UTMB IS SOLIDLY STUCK IN THE MIDDLE OF THE RANKS WHEN IT COMES TO QUALITY AND SAFETY, ACCORDING TO THE 2015 VIZIENT QUALITY & ACCOUNTABILITY STUDY—AMONG 102 MEMBER ORGANIZATIONS, WE RANKED 58TH OVERALL.

While we performed well in patient experience and equity, in many other areas (i.e., efficiency, mortality and effectiveness), we did not perform as well. At UTMB, we have the expertise, experience and talent on board to deliver the very Best Care, so why don’t our national rankings among other academic medical centers reflect it?

One of the major factors influencing our performance ranking is our data, which is derived largely from what we document in our patients’ medical records. This information is then translated into coded data that is used for quality report cards, physician report cards, reimbursement, public health data, and disease tracking and trending. This information is also submitted to various agencies, such as Vizient and the Centers for Medicare & Medicaid Services (CMS).

Organizations like Vizient (a member services organization to which we voluntarily belong) help academic medical centers better understand their performance and benchmark against similar organizations. Meanwhile, CMS determines the Medicare reimbursements we will receive under its pay-for-performance programs, which reimburse hospitals and other providers for patient care based on their performance in cost, quality and appropriateness of care.

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In recent years, both after receiving our results from CMS and during improvement efforts, UTMB teams reviewed patient charts and confirmed that the care we deliver reflects good quality. However, a close examination of our data identified needed changes to documentation and coding in order to more accurately reflect the severity and complexity of our patients’ illnesses and the specificity of their complications. This ultimately also helped improve our patients’ outcomes.

In other words, analyzing our data helps us understand if our quality performance is related to clinical practice problems, coding issues, or documentation issues. It should be noted that UTMB is not the only organization facing these challenges, nor are we the only ones striving to improve. Achieving Best Care requires a multifaceted approach, including strong care management, rich and accurate data, and ongoing process improvement.

Here’s an example of how documentation can affect patient care processes: consider that when clinical documentation is insufficient, subsequent care providers are left unaware of patient complexity. This could result in additional costs due to repeated tests or exams when the original, treating clinician failed to fully document what was performed, what diagnosis has been ruled out, or what treatments were already undertaken. It also may become more difficult to determine why a patient presented for readmission, for example.

Documenting a differential diagnosis and using the term “rule out” is a good thing early in the course of a patient’s hospitalization. That’s because “rule out” diagnoses can be captured by the hospital, and they help paint the picture of how sick your patient is. However, as the clinical investigation provides more information, differential diagnoses need to be narrowed. Subsequent documentation should indicate if a condition is “confirmed” or “ruled out” based on test results or input from a consultant. The final diagnosis should be clearly documented.

Nationally, sepsis is a leading cause of disease-related death (see page 7), and as a frequent cause of inpatient mortality, it is a key focus of UTMB’s Best Care initiative. Clinical documentation and coding play a role in understanding and evaluating sepsis care, because a physician may write, “consider sepsis,” which may trigger hospital coders to code “sepsis” despite the absence of life threatening organ dysfunction in the setting of an infection—this is something that can inflate the number of expected deaths, impacting our performance in mortality rates. Additionally, if sepsis is suspected, but the evidence-based recommendations for care were not followed (based on medical record review), it may put a patient at risk and also adversely impacts our performance.

That is why adherence to evidence-based practice and “hard wiring” the steps in the EMR are important areas of Best Care focus.

**How do documentation and coding affect quality rankings and reimbursement?**

Clinical documentation specialists and hospital coders must carefully query providers to clarify documentation, when needed. Hospitals have found that the following issues have been sources of coding errors:

- Incomplete or inadequate provider documentation.
- Incorrect principal diagnosis selection, such as:
  - Coding a condition when a complication code should have been used.
  - Coding a symptom or sign rather than a diagnosis.
  - Assuming a diagnosis without definitive documentation of a condition.
  - Coding only from the discharge summary and not the complete medical record.
  - Incorrectly applying the coding guidelines for principal diagnosis, especially when two or more diagnoses equally meet the definition of principal diagnosis.
- Incorrect or missing comorbidities or complications.
- Incorrect present on admission (POA) assignment.
- Limitation of coding to the Medicare Severity Diagnosis-Related Group (MS-DRG) (i.e., not coding the full record because reimbursement will not change with additional codes).
- Incorrect MS-DRG assignment.
- Encoder errors or incorrect encoder pathway.
- Incorrect memorization of diagnosis and procedure codes.

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Most MS-DRGs fall into one of three categories based on the severity of the secondary diagnoses:

Major Complication / Comorbidity (MCC)
- Usually results in increased hospital resource utilization
- Reflects the highest level of severity
- Has a major impact on the MS-DRG payment

Complication / Comorbidity (CC)
- Usually results in increased hospital resource use, but at a lower rate statistically than MCCs.
- Can impact MS-DRG payment, but at a lesser rate than MCCs.

Non-Complication/Comorbidity (Non-CC)
- An additional diagnosis that does not usually impact severity of illness or resource utilization
- Does not impact MS-DRG payment

There are many factors that go into ensuring our clinical documentation and coding accurately reflect the care we deliver—that’s why UTMB clinical documentation and coding specialists are working closely with providers to make improvements across the board, and they are focused on several areas with the greatest opportunity for improvement.

In the inpatient setting, a clinical documentation specialist works with the provider while the patient is admitted to review documentation and to provide feedback to the provider. This feedback helps ensure that documentation is high quality and corresponds to the care that was delivered as well as the diagnoses that are being made. After the patient is discharged, a hospital coding specialist will assign ICD-10-CM codes to the diagnoses along with present on admissions codes and ICD-10-PCS codes (PCS stands for “procedure coding system”) to any procedures performed.

This coded information determines which Medicare Severity Diagnosis Related Group (MS-DRG) the patient’s care falls into, which determines the amount of reimbursement that will be paid for the care provided. Hospital coders must choose and assign codes in the correct order, based on severity of illness and resources utilized. The higher the severity of illness and the more resources used, the higher the reimbursement.

The severity of illness under the MS-DRG system is determined by the presence or absence of complications/comorbidities (CCs) or major CCs (MCCs)—a focus of Best Care. Therefore, the specificity of both the principal and secondary diagnoses is imperative to reimbursement accuracy:

- The **principal diagnosis** is the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care. Final MS-DRG assignments are based on the principal diagnosis and secondary diagnoses, as well as the principal procedure and secondary procedures, sex, and discharge status, all of which are characterized through ICD-10 codes.
- Once a principal diagnosis is assigned at the highest level of severity, a **secondary diagnosis** can be chosen. Classified as complications/comorbidities (CCs) or major CCs (MCCs), the presence or absence of a CC or an MCC code as a secondary diagnosis changes the DRG.
- When documentation does not support an appropriate CC or MCC, or a secondary diagnosis is not accurately captured, the level of reimbursement can be negatively impacted. It can also adversely impact quality ratings—under-documenting makes it more difficult to accurately predict mortality risk, for example.
- Appropriately and accurately documenting the presence of one or more CCs or MCCs will impact hospital reimbursement by accurately reflecting the patient’s true severity of illness and risk of mortality.

Clinical Documentation Specialist Dr. Tu-Quynh Edwards explains, “There are over 1,500 MCCs and 3,000 CCs. No one can possibly remember them all, so my advice to physicians is to document patients’ clinical conditions and comorbid processes with as much specificity as possible in order to maximize capture. More is not always better—’concise and precise’ is the key to good clinical documentation.”

Sources: “Documentation and Coding for Patient Safety Indicators (PDF),” AHRQ; “Documentation and Data Improvement Fundamentals,” AHIMA http://library.ahima.org/doc?oid=60174#.V7dcvKKWiWUs/; “ICD-10 and the Order of Things”, For the Record, Vol. 28 No. 1 P. 10
UTMB’s “Care Transitions Program,” was selected out of 1,451 projects statewide to be highlighted at this year’s Texas Health and Human Services Commission (HHSC) DSRIP Statewide Learning Collaborative, which will be held in Austin on August 30-31, 2016.

The Care Transitions Program was initially piloted in 2011 after UTMB received funding from a Social Services Block Grants (SSBG). SSBGs enable states or territories to meet the needs of its residents through locally relevant social services, such as case management, health-related services, housing and more. The goal of the original five-month pilot was to reduce the readmission rate of a group of 97 uninsured patients with chronic disease diagnoses, and the results were very promising. So, when the Medicaid Transformation Waiver came along in 2012, UTMB’s Community Health Program immediately jumped at the opportunity to reestablish the project.

The 1115 Medicaid Transformation Waiver provides needed funding to hospitals and providers so that they may implement innovative projects like the Care Transitions Program to better serve Medicaid and Low-income and/or Uninsured (MLIU) patients. Specifically, Delivery System Reform Incentive Payment (DSRIP) payments under the program, which are awarded when project metrics are met, help hospitals and providers transform their service delivery practices to achieve the “Triple Aim” of health care—better experience, better outcomes and better cost. The waiver program also provides funds for Uncompensated Care (UC). Payment programs for both UC and DSRIP projects are funded through a combination of federal and local money.

Statewide, the Medicaid Waiver program helps Texas integrate its systems of care through shared learning opportunities to ensure patients receive the right care, at the right time, and in the right setting. The waiver also helps provide medical home care from a multidisciplinary team that effectively manages chronic diseases and provides equitable care.

UTMB’s Care Transitions DSRIP project specifically focuses on improving the transition of care from the hospital to the home setting. Patients in the program are age 18 and older of Galveston County who have Medicaid, Medicare/Medicaid (dual eligible) or are uninsured with a diagnosis of acute myocardial infarction, congestive heart failure, or pneumonia. Five years since the project’s start, the team has met 100 percent of its metrics. The resulting financial incentive for this performance is calculated each year of the project using Federal Medical Assistance Percentage (FMAP) rates for Medicaid.

Director of Outpatient Care Management Alison Glendenning-Napoli explains that the key to the program is making contact with the patient while they are still in the hospital “Patients are contacted by the team before they are discharged home. After they are signed up, the patient’s care manager works with the care team to plan care transitions before discharge. The care manager can then speak up about concerns or anticipated challenges and work with the care team to identify more affordable treatments, ultimately helping the patient to comply with the care plan."

For example, the care transition team may be working with a low-income pneumonia patient who is ready to be discharged, but will need to continue their medication treatment at home for another 7-10 days. The prescription required for their treatment, however, may potentially cost up to $200 to fill. This would be a clear barrier to compliance if the patient can’t afford their medication and puts them at an increased risk for 30-day readmission to the hospital. So, the team can then seek a more affordable course of treatment for the patient.

After each patient in the program is discharged, the care transition team conducts a home visit within 48 hours. The visits help the care manager determine how well the treatment plan is working. They can also provide education to the patient to help them stay out of the hospital by teaching the patient about their diagnosis, medications and self-care needs. The care manager can also teach patients about “red

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flags” that could signal the potential for readmission.

Craig Kovacevich, associate vice president, Waiver Operations & Community Health Plans at UTMB, explains the significance of sharing the project’s results and lessons learned at the upcoming HHSC DSRIP Statewide Learning Collaborative. “When HHSC put out a call for nominations for projects in their region, we felt this project most closely met the spirit of the waiver and also had some tangible outcomes,” he says. “It’s serving UTMB’s mission in tandem with the HHSC mission. In UTMB’s capacity as DSRIP Region 2 Anchor, we are responsible for shared learning to facilitate the regional learning collaborative.”

Sharing progress of various DSRIP projects is ongoing. “Other providers have shadowed our Community Health Program team and the social workers, and our community health workers have also done presentations for regional partners. The upcoming formal learning collaborative is focused on 30-day readmissions,” he explains.

UTMB has 31 unique 1115 DSRIP Waiver projects ongoing. Of all the projects, those run through the Community Health Program touch the majority of other projects—although projects are individual in scope, there is a blend between projects. For example, the Patient Advocacy Navigation Team’s project, Care Transitions Program Care Management Registry (led by Jennifer Zirkle, director of care management and utilization review), provided the ability to analyze social, functional, psychological and economic factors that potentially impact preventable readmission. Many of the patients who have benefitted from the Care Transition Program have also been impacted by the Video Remote Interpretation (VRI) project.

The five-year 1115 Waiver period was initially scheduled to end in September 2016, but the Centers for Medicare and Medicaid Services (CMS) recently approved a 15-month extension for Texas, extending the program through December 2017. The waiver has provided important funding, but was not intended to be a permanent funding source. Renewal planning for the potential next round of the waiver is underway; meanwhile, the state is trying to determine how to address the needs of MLIU patients over the long term.

UTMB is currently making preparations for a visit by the new HHSC Executive Commissioner, Charles Smith, who will tour Region 2 this fall to see 1115 Waiver projects in action.

The UTMB Access Center celebrated the Olympic Team USA with a “Go Team USA” week. Staff members channeled their inner Olympian and dressed in red, white and blue throughout the week, ending with a Team Spirit challenge—access teams were asked to creatively display how they will participate in making the quantum leap towards helping UTMB achieve an “Olympic Gold Medal” in Best Care this year.

UTMB ACCESS CENTER CELEBRATES TEAM USA

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L to R: Aneatrice (Gail) Farr, Linda Connor, Robert (Bob) Hewitt, Edna Bazan, Tammy Gutierrez, Cristina Rodriguez, Connie Perez, Pam Kuchta, Richard Herrin and Suzette Cerrillo and Grant Broussard

The Primary Care Pavilion Teams showing team spirit for Best Care with their AIDET gold medal
With the recent opening of Jennie Sealy and League City Hospitals, UTMB Health is in the window for an accreditation extension survey visit from The Joint Commission (TJC). The extension survey will be conducted to ensure that the three-year accreditation awarded to UTMB in November 2015 is still appropriate under the new conditions.

The surveyors could arrive at any time, so continual readiness is key. In Jennie Sealy Hospital, the focus of the survey will be on Life Safety and Environment of Care standards. On the League City Campus, the focus will on following policies and procedures. Please keep in mind that while these are the anticipated areas of focus, anything may be subject to survey.

UTMB’s success on The Joint Commission surveys will require everyone’s familiarity with Joint Commission requirements in their particular area.

- For readiness checklists, a list of TJC “hot topics” and more information on Joint Commission Accreditation preparedness, please visit [http://intranet.utmb.edu/qhs/TheJointCommission](http://intranet.utmb.edu/qhs/TheJointCommission).
- If you have questions, contact Janet DuBois, Associate Director of Accreditation, [jbdubois@utmb.edu](mailto:jbdubois@utmb.edu).
- One call does it all for all service and facility issues: dial 2-4040 to report items needing attention!

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**DIVERSITY COUNCIL | Breastfeeding Awareness Month**

In 2010, the US Health Department and Human Services released a set of health promotion and disease awareness goals and objectives with a ten-year target, known as Healthy People 2020. Healthy People 2020 reflects the idea that setting targets and providing science-based benchmarks to track progress can motivate action.

One of the goals of Healthy People 2020 (HP2020) is to increase the proportion of infants who initiate breastfeeding to 81.9 percent, and increase the number of infants who continue to breastfeed for six months to 60.6 percent. While breastfeeding rates continue to increase each year, many mothers are still not reaching the HP2020 recommendations.

The most recent edition of The Breastfeeding Report Card, a report published every two years by the Centers for Disease Control and Prevention (CDC), gives the following data for Texas in 2016: 81.9 percent of infants start out breastfeeding but only 46.5 percent continue breastfeeding through six months. The high rates of breastfeeding initiation indicate that many mothers want to breastfeed but may lack the resources and support to continue breastfeeding as recommended.

In 2014, UTMB took a giant step towards improving the health of newborns and infants by earning the Texas Ten Step Program facility designation from the Texas Department of State Health Services. The Texas Ten Step Program encourages breastfeeding as the preferred method of feeding for newborns and infants.

Based on the World Health Organization (WHO)/ UNICEF’s Ten Steps to Successful Breastfeeding, the program aims to assist birth facility’s support of breastfeeding mothers before, during, and after delivery; encourages them to identify breastfeeding resources for the mother after she is discharged; and assists facilities in improving on national performance measures such as the Centers for Disease Control’s (CDC) Breastfeeding Report Card. The goal of the Texas Ten Step Program is to increase breastfeeding initiation rates to the national goal of 81.9 percent.

Breastfeeding is a key strategy to improve public health and in order to improve the health status of our communities and our state, it is imperative that we find ways to support mothers and their babies. To find out more about Healthy People 2020 and the Texas Ten Step Program, visit:

- [http://texastenstep.org/](http://texastenstep.org/)
- [https://www.cdc.gov/breastfeeding/index.htm](https://www.cdc.gov/breastfeeding/index.htm)
Colloquially known as “blood poisoning”, sepsis is a life-threatening medical condition that arises when the body’s attempt to fight an infection results in the immune system damaging tissues and organs. This chaotic response, designed to protect us, causes widespread inflammation, leaky blood vessels, and abnormal blood clotting resulting in organ damage. In severe cases, blood pressure drops, multiple organ failures ensue, and the patient can die rapidly from septic shock. Physicians draw from a list of signs and symptoms in order to make a diagnosis of sepsis, including abnormalities of body temperature, heart rate, respiratory rate, and white blood cell count.

Sepsis occurs as a result of infections acquired both in the community and in hospitals and other healthcare facilities. The majority of cases are caused by infections we all know about: pneumonia, urinary tract infections, skin infections like cellulitis and infections in the abdomen (such as appendicitis). Invasive medical procedures like the insertion of a catheter into a blood vessel can also introduce bacteria into the blood and trigger sepsis.

The reason for the rise in sepsis cases is likely due to a combination of factors, including poor socioeconomic conditions, increased awareness and tracking of the condition, an aging population with more chronic diseases, an upsurge in major surgical interventions and invasive procedures, broader use of immunosuppressive and chemotherapeutic agents as well as the spread of antibiotic-resistant organisms.

Sepsis is always caused by an infection, most often by bacteria, but sometimes by fungi or protozoa (such as malaria). That means that preventing infection is one of the best ways to prevent sepsis.

Many of the advances in modern medicine actually weaken our immune system, paving the way for severe illnesses like sepsis. These include cancer-fighting (chemotherapeutic) agents; some medicines used to treat severe rheumatism, gastro-intestinal illnesses, or to suppress the body’s rejection of a new organ following an organ transplant; as well as long-term use of medicines that weaken the immune system, like cortisone. People with diabetes or chronic liver or kidney diseases are also at greater risk. In addition, more and older people are having major operations, which further weakens their immune systems and puts them at risk of developing infections and sepsis.

Many infections can be prevented simply by good and consistent hygiene. Others can be prevented through the use of vaccinations. Small children and the elderly are more susceptible to infection by pneumococcus bacteria. This can lead to pneumonia, middle ear infections, sinusitis and meningitis. Today there are effective vaccines that lead to immunity to major pneumococcus pathogens. (Vaccinations are particularly important for patients who have lost their spleen or who were born without a fully functioning spleen.)

Another step in reducing the number of deaths resulting from sepsis is preventing bacterial resistance to antibiotics. **If you suspect sepsis, it is an emergency,** like a heart attack, stroke, or multiple trauma. The patient requires immediate medical attention in a hospital with an intensive care unit. His or her chances of survival depend to a large extent on receiving successful treatment for the infection that led to sepsis, including broad-range antibiotics and any other treatment necessary to eliminate the cause of infection. This treatment must also be supported by suitable steps to stabilize blood circulation, like infusions and medicine.

Every minute counts!

- Check Lactate
- Take blood cultures
- Give IV antibiotics
- Start IV fluid resuscitation (at least 30ml/Kg)
- Assess for organ dysfunction
- Monitor hourly urine output accurately

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RESOURCES:

- More information on sepsis bundles can be found at http://survivingsepsis.org/Bundles/Pages/default.aspx
- Learn more about sepsis at www.cdc.gov/sepsis and http://www.sepsis.org/
- CDC’s new Vital Signs materials are available here: www.cdc.gov/vitalsigns
- Learn how other states have successfully tackled sepsis by joining a state health department Town Hall: Vital Signs Town Hall: How Three States Tackled Sepsis –Tuesday, August 30, at 2 PM EDT
  - Conference Line (U.S. only): 800-857-0604
  - Passcode: 795-4413
- Read State Policy Approaches to Sepsis Prevention and Early Recognition
- The 1st World Sepsis Congress will take place completely online on September 8 and 9: Register here: https://event.webcasts.com/starthere.jsp?ei=1106962
- Register for CDC’s two FREE webinars with continuing education for healthcare providers.
  - Advances in Sepsis: Protecting Patients Throughout the Lifespan
    - Tuesday, September 13, at 3 PM EDT
    - Register here: https://cc.readytalk.com/r/nyb6mktutwf9&eom
  - Empowering Nurses for Early Sepsis Recognition
    - Thursday, September 22, at 2 PM EDT
    - Register here: https://cc.readytalk.com/r/jgtxnnpp9bw2&eom
- The 9th annual Falls Prevention Awareness Day (FPAD) will be observed on September 22, 2016—the first day of fall. The event raises awareness about how to prevent fall-related injuries among older adults.

Did you know that 1 in 3 Americans aged 65+ falls every year? Falls are the leading cause of fatal and non-fatal injuries for older Americans. Falls are costly—in dollars and in quality of life. However, falling is not an inevitable part of aging. Through practical lifestyle adjustments, evidence-based programs, and community partnerships, the number of falls among seniors can be reduced substantially.

Many falls are preventable. Stay safe with these tips:

1. **Find a good balance and exercise program.** Look to build balance, strength and flexibility. Contact your local area agency on aging for referrals. Find a program you like and take a friend.

2. **Talk to your health care provider.** Ask for an assessment of your risk of falling. Share your history of recent falls.

3. **Regularly review your medications with your doctor or pharmacist.** Make sure side effects aren’t increasing your risk of falling. Take medications only as prescribed.

4. **Get your vision and hearing checked annually and update your eyeglasses.** Your eyes and ears are key to keeping you on your feet.

5. **Keep your home safe.** Remove tripping hazards, increase lighting, make stairs safe, and install grab bars in key areas.

6. **Talk to your family members.** Enlist their support in taking simple steps to stay safe. Falls are not just a seniors’ issue.

Julia Tomilson (lactation specialist) helped me to learn how to breast feed my twins. It was an amazing experience and she gave great advice. (Obstetrics)

I would like to thank everyone that assisted in my recovery/hospital stay. From the ICU staff to 9th Floor Jennie Sealy staff and surgical team. My wife and I thank you! (Vascular Surgery)

My labor and delivery nurse, Joanna Kinsella, was so helpful and made me feel as if I was her only patient. She explained everything clearly, was quick to check on me if help was needed, and her passion for her work truly showed! (Obstetrics)

My grandson’s insurance lapsed and I must say, Dr. Mary Ann Best jumped through hoops to accommodate us and prescribe medications that I could afford to buy. It was a very crazy month trying to make things work, but I was so very appreciative for all of her the care concern. Dr. William Mize also played a part. This staff is priceless! (Bay Colony Pediatric Specialties)

Dr. Randall Urban was amazing the time he spent with me explaining my disease and the rationale behind the recommended treatment options. He will be my new provider. (Endocrinology, PCP Internal Medicine Specialties)

Dr. Lyuba Levine is one of the best doctors I have ever had. She is up to date on the latest research and best practices in addition to being extremely compassionate. (Gynecological Oncology)

Dr. Cynthia Binder is always a joy to see. My family loves her and she always explains things thoroughly. She has a glow about her that makes my son feel comfortable. (Texas City Pediatrics)

Dr. Shiloe Burzinski was very friendly and warm. She took the time to explain what she found and treatment options. She even phoned later in the week to personally go over my pathology report. I love Dr. Burzinski and care she provided. I cannot praise her enough. (League City Pediatric and Family Health)

Dr. Gurinder Luthra is the best GI doctor I have had since being diagnosed with Crohn’s Disease in 2011. Thank you! (Gastroenterology)

Dr. Gwyn Richardson is a very caring person and takes time to discuss my concerns. Dr. Richardson is as beautiful on the inside as she is on the outside—a truly wonderful doctor. (Gynecological Oncology)

Dr. Aaron Mohanty listened to all of my concerns and explained in detail how shunts work and how a surgery will proceed if one is needed. (Neurosurgery)

I have the utmost confidence in Dr. Joel Patterson; he is a caring and very competent physician. UTMB is fortunate to have him on staff. (Neurosurgery)

Dr. Lindsay Sonstein is one of the finest physicians that I have ever encountered. I trust her professional judgment. (Internal Medicine)

Dr. Dominique Washington (Resident Pgl-3) is absolutely, hands down awesome! I couldn’t ask for a better doctor to deliver my baby. (Ob/Gyn Resident Training)

I had surgery with Dr. Louis Stryker early in the morning. At 9:00 p.m. that evening, after a busy day, he took the time to visit and check on me. Amazing! (Orthopedics)

Dr. Michael Silva rocks! (Vascular Surgery)

Dr. Patrick Riley was my therapist. He was compassionate, understanding, had a wonderful personality and clearly explained things to me. Excellent! (Occupational Therapy)

I love Dr. Gwyn Rossi. She is amazing and I feel like I’ve known her forever. (Alvin Urgent Care)

The UTMB Primary and Specialty Care Alvin Clinic has always taken very good care of my family!

Dr. Lucas Blanton is an expert in his field and a wonderful human being. My primary care physician requested a referral, and Dr. Blanton worked me in to his busy schedule for a consultation on my upcoming hip replacement. Many thanks, Dr. Blanton! (Infectious Diseases)

While visiting Dr. Sharon Raimer for a regular dermatology check up, she discovered a problem that needed immediate attention and referred me to Dr. Andrea Wirt. I am very grateful for their speedy assistance and treatment. (Internal Medicine)