Maya Angelou once wrote, “I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.” Likewise, the type care we provide our patients is one of the longest lasting impressions we will leave.

The DAISY Award recognizes nurses for the super-human work they do for patients and families every day. Recently, two UTMB DAISY award recipients went above and beyond for patients in extenuating circumstances, and truly demonstrated what the UTMB spirit of working wonders and providing Best Care is all about.

Eric Ward, a nurse clinician III in the surgical intensive care unit, had a patient who was admitted after a heart attack. This patient was a world-class athlete visiting from a Scandinavian country to compete in a triathlon at Moody Gardens. The man needed a coronary artery bypass graft (CABG), but he wanted to wait until his wife could arrive from overseas before the operation, which the health care team decided would be okay.

continued on page 2
For several days, Eric took care of the patient and got to know him and his story. Eric found out that before his heart attack, the patient had left his bicycles, which were extremely expensive, locked up at Moody Gardens for the triathlon. Since being admitted to the hospital, he was unable to retrieve them and was worried.

As an active person himself, Eric understood the patient’s concern. On his first night off of work, Eric went to Moody Gardens to arrange the release of the bikes, and before the patient’s surgery, he coordinated with the other nurses from the unit to deliver the bikes to the patient.

Thanks to Eric's compassion and willingness to go above and beyond, the patient and his wife had one less thing to worry about before the successful surgery.

Jeanette Mitcham, nurse clinician III in the neuro/neurosurgery critical care unit (NCCU), assumed the care of a stroke alert patient who was two days postpartum, and whose baby was still in the nursery. Understandably, the patient’s only concern was being separated from her newborn baby, and this was causing her a great deal of anxiety. Unfortunately, the nursery was unable to transport the baby to Jennie Sealy Hospital to visit her mother due to fact that the Neuro-Critical Care Unit (NCCU) is not set up with the electronic infant abduction safety devices in place in the Mother & Baby Units in John Sealy Hospital.

Jeanette approached the attending physician in the NCCU, Dr. Anish Bhardwaj, chair of the Department of Neurology, to find out what it would take to get permission to bring the patient to the nursery in John Sealy Hospital to see her baby. He informed her that the patient would have to be cleared by an additional CT scan, approved by himself, personally. She immediately coordinated with staff to get the imaging performed and received permission to take the patient off of the unit. Jeanette then coordinated with the nursery to ensure they could accommodate a visit from the patient and her husband. She obtained a wheelchair connected to ICU monitors and transported the patient to visit her baby.

Jeanette demonstrated true compassion not only as a nurse, but as a mother who could empathize with what her patient was going through emotionally. Her actions allowed for the alleviation of the patient’s anxiety and allowed for critical mother-baby bonding.

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Compassionate care is not about single instances of the care provided by UTMB nurses, physicians and providers, but the consistent, exceptional work done each and every day, across all units, clinics and campuses. If you have a story of compassionate care, email us at friday.focus@utmb.edu

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**UTMB Health Resource Center Offers Caregiver Education & Support Sessions**

UTMB’s Health Resource Center, located on the 2nd Floor of Jennie Sealy Hospital, is now offering free educational and support “Time Out” sessions for caregivers and families every Wednesday at 2 p.m. The sessions are open to everyone and offer participants a chance to network and find resources, learn self-care and relaxation tips, plan for their loved one’s hospital discharge, explore health-related topics, and more.

The HRC is also now offering notary services at no cost for patients, visitors and staff. The service is available Monday-Friday from 8 a.m. to 5 p.m. For inpatient needs, a notary can come to the unit.

Contact Savannah Parks at 409-266-7542 or sjparks@utmb.edu for details.
Every other month, 13 volunteers from the group, Helping Others, gather together to knit blankets and hats, sew pillows and totes, and collect other goodies to donate to patients. They then pack their cars to the brim and deliver their handmade goods to hospitals on the UTMB Galveston Campus and to Shriner's Hospital.

The soft blankets and baby beanies are placed in the mother/baby discharge lounge for new mothers to take before they leave the hospital, and volunteer services distributes the remaining items to other patient care areas throughout the hospital.

Thank you for your service, Helping Others!

To donate or learn more about UTMB Volunteer Services, visit https://www.utmbhealth.com/support-pages/community/volunteer-services/home.

Top right: The ladies of Helping Others load their cars to deliver their goods to UTMB and Shriners Hospital
Bottom right: Handmade blankets make the discharge lounge an inviting place for new mothers and babies.
Quarter 1 and Mortality Performance

UTMB’s FY17 first-quarter results show that so far, we have performed better than our goal for patient satisfaction, readmissions, mortality, and safety-related measures; however, we missed our target for length of stay. Overall, we are tracking in the right direction to achieve Best Care. Nevertheless, we have significant work ahead of us, as our performance targets for each future quarter will become more challenging. As we are working to improve our results, so are all other academic medical centers (AMCs), so we must stay focused!

The Vizient Quality & Accountability uses statistics on severity of illness, length of stay, 30-day readmission rates and utilization of resources in order to make comparisons between the care UTMB provided and other AMCs nationally. There are six major performance categories that the study tracks:

- **Efficiency** – we track our performance for this measure by monitoring our patients’ average length of stay in the hospital.
- **Effectiveness** – we track our performance for this measure by monitoring the rate of patient readmissions to the hospital within 30 days of a previous discharge (from UTMB).
- **Patient Safety** – we track our performance for this measure by monitoring an overall patient safety measure called the Patient Safety for Selected Procedures Composite Score (PSI-90), as well as a specific bloodstream infection rate measure.
- **Mortality** – we track our performance for this measure using the mortality index, which is the statistical measure of the number of people that died from their illness or injury at the hospital. It compares the actual (observed) mortality rate to the number of patients that were expected to die during a given time period.
- **Patient-Centered Care** – we track our performance for this measure using the results of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, which measures patient satisfaction.
- **Equity of Care** – the Quality & Accountability Study uses demographic information on our patients to determine how consistently patients receive the same treatment, regardless of differences in race, age, gender, payer status and/or economic status.

Mortality accounts for 25 percent of the total Quality & Accountability score and significantly impacts our overall ranking in the Quality & Accountability Study—overall, UTMB ranks in 76th place among 102 AMCs. For mortality specifically, UTMB ranks in 94th place. Therefore, improving our Mortality Index score is a priority area for improvement at UTMB.

While all hospitals seek to prevent patient deaths wherever possible, not all deaths can be avoided. Some patients have higher risks that are associated with potential death; in other cases, patients sometimes choose to discontinue treatment, opting to move into hospice care. By delivering an excellent...
quality of care, always adhering to processes of care that are based on scientific evidence, and by always practicing patient safety to avoid any potentially preventable medical errors, it is possible to save the lives of many patients who are at a risk of passing away.

So, if we know we are taking good care of our patients, why does our performance ranking not reflect it? In the Lunch & Learn presented Jan. 25th by Dr. Gulshan Sharma, vice president, chief medical and clinical innovation officer, it was explained that our performance according to the study is based solely on the information that is included in the medical record. And, when a patient doesn’t look as sick on paper as they were in the hospital bed and they pass away, it reflects poorly on our performance.

Here’s how it works. When the physician or provider documents a patient’s diagnoses along with the care they provided in the medical record, it is translated into medical codes. The codes, known as ICD-10 codes, are then used to determine how ill the patient was and determine which Diagnosis Related Group (DRG) the patient’s care falls into. The DRG is used not only to measure a provider or medical group’s performance in terms of how well they took care of their patients, it also determines how much they will be paid for the care they provided. Medicare Severity Diagnosis Related Group (MS-DRG) is the most widely used system.

The level of severity of illness under the MS-DRG system is determined by the patient’s primary illness or injury, as well as the presence or absence of complications and/or co-existing illness, which are referred to in medical terms as comorbidities (CCs) or major CCs (MCCs). CC/MCCs can include, but are not limited to, conditions such as hypertension, anemia, chronic illnesses, and other severe illnesses or injuries. Therefore, the specificity in the clinical documentation of both the principal and secondary diagnoses are imperative to accurately depicting the care we deliver.

At UTMB, an internal review of 30 sepsis cases in the DRG 871 (severe sepsis with CC/MCC or mechanical ventilation less than 96 hours) confirmed that our performance was, in fact, negatively impacted not by the care we delivered, but rather, because of under-documentation. Dr. Peter Starr, a resident in Internal Medicine who conducted the research, explained that for sepsis, there are approximately 30 factors or diagnoses that impact predicted mortality. What his research revealed is that there was a systemic tendency to under-document these factors by either one large complication or co-morbidity or several small risk factors. This degree of under-documentation reduced our expected mortality rate, which put us at a higher risk for poor performance.

Clinical Documentation Specialist Dr. Tu-Quynh Edwards, explains that co-existing conditions, even though they may be chronic and stable, should always be documented alongside the primary illness because they still require monitoring, medication, and an increased level of care throughout the patient’s hospital stay. Complete and specific documentation is necessary in order to paint the most accurate clinical picture and accurately risk-stratify patients.

**DOCUMENTATION IMPROVEMENT TIPS:**

Some tips for appropriate documentation are as follow:

**TIP 1: Be specific.** For example, for congestive heart failure (CHF), make sure to document the chronicity and severity of the heart failure, (e.g. document “acute on chronic systolic” or “chronic diastolic heart failure”). Terms such as “CHF” or “heart failure with preserved ejection fraction” are non-specific in coding terms.

**TIP 2: Don’t use symbols.** An arrow up ↑ or down ↓ with a “K” means nothing in coding terms. Instead, be sure and document “hyperkalemia” or “hypokalemia”.

**TIP 3: Add a linking statement when applicable.** It is important for providers to add a linking statement to their attestation. For example, a patient with severe pneumonia and multi-organ failure can best be characterized by a statement like, “patient with acute hypoxic respiratory failure, acute renal failure secondary to ATN, and metabolic encephalopathy in the setting of severe sepsis from community-acquired pneumonia secondary to Strep pneumoniae.”

For more info about our Clinical Documentation Improvement efforts and to see our progress in all of our Best Care efforts, please visit intranet.utmb.edu/best-care.
The next Best Care Lunch & Learns will be held in Levin Hall Dining Room on the Galveston Campus at noon:

- Tuesday, Jan. 31: “Reducing Preventable Readmissions and Improving Patient Safety” with Dr. Mark Kirschbaum, vice president and chief quality, safety and clinical information officer
- Wednesday, Feb. 8: “Reducing Length of Stay and the Patient Resource Optimization Program” with Deb McGrew, vice president and chief operating officer, UTMB Health System

All sessions will be streamed live and recorded.

Wednesday, Feb. 8. The topic will be “Reducing Length of Stay and the Patient Resource Optimization Program” with Deb McGrew, vice president and chief operating officer, UTMB Health System

The sessions will be streamed live online and recorded for future reference.

http://intranet.utmb.edu/best-care/
SHOUT OUTS!

CONGRATULATIONS TO THE FIRST ALWAYS AWARD RECIPIENTS OF 2017!

LEFT: Inpatient Always Award Presented by David Marshall, chief nursing & patient care services officer to Jason Ziegler, nurse manager, on behalf of the Ortho/Trauma Unit. RIGHT: Ambulatory Always Award presented by Anne O’Connell, vice president of ambulatory operations to Andrea Mitchell on behalf of the Children’s’ Clinic of Clear Lake.

Dr. Shreyas Modi and Dr. Romin Thomas explained everything thoroughly and were very helpful in helping me understand what happened to me. They were supportive of my choice of palliative care and hospice. (Internal Medicine, Cardiology)

I was blessed to be so close to UTMB when I had my heart attack. The team that took care of me saved my life! Rebecca Travis (nurse clinician II) was professional, caring and was all-around “top notch.” he should be commended. Many thanks! (MICU/CCU)

I cannot speak highly enough of my nurse, Susan Roy (nurse clinician III)! She was wonderful and very caring. (UTMB Angleton Danbury Campus, LDRP)

Penny Wagner (nurse practitioner) is an outstanding and very sensitive person. UTMB needs more like her! (UHC Medicine Specialties, Pulmonary Disease)

Dr. Aakash Gajjar has been my cancer provider for 5 years and he has truly blessed my life. I’m still alive! He tells me what I need to know. He is right to the point, yet so kind and sensitive. (General Surgery)

Our nurse Courtney Dolliloje was so patient and kind to my son, he asked to go back the next day! (Island Pediatric Urgent Care)

Dr. Jack Alperin is one of the best hematologists I have had the pleasure of having. I feel so lucky to have him on my medical team. (UHC Hematology/Oncology)

Dr. Syed Gilani called me himself to provide information after the appointment. That was exceptional. (Interventional Cardiology)

I would love to take this time to thank everyone involved in my mother’s stay Jennie Sealy Hospital. To all the surgeons, nurses, rehab therapists, dieticians, custodians and everyone else I can’t think of. My mother was admitted on November 29, 2016 for a severe heart attack. Everyone was so helpful. Every person took time to explain everything they were doing and why they were doing it. They even said why and how her heart attack happened and explained in our language how they fixed her heart problem. Sincerest thanks from me, my mother, and all of our family and friends.