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The nurse practitioner immediately called the radiology department in Galveston to set up an appointment for Mrs. Slovak to receive an ultrasound the following day. During the ultrasound, the technician noticed something that she didn’t recognize. She called manager in to review the ultrasound, who immediately recognized the severity of the situation and called Dr. Jason Ross, senior radiology resident, to review the case.

Dr. Ross immediately suspected cancer. He recalls their meeting, “I saw what was going on and it concerned me. As a radiologist, I generally want bad news to come from someone who the patient knows. I don’t want to scare the patient. It’s better to have the primary care physician, the one who the patient has a relationship with, deliver news. They can do it better than I can.”

After reviewing the patient’s records, Dr. Ross saw that Mrs. Slovak did not have a primary care physician and the nurse practitioner from her original appointment was out of town, so he reached out to the internal medicine physician at the clinic for help. After assessing the situation over the phone, the physician asked Dr. Ross if he would be willing to talk to Mrs. Slovak and her husband.

Dr. Ross explains, “It’s not something in my wheelhouse—not something I do every day—but she was a patient under my care. I was going to try to help, even if I was a little uncomfortable.”

He continues, “For her peace of mind and continuity of care, I needed a CT scan to be performed that same day. As a radiologist, I don’t have a

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follow-up clinic, and the person who told her about the ultrasound needed to be the same person who told her about the CT results.”

Dr. Ross worked with the internal medicine physician to schedule the CT scan, talked to Mrs. Slovak’s insurance provider, and then returned to explain to her what they suspected was the cause of her symptoms.

Mrs. Slovak shared her experience that day, “I just had a feeling that there was something going on. I didn’t rule out cancer or think about cancer necessarily, but I was very grateful that I was going to get an answer that day.”

After the CT scan results were in, Dr. Ross met with Mrs. Slovak and her husband and confirmed the mass was pancreatic cancer. By Monday, Mrs. Slovak delivered the news to her children and was admitted to the hospital. She could finally receive something to ease the pain.

When asked if she would have preferred to hear her diagnosis from a primary care doctor, Mrs. Slovak replies, “Oh, no. Dr. Ross saw the results firsthand. No other doctor knew as much about me as he knew, at the time. He did it very well. If it wasn’t for him, everything else would have been delayed and I would still be miserable.”

Dr. Ross shared the lessons he learned from this experience and what he hopes will help other specialists who may someday find themselves in a similar situation: “I sometimes feel like I didn’t do enough and I wish that I could do more. But what I hope other radiologists or specialists who don’t typically have direct relationships with patients will learn from this is, if a patient doesn’t have someone else, even if we’re uncomfortable, we can make a difference.”

For patient Irene Slovak and her husband, it was their radiologist and his dedication to compassionate and exceptional care who changed everything.

“Never believe that a few caring people can’t change the world. For, indeed, that’s all who ever have.” – Margaret Mead

FOUR GENERATIONS IN HEALTH CARE

Submitted by the UTMB Diversity Council

In health care systems today, there are four generations of providers and multiple generations of consumers. This cross-generational influence spans health systems from employees to medical professionals and patients. Overall, the generations are grouped and represented in years from before 1942 through 2000. Those born after 2000, also known as Generation Z, are not represented; statistics are not yet available on how this cohort will impact health care in the years ahead.

A study conducted by Medscape and WebMD1 had each generational group weigh in on their preferences about the patient/medical provider relationship. They found:

• The Silent Generation (1925 – 1942) prefers significant provider guidance and directions on what steps to take in managing their health care.

• Baby Boomers (1943 – 1960) prefer face-to-face engagement with their healthcare professionals and will utilize some portals.

• Member of Generation X (1961 – 1981) are curious and want to be educated about their care. They will research available sources online, use some of the areas offered by electronic medical record (EMR) portals, and communicate somewhat through text and email.

• Millennials (1982 – 2000) want providers to connect with them and build personal relationships, while utilizing mobile medicine platforms for information and appointments. It is not necessary for them to have “in house” appointments, instead opting for electronic engagements when available.

The Silent Generation tends to immediately trust medical professionals and prefer direct guidance from them. On the other end of the spectrum, Millennials first gather information about their condition from a variety of sources and prefer telemedicine and communications thought email, text, and wearables. Baby Boomers and Generation Xers land in the middle, preferring a mix of both. They also desire professional guidance and engage via technology when convenient (i.e., EMR lab results, texting physicians for prescription refills, etc.).

Without question, technology has a starring role in the patient-provider dynamic in today’s health systems. Technology has created 24/7 patient access from any mobile device in the world. The survey results from a study2 conducted at a 2016 HMISS Conference provided some insight on each group and how technology engagement in the continuity of care is factored.

Understanding the needs of different generations contributes to better patient satisfaction, outcomes, and provider loyalty from patients and engaging in the patient’s preferred way will enrich the experience on both sides of health care.


Each year in the United States, at least 2 million people become infected with bacteria that are resistant to antibiotics, and at least 23,000 people die each year as a direct result of these infections, according to the Centers for Disease Control and Prevention (CDC).

The term “antibiotic” originally referred to a natural compound that kills bacteria, such as certain types of mold or chemicals produced by living organisms. Antibiotics are also sometimes referred to as “antimicrobial”.

The modern era of antibiotics began in 1928, when Sir Alexander Fleming discovered penicillin. Since then, antibiotics have transformed modern medicine and saved millions of lives. But even after his discovery, Fleming expressed his concerns about the fact that bacteria would quickly become resistant to penicillin—in 1945, after successful use of antibiotics during World War II to treat infected wounds, he warned that the “public will demand [the drug and]…then will begin an era …of abuses.”

Today, Fleming’s warning has already come to fruition. Antibiotics have been used so widely and for so long that the infectious organisms that antibiotics are designed to kill have adapted to them, making the drugs less effective. Diseases like *C. difficile* (healthcare-associated diarrhea), *Carbapenem-resistant Enterobacteriaceae* (a group of organisms that infect the bloodstream), and gonorrhea are now at the very top of the CDC’s list of top 18 drug-resistant threats to the U.S.

Repeated and improper uses of antibiotics are the primary causes of the increase in drug-resistant bacteria. In fact, it is estimated that nearly half of antibiotics prescribed for patients who visit a clinic in the United States are inappropriate. In the past, antibiotics had been the prescription for just about every common ailment. But illnesses like the common cold, flu, most sore throats, bronchitis, and many sinus and ear infections are actually viral, not bacterial, and antibiotics are ineffective against them. In many cases, it is best to let the illness simply run its course. Furthermore, antibiotics not only kill “bad” bacteria, but they also kill the “good” bacteria that keeps us healthy.

Additional reasons providers may inappropriately prescribe antibiotics include diagnostic uncertainty, a lack of opportunity for patient follow-up, lack of knowledge regarding optimal therapies, and patient demand. The smart use of antibiotics is key to controlling the spread of resistance. However, there are additional factors contributing to resistance of bacteria to antibiotic treatment.
For one, antibiotic production has declined. Antibiotic development is no longer considered to be an economically-wise investment for the pharmaceutical industry. Because antibiotics are used for relatively short periods and are often curative, antibiotics are not as profitable as drugs that treat chronic conditions, such as diabetes, psychiatric disorders, asthma, or gastroesophageal reflux. And, because new antibiotics are so rarely produced, healthcare providers now tend to hold onto the drugs for the worst cases only.

Antibiotic-resistant infections have become a substantial health and economic burden to the U.S. healthcare system, as well as to patients and their families. It has also become a big problem for hospitals. Because there are many sick individuals in the same area and so many invasive procedures are performed, the likelihood of getting an infection is increased; and, when and if a hospital-acquired infection develops, such as pneumonia or sepsis, the conditions are now much more complicated to treat. Nearly two million Americans per year develop HAIs, resulting in 99,000 deaths, most due to antibacterial-resistant pathogens.

Other reasons for antibiotic resistance include the use of antibiotics in food animals. Thus, antibiotics that are medically important to treating infections in humans should be used in food-producing animals only under veterinary oversight and only to manage and treat infectious disease, not to promote growth.

Because of concern over this growing problem, The Joint Commission released new regulatory guidelines in June 2016 that require hospitals to establish an antimicrobial stewardship program as a leadership priority. UTMB Health has already established such a program, which will be led Antimicrobial Stewardship Program Director Dr. Philip Keiser. Targeted work will be taking place across the Health System toward this endeavor, including taking “antibiotic timeouts” to reassess empiric antibiotics at 72 hours after their initiation. Additionally, a daily review of antibiotic use in patients will be conducted in order to assist clinicians in determining the best ways to desescalate antibiotic use, determining the appropriate length of therapy, and preventing drug-bug mismatches. Public education about antibiotic resistant bacteria is also an important key to preventing further problems with antibiotic-resistant infections.

THREE CRITICAL EFFORTS TO PREVENT HAIS:

1. PREVENT INFECTIONS RELATED TO SURGERY OR PLACEMENT OF A CATHETER,
2. PREVENT SPREAD OF BACTERIA BETWEEN PATIENTS, AND
3. IMPROVE ANTIBIOTIC USE. IT IS IMPORTANT THAT HEALTHCARE PROVIDERS TAKE THESE ACTIONS WITH EVERY PATIENT EVERY TIME TO PREVENT HAIS AND STOP THE SPREAD OF ANTIBIOTIC RESISTANCE.

NEURO/NEUROSURGERY UNIT
recognized by
FOOD AND NUTRITION SERVICES

Each month, Food and Nutrition Services distributes surveys to patients in order to determine how well they are performing. The survey includes three food service questions: rate the quality of food, the temperature of food, and the courtesy of the server. To help gather the data, Food and Nutrition Services requested the assistance of nurses to help distribute and collect the surveys. Recently, Food and Nutrition Services recently recognized UTMB’s Neuro/Neurosurgery Unit with a trophy for their help in exceeding the Press Ganey benchmark goal for satisfaction and number of surveys collected. Thank you all for your working together to deliver excellent care and service!

GIVE TO THE STATE CHARITABLE CAMPAIGN

We are now more than halfway through the State Employee Charitable Campaign (SECC). The SECC, one of the largest state employee campaigns in the nation, is an easy way to help the people, further the causes, and strengthen the communities that benefit from our support.

UTMB is nearing the $400,000 mark—that’s more than halfway to our goal of $525,000. It is not the amount we give, but more importantly, the fact that we have given. Our collective gift will go far and giving is easy. We can make a one-time contribution via cash, check or online, or we can make a pledge by payroll deduction (monthly or a single gift).

Last year, the statewide campaign raised and donated nearly $8.5 million for charitable organizations, with UTMB Health contributing more than $540,000. Through the SECC’s quick and simple process, you can choose to direct your donation to one or more of approximately 300 nonprofit organizations, ranging from local groups to well-known national and international charities.

Please consider making a donation through the SECC. For more information, visit https://www.utmb.edu/secc/.
EEEEK! YOU’VE BEEN SPOTTED!

CONGRATULATIONS TO THE NEWEST ALWAYS AWARD WINNERS!

Left: Inpatient Always Award presented by Asst. Chief Nursing Officer Josette Armendariz-Batiste to Nurse Manager Donna Britton and Medical Director Shreyas Modi on behalf of Inpatient Medicine and Cardiology Unit Jen 9B.

Right: Ambulatory Always Award presented by Vice President, Ambulatory Services Ann O’Connell to Lori Milner on behalf of UTMB Health Angleton Danbury Family Medicine Clinic.

KEEP UP THE EXCELLENT WORK!

HALLOWEEN PUMPKIN DECORATING CONTEST

Blocker Burn Unit
Epidemiology
TDCJ
Overflow
Pediatrics
Internal Medicine
Occupational Therapy & Physical Therapy
TDCJ 7
TDCJ ICU

Top: Chief Quality and Safety and Clinical Information Officer Mark Kirschbaum and Jill Bryant-Bova presented their hard work on reducing penalty costs for preventable complications at the 2016 Vizient Clinical Connections Summit.

Bottom: Mark Kirschbaum and Associate Professor, Internal Medicine-Endocrinology Maria Belalcazar also presented their poster, “Value of Outcome Data and Multi-disciplinary Input in the Development and Implementation of an Electronic Prescription Tool to Improve Quality and Cost-Effectiveness of Care” at the 2016 Vizient Clinical Connections Summit in Dallas, Texas.
UTMB SCHOOL OF NURSING HOSTS GOOD SAMARITAN FOUNDATION CONFERENCE

UTMB’s School of Nursing and the Good Samaritan Foundation joined together to host a conference, “Communications, Collaboration & Conflict Management: Translating ‘Soft Skills’ into Practice” at the Moody Gardens Hotel, Spa and Conference Center on October 17. This conference provided strategies for creating an environment of teamwork through communication, collaboration and conflict management as we embark on creating another culture for excellence in nursing education and practice. Resourceful and inspirational approaches in strengthening the nursing workforce through the power of meaningful recognition were also explored.

I’d especially like to recognize Dr. Sreeram Parupudi and his entire staff for their care during my recent procedure. They accommodated my request for no sedation or anesthesia of any kind. Thank you! (Gastroenterology)

**Blanca Anderson** was a great nurse who answered my questions, started my IV and was truly helpful. Thank you! (Ear Nose & Throat)

I have had several outpatient procedures done at UTMB. While the old area in John Sealy Towers was nice, the new Jennie Sealy Hospital is fabulous! (Orthopedics)

Special thanks to Dr. Stephen Kim, Fannie Madrigal-Perez (nurse clinician II, Emergency Services), Amy Miller (nurse clinician II, Transplant Unit) and Susan Nichols (nurse clinician III, Ortho/Trauma). I had a hip replacement and they gave the best care! (Emergency Department)

I am so appreciative of the nurses and techs that were taking care of me. Fatima Fajardo (nurse clinician IV), Tam Pham (patient care technician II), Margie Qualis (patient care technician I) and Rose Ambida Cinco (nurse clinician IV). I am grateful of their professionalism, their courtesy, and their compassion. God bless them all! (Medicine/Cardiology)

**Dana Robertson** (nurse clinician IV) from Labor & Delivery was amazing! She made my stay very comfortable. (Orthopedics)

Dr. Kanika Bowen-Jallow and Dr. Peter Rojas were wonderful. They even texted us days later to check on us after an infection. Dr. Denise Wilkes (Anesthesiology) was wonderful and attentive and Dr. Meagan Finke (resident pgl-3, Pediatric Medical Education) in the Emergency Department was very friendly. (Surgery-General Surgery)

All of the nurses who took care of me were good, but there was one who stood out above all of the rest. Eileen Pucci-Womack (nurse clinician IV) made my difficult stay a little easier. Keep up the good work. All of the staff help you run a great hospital.

I would like to applaud Patricia Rodriguez Lozaro (resident pgl-4) and Kevin Harris (patient care technician). They were excellent! (ACE Unit)

I’d like to recognize Laura Amos (patient care technician I). As I was leaving Jennie Sealy Hospital yesterday, Laura had stopped to help a patient who was walking with her IV pole near hospital administration office. The patient looked as if she was about to pass out. When asked if she was okay, the patient said she felt weak and dizzy. Laura stayed with her as I got a wheel chair and then Laura helped me get the patient in the chair and we took her to transportation who escorted her to her room. Laura’s actions were a wonderful example of demonstrating our UTMB service excellence standards!

Dr. Ali Hashmi was very through, patient, and showed lot of concern about my condition. I could not say enough good things about him. I wish all doctors were like him! Two words: just great! (Gastroenterology)

Dr. David Yngve was very sensitive to my son’s need for special anesthesia. He is the only doctor who understood my son’s condition. We drove seven hours to see him and have surgery done by him. He is awesome! (Surgery, Orthopaedic)

Dr. Dani Boyles took her time and went over all of my tests and medications. I am very happy with my visit and her genuine concern. (Family Medicine)

I really appreciated Cathy McLean (maternal and child specialist) and UTMB for fitting me in and being flexible when scheduling my appointment. It made me feel that they truly cared about my health and valued the importance of the urgency of the procedure. (Ob/Gyn General Outreach)

Dr. Andrea Glaser is an excellent doctor. She scheduled my daughter the following day for a test and was very concerned. She is very compassionate and we were so lucky to have her see my daughter. (Pediatric Urgent Care South Shore)

UTMB rehabilitation staff, especially Chad Davenport, were informative, caring and knowledgeable. My rehab could not have gone any better! (Outpatient Rehabilitation Therapy)

Dr. Janna McGaugh and Kat Conley (physical therapist assistant) are amazing! My daughter was in pain with her feet issues for more than two years before starting physical therapy at UTMB. She is now pain free more often than not! I can’t even thank these therapists enough! (Occupational Therapy)

Angelica Rendon (radiation therapist) and Jeremy Stanley (radiation therapist, sr.) could not be more nice or friendly. Their concern for my comfort was obvious. They make an unpleasant experience, pleasant. (Radiation Oncology)