closely with an advisory committee of Maine healthcare leaders to implement the James J. Dineen, MD, Maine–MGH Health Education Partnership (the Dineen MHEP). Development



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

officer, Labrini Malatantis, is assisting with this work. We're currently conducting a search for a senior program manager to join this team.

The goals of the Dineen MHEP are to:

- tailor state-of-the-art educational programs to the interests and needs of patients, families, veterans, nurses, physicians, and other healthcare professionals throughout the state of Maine
- deliver educational program in innovative, cost-effective ways designed by the MGH Academy and the Norman Knight Nursing Center
- collaborate with The Maxwell & Eleanor Blum Patient & Family Learning Center, the Home Base Program, and other MGH or MGH-affiliated entities to design meaningful educational programs in response to health-education needs identified by a baseline analysis. (The Home Base program is an alliance of MGH and the Boston Red Sox Foundation that provides services to veterans returning from Iraq and Afghanistan with combat-, deployment-, or stress-related issues)

continued on next page

The Dineen Maine–MGH Health Education Partnership will be launched in three phases and be conducted over a (minimum) ten-year period.

Phase I will utilize a number of existing programs that can be presented immediately so that learning can begin even as we conduct an initial needs assessment. Specific programs will be selected by the leadership team and introduced in collaboration with the Maine Advisory Committee.

Phase II will be a comprehensive evaluation and assessment of local, regional, and state-wide educational needs so we can begin to identify the clinical issues relevant to these areas. We want the education we provide to be meaningful, so it's important to design programs driven by the needs of the populations we'll be serving. We will employ a variety of tools and methods to conduct this needs-assessment; I've already met with a number of nursing groups, including the Organization of Maine Nurse Executives, to gain insight into the knowledge gaps that may exist throughout the state.

Health care in Maine is delivered in urban, rural, and often remote areas with relatively low public funding. Some of the major health issues affecting the state include a high rate of cancer deaths, low immunization in young children, heart disease, obesity, smoking, and substance abuse. Familiarizing ourselves with Maine's public health challenges and incorporating that information with the findings of our needs-assessment will help lay the groundwork for meaningful educational programming. We expect this phase to take approximately 12 months.

Phase III, the long-term implementation phase, will involve tailoring educational programs to meet the needs of the large and diverse healthcare system throughout the state. The MGH Academy is an interactive, on-line resource that provides world-class education to healthcare professionals to help improve and enhance clinical practice. This will be a pivotal component of the Dineen MHEP.

Along with educational programming, Phase III will include a widespread awareness campaign to inform nurses, physicians, patients, families, and the general public about this initiative and how to access programs from their areas.

As the Dineen MHEP unfolds, we will tap into the expertise of some established MGH patient and family learning resources, such as the HOPES Program (Helping Our Patients and Families through Education and Support); the Blum Patient & Family Learning Center; the Bulfinch Medical Group; and others.

We are fortunate to have this opportunity to advance our mission to promote education and service to the community. We're grateful to the Lunders and the Lunder Foundation for their generosity and foresight in funding both our new building and the James J. Dineen, MD, Maine–MGH Health Education Partnership. Some goals can only be achieved with support from philanthropic gifts. We will keep the Lunders in our thoughts as we strive to make the Lunder Building and our partnership with the great state of Maine something of which we can all be proud.

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In this Issue

The Clinical Recognition Program	1	Leadership Book Club	9
Jeanette Ives Erickson.....	2	Fielding the Issues.....	10
• The Lunder Building		• Healthcare Reform: on the Local and National Level	
Excellence Revealed Through Story-Telling.....	4	Announcements.....	15
Clinical Narrative	6	Blum Center's National Health Observance Discussion Series	16
• Carol Doherty, RN		• Heart Disease in Women	
Improving Access to Care.....	8		

Excellence revealed through story-telling

A Celebration of Excellence in Clinical Practice

—by Ann Jampel, PT, and Debra Whitaker, RN, co-chairs of the CRP Review Board

For one hour on Thursday, January 20, 2011, a standing-room-only crowd listened as advanced clinicians and clinical scholars brought themes of the clinical Recognition Program to life in a display of clinical story-telling at its best. A recent survey of MGH clinicians found that many had misconceptions about the Clinical Recognition Program. This Celebration of Excellence in Clinical Practice was intended to bring greater understanding of the four levels of recognition and demonstrate their importance as tools for professional development. Clinicians not yet recognized but practicing at the advanced-clinician or clinical-scholar levels were invited to learn more about the program.

In her welcoming remarks, Jeanette Ives Erickson, RN, senior vice president for Patient Care, described her pride in the work of clinicians at all levels of practice and how the clinical Recognition Program promotes reflective practice. Gaurdia Banister, RN, executive director of The Institute for Patient Care, thanked participants and commended them for their commitment to mentoring colleagues through this reflective and developmental process.

The session was designed to highlight certain themes and criteria of the clinical Recognition Program and show how evidence of these themes is embedded in the clinical narratives submitted by applicants. Attendees had an opportunity to hear mock Review Board questions and clinicians' responses to them. Through the ensuing dia-

logue, it became clear that past experience, formal training and education, and meaningful reflection informed each clinician's understanding and decision-making.

Deb Whitaker, RN, clinical scholar and co-chair of the CRP Review Board, moderated the session giving examples of the themes and criteria being discussed and introducing each pair of presenters.

Meaghan Costello, PT advanced clinician, spoke with Ann Jampel, PT, co-chair of the CRP Review Board, about how her understanding of the unique culture of chronic illness, adolescence,

*continued on
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Clinical scholar, Colleen Lowe, OTR/L (left), talks with clinical specialist and former member of the CRP Review Board, Gae Burchill, OTR/L.

Attendees had an opportunity to hear mock Review Board questions and clinicians' responses to them. Through the ensuing dialogue, it became clear that past experience, formal training and education, and meaningful reflection informed each clinician's understanding and decision-making.

and a mother's fear allowed her to help a 14-year-old boy with cystic fibrosis achieve his dream of playing baseball.

Pat English, RRT clinical scholar, spoke with Neila Altobelli, RRT, clinical scholar and review board member, about helping parents focus on their child instead of the daunting technology. English described her leadership in training and maintaining the competence of clinicians involved in ECMO (Extra Corporeal Membrane Oxygenation).

Social worker and advanced clinician, Lisa Scheck, LICSW, spoke with Marie Elena Gioiella, LICSW, clinical scholar and review board member, about the pros and cons of calculated risk-taking. Scheck described her thinking in filing a 51A in the case of a 14-year-old boy with newly diagnosed diabetes and the risk of not informing his mother she was doing so.

Commitment to continued learning and clinical inquiry was the focus of discussion for advanced clinician, Jennifer Mello, SLP, and review board member Joyce Shapiro Gordon, SLP. Mello described how she analyzed swallowing studies to bolster her case that patients with certain swallowing disorders should not be fed orally. She later presented her findings at a national conference.

Christine McCarthy, RN clinical scholar and review board member, spoke with Vivian Donahue, RN, review board member, about her ability to manage conflict. In a letter of support, a physician colleague described how McCarthy was able to mediate a conflict between a nurse and a physician on an issue related to care management.

Colleen Lowe, OTR/L, clinical scholar, spoke with Gae Burchill, OTR/L, former review board member, about the theme of movement (the only theme specific to physical and occupational therapy). Lowe spoke of her work analyzing the movement of a young teacher who after injuring her dominant wrist was unable to mobilize her arm. Lowe's ability to break down functional tasks into progressive activities that the patient could perform eventually led to the patient achieving her goal of being able to hold her husband's hand again.

After hearing these stories, many attendees commented on how lucky they felt to practice at MGH and work with such talented colleagues.

For more information about the Clinical Recognition Program, go to: www.mghpcs.org/ipc/programs/recognition.

About the Clinical Recognition Program

The Clinical Recognition Program asks applicants to analyze their practice related to the following themes:

- clinician-patient relationship
- clinical knowledge and decision-making
- teamwork and collaboration
- movement (for physical and occupational therapists only)

Clinicians in all disciplines incorporate these themes into care-delivery. The Clinical Recognition Program describes criteria within each theme to define four levels of clinical practice:

- Entry level clinician
- Clinician
- Advanced clinician
- Clinical scholar

Each clinician works with his/her director to assess practice in light of these criteria. Together they determine the clinician's level of practice and set goals for future development. Recognition at the first two levels—entry and clinician—occurs at the unit or department level.

A clinician seeking recognition at either the advanced-clinician or clinical-scholar level must obtain the endorsement of his/her director and assemble a portfolio (including a cover letter, resume, letters of support, and a clinical narrative) describing how his/her practice meets the criteria for the level being sought. The portfolio is submitted to an inter-disciplinary review board for consideration. Clinicians seeking recognition at this level participate in an interview with members of the Review Board.

Radiation oncology nurse: from cheerleader to caregiver and everything in between

The typical course of treatment for head and neck cancer patients is six to seven weeks. Not only am I their own personal cheerleader, I'm their lifeline to the help and support they need.

My name is Carol Doherty, and I am a staff nurse in Radiation Oncology. Caring for head and neck cancer patients can be challenging. Their treatment can be extremely aggressive requiring close monitoring and symptom-management throughout treatment and recovery. Often, they experience severe side-effects, such as thick secretions that require suctioning; nutritional challenges that require a feeding tube; and radiation-induced skin reactions or 'burns.' When patients undergo radiation treatment, they often undergo concurrent chemotherapy, which enhances treatment, but can also exacerbate the side-effects. With this combination of treatments, the result is often severe and painful mucositis within the lining of the mouth and difficulty swallowing. The typical course of treatment for head and neck cancer patients is six to seven weeks. Not only am I their own personal cheerleader, I'm their lifeline to the help and support they need.

Miss R is an 80-year-old woman who had a large squamous-cell cancer of the left forehead. She lives alone in an apartment and has been profoundly deaf since birth. I knew communicating with her would be a challenge.

According to her sister-in-law, who accompanied her to her appointment, Miss R was able to read lips and sign. She had no telephone, and her sister-in-law, who lived two hours away, was her only relative. I was



Carol Doherty, RN, staff nurse, Radiation Oncology

able to secure an interpreter for our weekly status meetings with the doctor. But even with the an interpreter, our first encounter was difficult, frustrating, and overwhelming for Miss R. Her sister-in-law, who was very helpful in assisting us to communicate, would unfortunately not be able to accompany Miss R to her daily visits once her seven-week course of treatment began. Good communication is an essential part of successful treatment.

The first two weeks of treatment are referred to as, 'the settling-in phase.' Once a patient becomes comfortable with treatment and begins to trust her caregivers, the bonding can begin. Weekly visits with the doctor allow patients to voice any concerns they may have and give the team a chance to assess any symptoms. We can give patients the information and tools they need to handle the situation.

Before Miss R began treatment, I met with the radiation therapists who would be involved with her care to discuss our approach, as I often do in complex care

continued on next page

I helped coordinate her visits to the surgeon's office to coincide with the shuttle schedule. I informed their office of her need for an ASL interpreter; called her sister-in-law to update her; and wrote down all the information Miss R would need. Understandably, she was concerned, but the doctor and I reassured her that there was every reason to be hopeful.

situations. Miss R's first week of treatment was frightening for her, but I was able to allay some of her fears by meeting with her every day prior to her treatments. We communicated through the written word, which worked out very well. She was able to tell me her fears, and I was able to modify the situation and reassure her. She was a lovely person who won my heart early on. I admired her independence, coming to the hospital by shuttle and making it to treatment on time every day. I looked forward to our daily visits.

In the beginning, she had difficulty with the mask, which is form-fitting and very restrictive. Head and neck cancer patients wear a mask to ensure precise delivery of treatment. It became more difficult for her to complete treatments every day. During one visit, she complained that the mask was pressing against the tumor making it uncomfortable. The average treatment lasts approximately 30 minutes, during which patients need to lie perfectly still. After collaborating with the radiation therapists and consulting with her physician, we gave her some pain medication and padded the tumor to make her more comfortable.

As her treatment progressed the tumor decreased in size, but she experienced skin-breakdown around the tumor site, which is not uncommon. This necessitated daily dressing changes both pre- and post-treatment. One day, when I removed the dressing, I discovered something I had never seen before—a colony of maggots had formed beneath the dressing and was eating the necrotic tissue around the tumor site. I was shocked, but I didn't want to frighten Miss R. I paged her physician and told him what I had discovered. He wasn't shocked at all. He said that maggots can have a therapeutic effect. He told me not to remove them; if we left them overnight, they'd be gone in the morning, and they'd most likely advance healing.

When I informed Miss R about the situation and the plan to leave the maggots in place, she seemed to take it right in stride. She said she had felt a slight pinching sensation as she slept the night before. As long as the maggots were confined by the dressing, she said she was fine to go home.

The following day the physician removed her dressing, and the maggots were gone. In their place was a clean, healthy, wound bed and granulating tissue.

As the tumor began to recede, the surrounding tissue became red and raw. Miss R began to worry that it wouldn't heal. This, coupled with her significant hair loss caused her great distress. I reassured her that her skin would heal and with her permission, I called her

insurance company to see if her policy covered the purchase of a wig. Unfortunately, it didn't. So I called a number of hair salons and compiled a list of the various costs, hours of operation, and other variables so she could make an informed decision when it came time to buy one. I advised her to give her skin plenty of time to heal before putting on a wig.

Miss R completed 35 radiation treatments, taking the shuttle from Chelsea every day. When I saw her one month after her treatment ended, her skin was well on its way to healing. But unfortunately, signs of a residual tumor were discovered at that time.

Miss R would need to see a surgeon at MEEI, part of our multi-disciplinary team. I helped coordinate her visits to the surgeon's office to coincide with the shuttle schedule. I informed their office of her need for an ASL (American Sign Language) interpreter, called her sister-in-law to update her, and wrote down all the information Miss R would need. Understandably, she was concerned, but the doctor and I reassured her that there was every reason to be hopeful.

Getting to know patients as individuals allows you to tailor your care to meet their unique needs, provide an integrated plan of care, and fully utilize the resources of the multi-disciplinary team.

Miss R did have residual disease. She underwent a wide excision and a successful skin graft and will return to see us some time soon. I look forward to seeing her again. Caring for head and neck patients is challenging but extremely rewarding. It inspires me to do the best I can. I enjoy problem-solving, patient-assessment, and collaborating with other team members to ensure successful completion of treatment and positive outcomes.

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

Clearly, neither Carol nor Miss R is a woman who shies away from a challenge. Carol recognized Miss R's independent spirit and strength of character—whether taking the shuttle to her appointments, openly sharing concerns about her treatment, or agreeing to allow maggots to remain on her wound (how many of us would have done that?) Together, these two formidable women met every obstacle with honesty and resourcefulness. Through daily, caring contact and a coordinated team approach, Carol established a bond with Miss R, and because of that trusting relationship, Carol was able to use the full range of her extensive talents.

Thank-you, Carol.

Improving access to care

Disabilities Awareness Training Program for the MGH community

—by Zary Amirhosseini and Sheila Golden-Baker, RN

MGH is making many improvements to the physical environment to make access to care more welcoming for individuals with disabilities, such as the new reception desk in the Volunteer Office, which was lowered to accommodate individuals in wheelchairs.

Did you know there's a federal law that protects people with disabilities? Did you know there are disparities in the care provided to people with and without disabilities? Do you know how to accommodate the special needs of patients with disabilities?

These are only some of the questions that will be asked as part of the Disabilities Awareness Training Programs being offered to the MGH community.

MGH is committed to providing a welcoming and inclusive environment for patients with disabilities. The Council on Disabilities Awareness has accepted this challenge and created a multi-pronged approach to

help meet this goal. The multi-disciplinary group is looking at architectural barriers, equipment needs, policy- and procedure-development, improved signage, and awareness training for all MGH employees.

Zary Amirhosseini, disability program manager, and Sheila Golden-Baker, RN, professional development specialist, are collaborating with the Institute for Community Inclusion (ICI) at UMass, Boston, to provide disability awareness training for the entire MGH community. Twenty one-hour sessions, including off-shift and weekend sessions, will be offered monthly in O'Keefe Auditorium. Three sessions have already been held with positive feedback from staff. Beginning this month, the program will be available on HealthStream, our on-line learning system, for clinical staff and by June for non-clinical staff.

Training includes information on the prevalence of disabilities and related healthcare disparities. It discusses The Americans with Disabilities Act and how it relates to health care. Communication, accommodation strategies, and internal resources are included. The hope is that all MGH employees will become skilled at supporting and meeting the needs of patients, visitors, and employees with disabilities.

Videotaped interviews with individuals with disabilities, physical and intellectual, help illustrate scenarios that employees may encounter in the course of a typical day. Participants will gain insight into the challenges individuals with disabilities face trying to overcome physical barriers in order to access care. Staff are encouraged to reflect on the presentations and think about how they might approach these situations differently with heightened awareness.

For more information, contact Zary Amirhosseini at 3-7148.



Leadership Book Club: a great forum for sharing knowledge

—by Lori Pugsley, RN, and Brenda Miller, RN

Recently, the Nursing Leadership Book Club opened its meetings to leadership from other disciplines in an effort to attract a more diverse membership and expand the focus of discussions.

The Nursing Director Leadership Book Club began about two years ago when nursing directors from diverse services sought an opportunity to discuss relevant topics with their peers, enhance their knowledge in certain areas, and share ideas and best practices. The original concept was: keep it open, keep it simple, and allow for free discussion. Regular attendees report that relationships have deepened as they've come together to talk, share, and strive to become better leaders. Participants have found the in-depth discussions so rich and useful, they've expanded the meeting time to an hour and a half every two months. And recently, the Nursing Leadership Book Club opened its meetings to leadership from other disciplines in an effort to attract a more diverse membership and expand the focus of discussions.

Nursing directors, Lori Pugsley, RN, Newborn Family Unit, and Brenda Miller, RN, Pediatric Intensive Care Unit, co-lead the group. Ac-

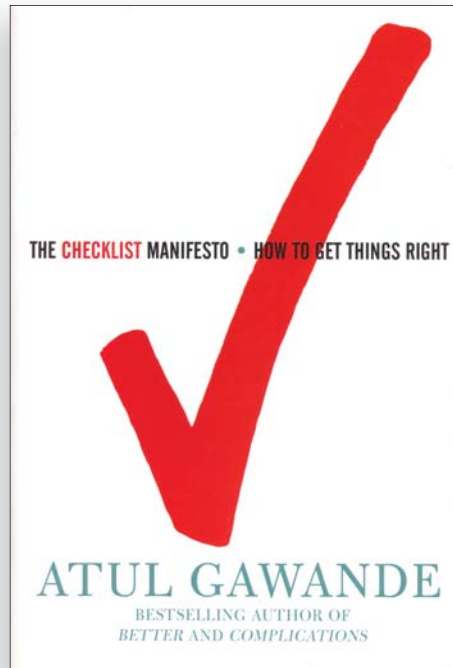
cording to Pugsley and Miller, "The book club has really fostered a forum for building relationships and tapping into the wisdom of our colleagues on other units. Since opening it up to all leadership positions within Patient Care Services, there's greater opportunity to integrate learning, which translates to better outcomes for patients and greater growth and development for participants."

Some of the books discussed at book club meetings include: *Influencer: the Power to Change Anything*;

Made to Stick: Why Some Ideas Survive and Others Die; and *The Checklist Manifesto How to Get Things Right*.

The next meeting of the Leadership Book Club will be April 5, 2011, in White 604, from 2:00–3:30pm. The book slated for discussion is *The Healing of America* by TR Reid. Future book club meetings will be held: June 7th; August 2nd; October 4th; and December 6th.

Book clubs are a great way to learn, get to know colleagues, and share best practices. And they're not just for leadership. For information on how to start a book club, call Lori Pugsley, at 4-6753, or Brenda Miller, at 4-4316.



Healthcare reform on the local and national level

Question: There's so much going on—care re-design, budget review, patient affordability work. How do I keep track of it all?

Jeanette: We're working hard to communicate clearly and consistently about what's going on through publications like *Caring Headlines*, *Fruit Street Physician*, and Dr. Slavin's monthly e-newsletter, "From the Desktop." And we just launched an intranet site: <http://priorities.massgeneral.org>, where you can find an overview of the work under way, relevant articles, presentations, and e-mails. We will continue to post updates to this site as they become available.

Question: How are you identifying cost-cutting ideas? Can I get involved?

Jeanette: We welcome your participation. Please share cost-cutting ideas with your supervisors. Administrative leaders have been asked to identify budget-reduction ideas ranging from 2–10% of current spending, so small ideas are as important as big ones. You can also make suggestions via the new intranet site at <http://priorities.massgeneral.org> using the live "Feedback Forum" link.

Question: I read that re-designing employee health insurance may be part of this work. What will that look like?

Jeanette: We don't know yet, but the idea of looking at our own health insurance is a good one. Because Partners is a large organization, insuring tens of thousands of employees and their families, we have an opportunity to apply some of the best care re-design and cost-cutting ideas to our own health insurance. I hope we can move away from a payment system focused on one physician visit, test, or hospital stay and move toward a system focused on care for specified periods of time—before, during, and immediately after knee-replacement surgery, for example; or a diabetic patient for one year. That kind of model has the potential to improve care, reduce duplication of services, and lower costs.

Question: Congress voted to repeal national health care reform. How and when will that affect us?

Jeanette: It's unlikely that the new law will be repealed in its entirety—that would take the approval of the House of Representatives, the Senate, and the President. Some feel the vote in the House of Representatives was a 'symbolic gesture' to bring attention to aspects of the law that some think should be changed. The fundamental elements of the law will remain, but some provisions such as those requiring new government spending or new government reporting requirements may be repealed. Several different courts have been asked to rule on the constitutionality of the new law, a question that will likely end up before the Supreme Court.

Question: In your December 2nd column, you mentioned two federal healthcare pilots — the Medicare accountable care organization (ACO) pilot, and the Health Care Innovation Zone pilot. Can you tell us more about those?

Jeanette: You've probably noticed lots of references to ACOs if you're reading about health care these days. The federal government is still crafting regulations to guide the rules for ACOs and health care innovation zones. The idea in both cases is to create environments in which all providers—physicians, hospitals, nursing homes, rehabilitation facilities, and home health agencies—are encouraged to work together to control costs and streamline care. Health care innovation zones have the added feature of being designed especially for academic medical centers like MGH that must constantly balance the demands of patient care and teaching. Federal anti-trust laws make collaboration among providers a delicate matter, so the Justice Department will have to make a determination about when it's okay for organizations that normally compete with one another to work together.

Announcements

Red Sox Foundation and
Massachusetts General
Hospital

Home Base Program

Participate in this year's annual Run to Home Base, a 9-kilometer run to support our veterans ending at storied Fenway Park—an unforgettable experience for any Red Sox fan. Runners must raise \$1,000. Support may also be provided by "virtual runners" or donating directly. All proceeds benefit the Red Sox Foundation and Massachusetts General Hospital Home Base Program.

Registration is now open. For more information, or to register, go to: www.runtohomebase.org.

Run to Home Base will be held Sunday, May 22, 2011.

National Patient Safety Awareness Week

The Center for Quality & Safety is proud to present:

"E-patient Dave"
presented by
Dave deBronkart

March 9, 2011
1:00pm

O'Keefe Auditorium

Dave deBronkart believes patients should be fully involved in their care. He shares his story as a cancer patient and active member of his care team.

For more information, call The Center for Quality & Safety at 6-9282.

Blum Center event

Healthy Living Series:
"Preventing Heart Disease"

February 22, 2011
12:00–1:00pm
Blum Patient & Family
Learning Center

For information, call 4-3823.

New MGH phone numbers

Due to the increasing need for telephone lines, MGH has begun using a new area code and three-digit exchange number in addition to the existing 724; 726; and 643 exchanges. In January, MGH Telecommunications began incorporating the new area code and exchange number: 857-238-XXXX.

Staff will still be able to dial the five-digit extension (8-XXXX) when calling internally.

For more information call the Help Desk at 6-4357.

Educational Ethics Forum

Save the date

The MGH Ethics Task Force and the PCS Ethics in Clinical Practice Committee are offering an educational program to assist clinicians in differentiating between capacity and competency—their impact on patients' ability to make healthcare decisions, and the ethical dilemmas that challenge providers in providing safe, compassionate care.

February 23, 2011
7:30am–4:00pm

Thier Conference Room

Register by February 16, 2011

For more information, or to register, call The Norman Knight Center for Clinical & Professional Development at 6-3111.

Scholarship to Advance Workforce Diversity

Partners HealthCare and the University of Massachusetts College of Nursing and Health Sciences are offering the Clinical Leadership Collaborative for Diversity in Nursing, a scholarship to advance workforce diversity.

Recipients receive a minimum of \$5,000 to be used for tuition.

Applications must be submitted by February 22, 2011. Recipients will be announced March 15th.

For more information, call Julie Goldman, RN, at 4-2295

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>.

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For more information, call:
617-724-1746

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March 3, 2011

National Health Observance Discussion Series

“Women’s Heart Health”

—by Mallory Hillard, community health intern

February is American Heart Month. As a means of raising awareness about cardiovascular disease, the Maxwell & Eleanor Blum Patient & Family Learning Center’s National Health Observance Discussion Series focused on women’s heart health.

Heart disease is the leading cause of death among women in the United States. More than 461,000 women die annually from heart disease. On February 9, 2011, Nandita Scott, MD, director of Education for Corrigan Women’s Heart Health Program, presented, “Heart Disease in Women: Dispelling the Myths,” in which she talked about the history of heart disease in women, risk factors and prevention, and some of the common misconceptions about women and heart disease.

For generations, heart disease was perceived as a condition that only affected men. Because of that, the risks and symptoms of heart attack in women were underestimated, which may be why there’s a gap in heart-disease-related deaths between men and women. Scott’s presentation provided useful information about reducing the risk of heart disease and how to maintain a healthy heart.

Look for the Blum Center’s Healthy Living Series, “Preventing Heart Disease,” February 22, 2011, at noon. For more information, call 4-3823.



Nandita Scott, MD, director of Education for Corrigan Women’s Heart Health Program (left), presents, “Heart Disease in Women: Dispelling the Myths.” Health educator, Jen Searl, looks on.

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February 17, 2011

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