



# Maryland Association for Healthcare Quality

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## In This Issue

- President's Message
- Perception of Pain
- MAHQ Fall Education Conference
- From NAHQ E-News
- Did You Know
- Open Board
- 2010 MAHQ Board of Directors Roster

## PRESIDENT'S MESSAGE

Dear MAHQ Members,

It's hard to believe another year is quickly coming to an end and on behalf of the MAHQ Board; I would like to thank you for your support throughout the year. I would also like to thank the MAHQ Board members for all of their valuable time and effort to assist with our mission to advance the practice of quality improvement in healthcare across the continuum of care and support our members' professional development.



Fifty persons attended our fall educational conference "Innovative Transformations in Healthcare 2010" held on October 27th at Anne Arundel Medical Center's beautiful Health Sciences Institute. After many months of collaborative efforts by the MAHQ Board members, we were proud to dedicate our conference to two topics for which our association members were most interested: Maryland's Patient Centered Medical Home initiative and the impact of electronic medical records on safety. Over 70% of the participants rated the overall conference as excellent and 94% rated the facility as excellent! Your evaluations also gave us improvement ideas and suggestions for topics for next year. The Board will use your valuable feedback to improve on our conferences in 2011 – thank you!

This past October, the MAHQ was also a conference series partner with DiversityRx at the 7<sup>th</sup> annual National Conference on Quality Health Care for Culturally Diverse Populations. The Conference took place at the Renaissance Baltimore Harbor Hotel where conference attendees learned about the implications of healthcare reform on culturally diverse populations; how to implement new Joint Commission standards on culturally and linguistically appropriate services; and how to respond to health IT and demographic data collection recommendations from the Institute of Medicine and federal health agencies.

### Save the Date:

The MAHQ is partnering with the NAHQ to offer you the CPHQ Review Course. The 1.5 day course will be taught by a NAHQ instructor on **Thursday, October 20th and Friday, October 21st, 2011**. The venue will be in **Annapolis Maryland** at the Anne

Arundel Medical Center's Health Science Institute. If you are thinking about taking the certification exam or would like a refresher, please consider signing up. Registration information will be forthcoming.

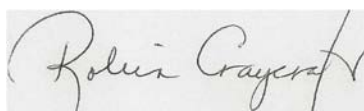
### **A Look Ahead: MAHQ/QIP series: 2011**

The **Maryland Association for Healthcare Quality (MAHQ)** in partnership with the **Quality Indicator (QI) Project**<sup>®</sup> will host 4 one-hour webinar sessions geared toward healthcare professionals interested in expanding their quality and performance improvement skills. CPHQ continuing education credits will be awarded for each session. These sessions will be offered at no charge for MAHQ members and for QI Project clients. The topics planned include:

Quality Basics  
Value-based Purchasing (VBP)  
SPC and Working with Small Numbers  
Core Measures Best Practices

Date and times will be announced soon. We are hoping for a January 2011 start.

Please consider attending a future Board meeting as we are open to your ideas and suggestions for educational offerings. The Board meetings are held on the 4<sup>th</sup> Thursday of each month from 6pm-8pm at Rams Head Tavern in Savage Maryland. Due to the Thanksgiving Holiday this month, our meeting date was moved to Thursday December 2<sup>nd</sup> which will be our final meeting of 2010. Please come and join us - the food is terrific and the Board members are friendly and open to new ideas.



Robin Craycraft, RN, MSN, CPHQ

### **MAHQ FALL EDUCATIONAL CONFERENCE** **Peter Libby**

The MAHQ Fall conference was held Wednesday, October 20, 2010, at the Health Sciences Institute at Anne Arundel Medical Center. Titles ***Innovative Transformations in Healthcare 2010*** the main topic, The Patient-Centered Medical Home, was selected from feedback of participants attending the spring conference. Over 50 people registered in advance and there was at least one walk-up registrant.

Participants were greeted by a wonderful continental breakfast followed by speakers representing the private and public sectors, including several national experts speaking on the Patient-Centered Medical Home (PCMH) topic. The morning sessions were led by Ben Steffen from Maryland DHMH and Edwina Rogers of the Patient-Centered Patient Care Collaborative (PCPCC) in Washington, D.C. The two spoke to the PCMH model; what it is, why it has been selected as a model of care and the goals and expected outcomes of the care model. Maryland is preparing to launch a pilot program beginning in 2011.

The first session after an excellent lunch, was a roundtable discussion featuring Dr. George Lowe (Mercy Medical Center), Patricia Mack, R.N. (Johns Hopkins Family Physicians) and Dr. Frederick Kotler (VA Health Care System) all manage or operate programs based on the PCMH Principles. Their insight into HOW the PCMH concept functions was very beneficial and helpful to understand factors that can make the transition easier.

The final presentation for the day was by Dr. Frank Genova from Kaiser-Permanente Health System speaking on the Impact of Electronic Health Records on Patient Safety. Dr. Genova provided an overview of the benefits and enhancements that EHR has had on practice; such as in the area of e-prescribing and avoiding allergies and contraindications and also the benefit of peer-to-peer communication and patient safety and confidentiality.

Feedback from participants was positive and offered many good suggestions for the spring conference, so keep an eye out for news about upcoming educational events. Lastly, I would like to take this opportunity to thank everyone that did so much to help in making this conference such a success. I cannot possibly name everyone, but Robin, Sally, Cheri, Barb, Josephine, Laura and Bijoy ( and of course, Elwood) are a small sampling of individuals that did SO MUCH – your assistance guidance and support are greatly appreciated.

**Elizabeth Shapiro, C.R.N.P.**

### **Perception of Pain: Why a Scale From One to Ten is Not Enough**

“Ouch, that hurts,” We stub our toe. We trap a finger in a drawer. Unexpected pain happens to everyone. We can all relate to acute, brief episodes of pain. Chronic pain is another story for the patient and the health care provider. When the “story or history” is long or circuitous, the frustration level intensifies for both participants in the health care interaction.

A description of a painful experience includes a variety of parameters. The symptom may be familiar to the patient, and he or she may be prepared to answer questions regarding the location or duration of the pain, or what makes it better or worse. When unfamiliar vocabulary is used, such as radiation of pain, or intensity, the patient may not be able to communicate as well.

The Wong-Baker picture” scale (2001) contains a frequently used standard “pain scale” with six smiling to frowning faces for children or adults. This may also be used as an objective tool, for a patient who may not be able to respond due to mental or physical disability.

An example of a common adult scale is described separately in terms of both intensity and distress by the Agency for Healthcare Research and Quality (1992). It has a range of #1-#10. It is often used verbally, or as a written task for adults. Ten represents the worst pain that a patient can imagine. The patient is instructed to assess the level of pain he is having “right now”. This is especially difficult when the pain is variable in intensity and presence. It is often confusing for both patient and provider when the patient has pain in more than one location. This may be very frustrating for the patient when asked to report

his level of discomfort as a total score.

Other tools, for non-verbal indications of pain may facilitate the assessment of pain by noting vocal complaints, facial grimace, bracing, restlessness, rubbing, and vocal complaints. A comparison of symptoms at rest and with movement can be made. Such a scale by the NIH is noted by Feldt (2000), and can be used as an alternative to the methods noted above.

Unidimensional scales such as #1-10 are easy to administer, but may require hearing and writing ability, and they may address only intensity. Multidimensional scales such as the Pasero and McCaffery questionnaires (2008), are more time consuming, but look at pain from several domains that can not be answered by a single question.

Patients often do not remember pain accurately when it has subsided, or when it is brief. It should be noted that pain is highly influenced by distraction, and the patient's "right now" has been changed by the interaction with the person with whom he is addressing the pain issue.

A female patient may describe symptoms that she perceives were as painful as when she was in "labor". The provider may not have ever had that experience, or perhaps had a very different childbirth experience. Pain that moves to another location may bring additional confusion to the patient. How do you describe multiple sites of discomfort? Which one is the provider asking about? When you are in pain, you are generally frightened and the conversation may be tangential and easily misinterpreted.

The patient may be affected by familiarity with the person asking the questions, availability of "notes," or supportive family or friends. When patients and providers interpret pain descriptors differently, the quality of the interaction and ultimately care and safety may be affected. Consider the many factors involved in the interactive and very dynamic state of pain perception. The description and perception of that pain occurs on "both sides of the bed," impacting the quality, expediency, and level of compassion offered to the patient. Note that pain levels may vary with setting or interviewer. Patients and providers are both influenced by their past experiences with pain, as well as concerns that are specific to this complaint or relevant to other painful experiences.

Experiential process – Both the patient and the providers are experiencing this assessment process, and bringing their own perceptions to the interaction. The sense of support that the patient feels, affects the interaction, process of communication, and ultimately the perception of the pain as well. The setting in which the communicative process takes place also impacts the interaction. A busy ER or ICU usually is a more stressful location for the exchange of information, and should be considered as a factor in the assessment process.

#### Reporting – the missing link

It is vital that the reporting of symptoms by the health care worker, patient, or caregiver be as accurate as possible. The description of the problem, intensity, and character of the symptoms must be described and communicated accurately and efficiently. This will facilitate an environment of safety avoiding delays in diagnosis and treatment. We must be aware that the patient or his provider's perception of his symptoms may interfere with

or limit the diagnostic process. If the patient does not feel that his perception of pain was adequately understood, then he may not report any further symptoms or exacerbations, or proceed with follow-up recommendations. The patient may misinterpret his own symptoms and doubt his ability to interpret, report, or seek appropriate care.

### **“HOW ARE YOU, HOW DO YOU FEEL?”**

**THE GOAL:** to better understand how your patient is feeling, to facilitate an accurate diagnosis and treatment plan, to provide safety and compassion. We must strive for accuracy in the interpretation of the patient’s perception of pain to foster:

1. Accuracy of diagnosis
2. Choice of laboratory or radiological evaluations, etc. or lack thereof
3. Productive communication among health care providers, patient and family
4. Appropriate methods for pain relief
5. Safety of patient from harm or neglect
6. Follow up of perception of pain with treatment or intervention
7. Choice of the most advantageous use of community and patient resources with regard to safety and efficacy

**EXPECTATIONS AND CONSIDERATIONS:** The patient and the provider of care may have different expectations for the relief of pain. The patient may never have ever experienced pain on a scale of a one, or a ten. The provider may not be familiar with the common or uncommon presentations of this particular pathologic condition. When the disease is undiagnosed, the interpretation of painful symptoms is more difficult to assess.

#### **ASSESSMENT TOOLS:**

1. Scale #1-#10 numerical scale
2. Faces - #1-10 smiling to frowning faces
3. Non-verbal scales
4. Multidimensional scales
5. History - with regard to function, position, date or time when pain started. What makes it worse? Are symptoms present now? What could you do before the pain started, last week, after it worsened, yesterday, now?
6. Pain - character, intensity, patient’s descriptors, or functionality?
7. Is the pain better or worse now (note symptoms prior and during assessment)?
8. Are the symptoms presently at the same level or character as the complaints that initiated the present concern?

#### **SETTING:**

1. When questioned, how close to time of active symptoms? Are symptoms presently at the same level as those described, those initiating concern?
2. Is the patient in the ER, or ICU? Is it a chaotic or calm environment?
3. Is the patient being interviewed by his primary care provider? What is the relationship of the interviewer to the patient? Is the patient an in-patient or an outpatient? Is his caregiver familiar with the patient or his history?
4. Is a family member or friend present who may be able to assist in reporting?

## PATIENT VARIABLES:

1. Complexity of disease processes to be considered.
2. Time and setting (post-trauma, post-operative, post-physical or mental abuse), anyone else ill or in crisis situation at home or in family?
3. Patient variability of sensitivity to pain.
4. Differences in-patient reporting; not wanting to alarm himself, his family, or the “busy doctor”.
5. Preparation for pain symptoms; chronic, acute, or new symptoms?
6. Secondary gain-attention? Lonely?
7. Underreporting of a variety of factors; patient may not want to be admitted to the hospital, due to work or family responsibilities, etc.
8. Age of patient as a factor; adult- ability or lack of ability to interpret and speak for himself, child - who may need to have a parent to interpret his usual symptom status, an aged patient- who may live alone and may need an observer of his symptoms to aid in the assessment.
9. Adolescents have special issues with regard to somatic complaints. The provider must seek to hear and react to their concerns from their viewpoint.
10. Consideration of any potential medication side effects.
11. Consideration of any reactive fear from present or past experiences in the health care setting.
12. Cultural differences in comfort and trust levels when reporting concerns to a provider who may not be of the same culture or ethnicity.

The responsibility and repercussions of interpreting the patient’s level of pain, belongs to all of us, on both sides of the bed. The cost of misinterpretation is found on the ledger of wasted health care dollars, for inadequate or inappropriate services. The cost to our patients can be measured in morbidity and mortality statistics.

We all know that the “patient’s history” usually provides the answers, but only if we find the time and the way to listen and understand it. Pain is the symptom that brings patients to the health care system most urgently. How we react affects the patient’s medical and financial future. More importantly, the patient’s safety is dependent upon the accuracy of a continuous assessment of health status, with pain as an important parameter.

We must evaluate our own clinical setting to determine if our clinical assessment encompasses the patient’s perception of his pain status. Does this seem to be congruent with our impression, after listening and looking at the patient? Do we have a full picture of the history and character of his present or past discomfort? Have we given ourselves the time and environment to make an assessment accurately?

Due to the many variables that interfere with the pain assessment process, it would be beneficial for medical and nursing research to examine the above issues further. It is vital that clinicians identify factors that limit accuracy of pain evaluation in their practice. Research that compares subjective and objective measures may be useful in this endeavor.

## From NAHQ e-news

### Joint Commission: Tackling Miscommunication Among Caregivers

Recognizing that about 80% of serious medical errors involve miscommunication among caregivers when patients are transferred or handed-off, 10 U.S. hospitals and healthcare systems have teamed up with The Joint Commission Center for Transforming Healthcare to apply new methods to stop these dangerous and potentially deadly breakdowns in patient care.

"We know that breakdowns in communication that can occur when patients are handed off from one caregiver to another are a leading cause of patient harm and medical errors," stated Ronald R. Peterson, president of the Johns Hopkins Hospital and Health System, Baltimore, MD, one of the participating hospitals. "Few areas within the spectrum of patient care give us such an enormous opportunity to improve patient outcomes and reduce mistakes as improving these communications. The Joint Commission's initiative in this area is a welcome start."

When the Hands-Off Communications Project began in August 2009, the participating hospitals found that more than 37% of hand-offs were "defective," meaning they didn't allow the receiver to safely care for the patient. Since then, many of these hospitals were able to reduce their defective hand-offs by an average 52% by embracing the Joint Commission's SHARE tactics. SHARE stands for

- **Standardize critical content** to ensure that a patient's history and other key information are readily available and easy to comprehend.
- **Hardwire within your system.** Identify new and existing technologies to aid in a patient's hand-off.
- **Allow opportunity to ask questions.** Rather than take all information about a patient at face value, check and double check with others involved in the patient's care to ensure accuracy.
- **Reinforce quality and measurement** by holding staff accountable, monitoring compliance, and using data to determine improvement.
- **Educate and coach** all colleagues on what constitutes a successful hand-off.

The other nine hospitals participating in the collaboration include Exempla Lutheran Medical Center, Wheat Ridge, CO; Fairview Health Services, Minneapolis, MN; Intermountain Healthcare LDS Hospital, Salt Lake City, UT; Kaiser Permanente Sunnyside Medical Center, Clackamas, OR; Mayo Clinic Saint Mary's Hospital, Rochester, MN; New York Presbyterian Hospital, New York City; North Shore-LIJ Health System Steven and Alexandra Cohen Children's Medical Center, New Hyde Park, NY; Partners HealthCare, Massachusetts General Hospital, Boston, MA; and Stanford Hospital & Clinics, Palo Alto, CA.

### Study: 'Medical Team' Approach Reduces OR Mortality Rates

A team training approach can reduce operating room mortality, according to a [study](#) published this week in the *Journal of the American Medical Association*. The Department of Veterans Affairs has implemented the "Medical Team Training" (MTT) approach, which focuses on improving operating room (OR) communication, teamwork and efficiency, at 74 hospitals nationwide. In a study examining mortality for more than

100,000 surgical procedures conducted at 108 VA hospitals from 2006 to 2008, VA researchers found that facilities that had implemented the MTT approach experienced an 18% reduction in their mortality rate compared to 7% for facilities that had not. "Patients can suffer inadvertent harm at times, despite care from well-trained, experienced and conscientious health care providers," said Douglas Paull, MD, co-director of the Medical Team Training program at VA's National Center for Patient Safety in Ann Arbor, MI, and a study co-author. "The cause in many such instances is faulty teamwork and communication. Fortunately, teamwork and communication skills, often referred to as non-technical skills, can be measured, learned, practiced and enhanced." (*AHA News Now*, October 22, 2010)

## **Hospitals and Meaningful Use**

*Janette A. Orton, MS RN CPHQ*

The Health Information Technology for Economic and Clinical Act (HITECH) defines incentives and penalties in Medicare and Medicaid payments for hospitals, critical-access hospitals, and physician providers who can demonstrate meaningful use of an electronic health record (EHR).

### **What is *Meaningful Use*?**

*Meaningful use* is described as the use of a certified EHR in a meaningful clinical manner such as prescribing, electronic exchange of health information to improve quality of care at a patient and public level, and submission of clinical quality measures. These three functions will support the five goals of HITECH to

- improve the quality, safety, and efficiency of care while reducing disparities
- engage patients and families in their care
- promote public and population health
- improve care coordination
- promote the privacy and security of EHRs.

The first of three phases for meaningful use begins in 2011. The first phase includes 24 meaningful use objectives. For hospitals, an EHR or combination of EHR modules must be certified for all 24 modules. Then, clinicians must meet all 14 core objectives and complete 5 of 10 additional menu-set objectives to qualify as meaningful use. After 2015, penalties will apply for failure to comply with meaningful use standards. The Department of Health and Human Services and the Office of the National Coordinator have designated Regional Extension Centers to assist hospitals, critical access hospitals, and providers in achieving meaningful use.

### **Core Requirements for Hospitals**

Each component of the core and menu objectives specify structured electronic content and the percentage of patient records required for certification. In brief, the core requirements for hospitals include

- patient demographics
- vital signs such as height, weight, and blood pressure
- up-to-date problem list
- active medication list

- active medication allergy list
- smoking status of patients 13 years of age and older
- an electronic copy of discharge instructions
- an electronic copy of health information from the hospitalization
- computerized provider order entry
- implanted drug-drug or drug-allergy interaction checks
- implemented capability to electronically exchange key clinical information among providers
- an implemented clinical decision rule and track compliance
- implemented systems to protect privacy and security of patient data
- captured data from the EHR to report venous thromboembolism, emergency department, and stroke core measures to the Centers for Medicare & Medicaid Services.

### Questions to Ask

Preparing for meaningful use requires early evaluation and planning. The following questions may provide a starting place:

- Who is my current EHR vendor and are they planning to become an EHR-certified vendor? What is the vendor's time line for certification and implementation? Will there be additional costs for submitting data?
- Are there EHR modules that will be needed to supplement existing EHR?
- Will my EHR vendor process the quality measure algorithms or will my organization need to work with another vendor such as a core measure vendor?
- Am I leveraging support provided by my Regional Extension Center?
- What criterion needs to be incorporated into contracting to assure compliance over the three phases of meaningful use?
- Does my organization have a formal plan or oversight steering committee
- Will there be workflow process change or training for staff and physicians?
- Has my organization assigned resources to review and comment on future phases on meaningful use?

Additional information can be found at [Office of the National Coordinator for Health Information Technology website](#).

*Janette A. Orton is clinical operations data manager at Intermountain Healthcare, Salt Lake City, UT, and incoming chair for the National Quality Forum.*

### **DID YOU KNOW.....**

.....We encourage you to submit an article, which may be about an interesting session or seminar that you have attended, your recent experience with JCAHO, project results,

study or research results, or anything that would be of interest to quality professionals. If you submit an article that is published in the newsletter, you will receive a complimentary conference registration to be used during the upcoming year (excluding the CPHQ review course). Please email your submission to the Newsletter Committee Chair Laura Schwartze at [laura.schwartze@hughes.net](mailto:laura.schwartze@hughes.net)

## **BOARD MEETINGS OPEN TO MEMBERS**

Board of Director's meetings is held monthly, ten months of the year. Meetings are usually held on the fourth Thursday evening of the month in rotating locations, for the convenience of the Board members. Some meetings are now conducted via teleconference. We welcome the attendance and input of the general membership, at all meetings. Contact any Board Member by email for information and directions. Verify the location and time on the morning of the meeting.

## **MARYLAND ASSOCIATION FOR HEALTHCARE QUALITY BOARD OF DIRECTORS 2010**

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