ADDING VALUE TO BEST CARE:
Why becoming a high-value practicing organization matters

From the introduction of the Affordable Care Act in 2010 to its implementation over the years and the recent efforts to revise or potentially replace the law, one thing is certain: The U.S. health care system is complex and expensive.

Whatever the outcome of America’s future health care policy, UTMB remains dedicated to Best Care – that means we deliver the right care, at the right time, in the right way, for the right person, and have the best possible results for every patient, every time.

When UTMB was challenged by University of Texas System Chancellor William H. McRaven to become a “top 20” academic medical center last year, it was the catalyst for our organization to realize our vision to “be the best.” So far, UTMB has moved into the top 10 of the Vizient Quality & Accountability Study out of 107 participating academic medical centers (year-end results will be available at the end of September). This achievement is certainly something to celebrate, but it is also something we must sustain, because every health system is working hard to improve.

The study offers academic medical centers the chance to assure patients about their strong reputation in quality care, but it also fosters a drive and focus among academic medical centers to improve quality improvement on a national level. Together, the study’s six major components include mortality, efficiency, effectiveness, safety, patient centeredness and equity. A metric for cost is nestled within the efficiency category, but was not considered in the FY17 study due to changes in methodology. However, in the FY18 study (which began July 1, 2017), cost was

continued on page 2
reintroduced and will account for 5 percent of our total score. Its inclusion underscores the importance of value in health care. In fact, all categories of the study matter when it comes to creating value, because among other factors, the high cost of care in the U.S. is significantly driven by poor quality and inefficiency.¹

A recent study by the Commonwealth Fund shows the United States ranks last overall among 11 industrialized countries on measures of health quality, efficiency, access to care, equity and healthy lives.²

Key findings related to the U.S. include:

- The U.S. rates poorly on deaths that were potentially preventable.
- More than one-third (37%) of U.S. adults reported forgoing a recommended test, treatment or follow-up care because of cost.
- On two of four measures of quality – effective care and patient-centered care – the U.S. ranks near the top (3rd and 4th of 11 countries, respectively), but it does not perform as well in providing safe or coordinated care.
- The U.S ranks last in efficiency, due to low marks on the time and dollars spent dealing with insurance administration, lack of communication among health care providers and duplicative medical testing.
- Forty percent of U.S. adults who had visited an emergency room reported they could have been treated by a regular doctor, had one been available.
- The U.S. has 2.4 practicing physicians per 1,000 people.
- There were also large discrepancies between the length of time U.S. adults waited for specialist, emergency and after-hours care compared with higher-income adults.

At the same time the U.S. is behind in quality, our cost for health care is about twice as much per capita as the rest of the developed world.³ One factor that drives the higher cost for care in the U.S. is that we are the only country in the study without publicly-financed universal health care coverage. At the same time, government spending on health care in the U.S. – mainly for Medicare and Medicaid – was high as well, at $4,197 per person in 2013.⁴ Not all health care spending is bad, of course. We go to doctors and hospitals more often, we are more likely to receive certain procedures (such as heart surgery), we continue to innovate and provide new treatment options to people with serious acute and chronic illnesses, and we lead the world in health care research and certain cancer treatments, such as breast and colorectal cancers.⁵

These factors are all part of the high cost, but Americans are also greater consumers of medical technology, including diagnostic imaging like MRIs, computed tomography and positron emission tomography exams. Our pharmaceuticals are more expensive and we consume more of them. Herein lies opportunity for improvement, because utilization of unnecessary tests, procedures and treatments increase patients’ financial burden without adding value, according to the High Value Practice Academic Alliance.⁶ In fact, some have estimated that 20 percent or more of total health care expenditures is due to various forms of waste, including overtreatment, failures of care coordination, failures of care delivery, administrative complexity and pricing failures.⁷ It is estimated that if waste reduction could be applied over the next 10 years, $3.6 trillion in wasteful spending could be saved – that’s 10 percent of projected health care expenditures over the time period.⁸

High health care costs hit Americans in the pocket book. Health care debt is the leading contributor to individual bankruptcy and home foreclosures, according to NIH studies.⁹ High health care costs drive higher insurance premiums, and both insured and uninsured patients

---

¹ The other countries included in the study were Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden Switzerland, and the United Kingdom.

² The National Health Expenditure is growing faster than Gross Domestic Product (GDP) per year and is a remarkably large slice of the U.S. economic pie at 17.8 percent in 2015, according to the Centers for Medicare & Medicaid Services.

---

continued on page 3
are burdened by medical expenses.\textsuperscript{xii} Twelve percent of 1,079 American adults recently surveyed by Consumer Reports said they had spent more than $5,000 of their own money on medical bills (not counting prescriptions or insurance premiums) in the previous year, and 11 percent said they had medical bills they had trouble paying.\textsuperscript{xiii} Furthermore, when people can’t afford care, they often forego treatment, ending up acutely ill, sometimes with more than one chronic condition.

Value is important to our patients. We have shown that we deliver Best Care. Now we must demonstrate that we deliver great value. In the coming months, UTMB will build upon our Best Care foundation to become a high-value practicing organization (HPVO) for our patients. While we maintain the strides we have made in all Best Care domains, we will work to reduce utilization of unnecessary tests, procedures and treatments; better manage valuable resources, such as blood products; and continue managing our patients’ medications and the protocols under which we prescribe (e.g., opioid prescriptions). We will also continue the Patient-Centered Resource Optimization Program (PROP), which seeks to reduce variation in care to ensure we are getting the best quality supplies at the best cost.

Promoting evidence-based medicine, disease prevention and chronic disease management, and eliminating waste are all largely aimed at improving the value with which care is delivered. We’ve made great strides so far thanks to so much hard work on behalf of so many. Let’s continue to focus on Best Care while beginning to define how we will approach costs. Together, this will create value for our patients and payors.


Texas City Physical Therapy/Occupational Therapy (PT/OT) clinic relocation

As of July 24, all staff and patients at the Texas City Outpatient PT/OT Clinic have been relocated other UTMB Health Rehabilitation Clinic locations — either League City Campus or Primary Care Pavilion. With the growth of our clinics at the Primary Care Pavilion in Galveston and the opening of the expanded Sports Medicine Clinic at the League City Campus, many patients are choosing to be seen at one of these locations. As a result, we are transitioning patients and staff to these locations to ensure we are good stewards of organizational resources.
Medical student brings No One Dies Alone program to UTMB

No one should have to die alone. Such was the belief of Sandra Clarke, a nurse at Sacred Heart Medical Center in Oregon, who launched the “No One Dies Alone” program in 2001 after being unable to meet the request of a dying patient in the ICU who asked for her presence in his final moments.

No One Dies Alone is a volunteer organization with a mission of ensuring the presence of a compassionate companion at the bedside of every patient who would otherwise die alone, and Sandra Clarke’s idea has since inspired the launch of hundreds of like programs across the country.

Christian Alch, a UTMB medical student and co-president of the Gold Humanism Honor Society, is currently working in collaboration with UTMB Volunteer Services to implement the No One Dies Alone program at UTMB. He first heard about the program when he joined the Gold Humanism Honor Society, and he immediately began researching ways to bring the program to UTMB.

“The mission of No One Dies Alone was so striking and powerful for me, and as I learned more, I began to dream of doing the same here in Galveston,” says Alch. “Dying alone in the hospital is something that should not happen to anyone. I believe that the people of UTMB can come together to meet a very critical need. Then, during my research into the program, I had a classmate write to me to see if the program was already underway – she had a patient on one of her units nearing the end of his life who did not have family in the area.”

In the No On Dies Alone program, all patients in the last 48 to 72 hours of their life who do not have friends or family available will be eligible to have a rotating team of compassionate companions sit with them at all times, if they desire. This will be coordinated by the nursing staff, who will notify the No One Dies Alone “vigil coordinator.” After confirming that the patient meets criteria, the vigil coordinator will identify a volunteer to report to the room and provide a caring presence for the patient, giving care and support in their final moments. The volunteers will serve in shifts ranging from two to four hours in length.

To launch the endeavor at UTMB, a committed, on-call team of caregivers and volunteers will be needed. Many students have already stepped forward to declare their interest, and Dr. Shabho Rao, clinical professor of Internal Medicine, Palliative Care, has agreed to be the faculty sponsor and provide training and assistance to volunteers.

Alch says the backing from UTMB leadership has helped get the program off the ground. “The leadership of UTMB have been unbelievably supportive of our work to launch this program. Carol Arvie-Goodeen, administrative manager of volunteer services, has been incredibly helpful and is committed to integrating No One Dies Alone into UTMB volunteer services. David Marshall, chief nursing and patient care services officer, and I met in June as well. He immediately set me on a path to bring this before leadership for the hospital. Additionally, Dr. Rao happily agreed to assist. All that said, doors have found a way of being opened. No One Dies Alone resonates with our hearts and I have been so blessed by the support that I have been shown at UTMB.”

Alch hopes to have the program implemented in UTMB inpatient units by fall 2017.
UTMB was named among the “Most Wired” in the 2017 Hospitals & Health Networks’ Most Wired Hospitals and Health Systems Survey. Many hospitals and health systems across the country have the technological pieces in place to drive efficiencies and improve both care and the patient experience, but they still have room to further integrate systems and processes and to conduct population health management. This year’s Most Wired list includes hospitals and health systems that rely on increased clinical capabilities, telehealth and mobile technology. Those who made the list are headed in the right direction to further integrate their electronic health record systems with population health tools, generate clinical quality measures from the EHRs and incorporate data from outside entities like retail pharmacies. Kudos to our Information Services team on this achievement!

AHRQ Culture of Safety Survey

Your input is valuable!

As part of UTMB Health’s ongoing effort to ensure a safe healing environment for our patients, we are asking that every clinical faculty and staff member who works in an ambulatory setting participate in this year’s Agency for Healthcare Research and Quality (AHRQ) Culture of Safety Survey geared to primary and specialty care clinics. (A survey will be conducted of inpatient areas in early 2018.)

This assessment, designed by the federal government, is the health care industry’s best tool for understanding, promoting and maintaining a culture of patient safety. Developed to assess clinical faculty and staff opinions about patient safety issues, medical errors and event reporting, this survey will help further assess the culture of safety at UTMB.

The survey includes items that measure areas or composites of patient safety across our clinical sites, and will offer us comparative data with other health systems across the nation. If you are a clinically focused UTMB faculty or staff member who works in an ambulatory setting for any portion of your time, please take a few minutes to complete the survey to help us evaluate our culture of safety.

The survey tool will be open for two weeks, and it should take no more than 10 minutes to complete. Your individual responses will be completely confidential. Once all results are returned, we will share the results and work with departments and other clinical groups to address opportunities for improvement.

If you have any questions or concerns regarding this survey, please contact: Stephanie Ramos, PT, in the Department of Patient Safety at (409) 772-1701 or stramos@utmb.edu.

To complete the survey for faculty and staff who work in ambulatory settings, visit: http://intranet.utmb.edu/qhs. Your input is very valuable to us as we strive to provide the safest possible patient experiences in the communities we serve. Thank you for completing this important survey for UTMB.
The University of Texas Medical Branch (UTMB) is tobacco-free, prohibiting all forms of tobacco use on its campuses and facilities. The University of Texas MD Anderson Cancer Center has begun conducting annual surveys to assess both the effectiveness and public perception of these policies and related services over time.

From UTMB’s Galveston campus, 121 respondents included students, staff and faculty. Of the respondents, 83 percent were familiar with UTMB’s tobacco policy on campuses that prohibits the use of any type of tobacco product. While the survey measures enforcement (pie chart below) and compliance separately, 31 percent of respondents said people only “somewhat” or do “not at all” comply with this policy. Future efforts should address this and the key findings.

- 45% of respondents said policies were “somewhat” or “not at all” enforced
- 55% said policies were “mostly” or “always” enforced

“During the past 30 days, on how many days did you smoke cigarettes?”

- 60% 0
- 17% All 30
- 5% 1 to 5

57% of respondents are “not sure” if services are available to help quit using tobacco.

48% of respondents said second-hand smoke on campus was a “concern/annoyance.”

Services to help the UTMB community quit smoking include:

- **Commit to Quit** offers coaching and support to UTMB and non-UTMB employees who are at a stage of readiness to prepare and take action to quit their tobacco use. For more information, please visit [https://hr.utmb.edu/hpw/commit_toquit](https://hr.utmb.edu/hpw/commit_toquit)
- **Appointments** to discuss non-addictive prescription medications
Sneak Peak: Renovating R. Waverly Smith Pavilion

The first phase of renovations to the R. Waverley Smith Pavilion will wrap up in October. The redesigned space will ultimately create a more direct, indoor route between Jennie Sealy Hospital and the Clinical Services Wing (CSW) and John Sealy Hospital and the Hospital Parking Garage. R. Waverley Smith and Jennie Sealy were husband and wife; along with John Sealy II, they established The Sealy & Smith Foundation in 1922.

Looking down from the second floor, workers are preparing a large open area for a new staircase; new elevators are nearby. From this location on the second floor, there will direct connections to Jennie Sealy, CSW, John Sealy Hospital and John Sealy Annex.

One new eagerly awaited feature is a direct connection to the Hospital Parking Garage, via a tunnel on the garage’s lower level. A similar tunnel currently simplifies patient access from the garage to Jennie Sealy Hospital. The tunnel is on the other side of the plywood walls in this photo.

Workers are finishing the floors on this section of the facility. When complete, the far wall will connect to Café on the Court.
Dr. Richard Wagner is very bright, professional and kind. He makes me feel that he is very interested in helping me. I highly recommend Dr. Wagner! (Dermatology)

Barbara Parish, Dr. Patrick Roughneen’s nurse practitioner is great. She’s caring, easy to talk to and always available when I need help. (Thoracic Surgery)

Dr. Robin Roberts was professional and caring. She explained my options. She talked in general terms but quickly changed to technical terms as she gathered how I perceived and understood what she was explaining. (Urological Surgery)

Dr. Shakira Dhamotharan was absolutely wonderful! She listened attentively and made my son and me feel comfortable. She went over everything thoroughly and answered all of my questions and concerns. I would definitely recommend her to any parent looking for a good pediatrician or family physician. (Texas City Urgent Care)

Dr. Natalie Slater was incredible! She took time to listen and thoroughly discussed all treatment options with us. She gave us time to make a decision for our child. I cannot say enough good things about her! (Island Pediatric Urgent Care)

I considered going other places, but I was so impressed with Dr. Angelica Robinson, I stayed with UTMB. I don’t think I could have found a better team of physicians. Dr. Dr. Colleen Silva, Dr. Linda Phillips, Dr. Sunny Hatch, Dr. Issam Alalin and my chemotherapy nurse, Patrick Wroblewski. I was scared and he made it so much easier by reassuring me. (Oncology)

The Ambulatory Always Award went to Pediatric Primary Care, Galveston Island West. Over the past quarter, the clinic has had high overall doctor satisfaction ratings (the rating was in the 94th percentile). Physician communication was near the 92nd percentile. Overall staff rating was in the 94th percentile. Patients commented on how knowledgeable, caring and professional everyone in the clinic is and that physicians listen well and are easy to understand. Practice Manager Daryl Ewing accepted the award on behalf of the clinic’s Practice Manager Jennifer Leonard.

The Inpatient Unit Always Award went to Jennie Sealy Hospital Surgery Unit (9C). Overall, the unit ranked in the upper 80th percentile. Communication with nurses was rated in the 95th percentile, and communication with doctors ranked in the 96th percentile. Hospital cleanliness ranked in the 99th percentile. Patients commented on the exceptional cleanliness of their rooms and excellent food service and quality. Overall, the entire staff was considered “exceptional and respectful.” Nurse Manager Dell Roach accepted the award on behalf of the unit’s Nurse Manager, Lee Alviza.