This month, UTMB received its first-quarter performance report for the 2018 Vizient Quality and Accountability Study. Our current overall ranking is No. 2 among the study’s 96 participating academic medical centers.

We have made significant improvements across most of the domains, including gains in the Mortality and Safety domains. Keep in mind that results of the study will vary throughout the year based on our ongoing performance – the final results will be available in October 2018.

There were some major changes to the methodology of this year’s study including the addition of a third category of hospitals. Formerly, the study included academic hospitals and community hospitals. In 2018, teaching hospitals were added (these are hospitals with residency programs, but without medical schools). In the Efficiency domain, Direct Cost was added, which accounts for 5 percent of the total study. In the Effectiveness and Safety domains, four new lab measures were added (two in each domain). There were also changes to the way service lines are weighted.

As UTMB strives to maintain its status as a five-star health system, we have started important work to become a “High Value Practicing Organization” for our patients by establishing a concerted effort to promote appropriate testing and treatments which will ensure we provide the safest quality care at an affordable cost to our patients. Value for our patients will be created through five focused areas for improvement:

continued on page 2
• **Antimicrobial stewardship** to reduce microbial resistance.
• **Blood management** to ensure patient safety.
• **Laboratory stewardship** to ensure appropriate testing, increase patient satisfaction and reduce patient harm.
• **Imaging stewardship** to ensure appropriate testing, increase patient satisfaction and reduce cost of care.
• **Opioid stewardship** to promote appropriate prescribing and prevent substance abuse.

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**UTMB’s Vizient Quality and Accountability Study results since the Best Care initiative began in June 2016**

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**ANTIBIOTICS STEWARDSHIP**

Antibiotic resistance is one of the world’s most pressing public health problems. According to the World Health Organization, up to 50 percent of antibiotic prescriptions are unnecessary or inappropriate, such as when they are prescribed for conditions we now know to be largely caused by viruses, like the common cold, the flu or diarrhea.

As a result of the overuse and misuse of antibiotics, many types of bacteria have adapted and strengthened to survive antibiotic treatment. Antibiotic resistance can cause illnesses that were once easily treatable with antibiotics to become dangerous infections which require more clinical resources to treat.

Because of the dangers of antibiotic resistance, antimicrobial stewardship programs are now mandated by The Joint Commission for inpatient hospitals. Under the direction of **Dr. Philip Keiser**, UTMB’s Antimicrobial Stewardship Program was launched in January 2017. His team consists of a multidisciplinary group of microbiologists, pharmacists, infection preventionists, nurses, quality improvement specialists and infectious diseases clinicians who have implemented a number of interventions to improve the quality of antibiotic use. These efforts include, but are not limited to, audits of antibiotic use when needed, feedback and recommendations on antibiotic use, narrowing coverage and duration, and bedside infectious diseases consultations.

**TEAM**

- Dr. Philip Keiser, Professor, Division of Infectious Disease Department of Internal Medicine; Director of the Antimicrobial Stewardship Program
- Dr. David Reynoso, Assistant Professor, Division of Infectious Disease, Department of Internal Medicine; Associate Director of the Antimicrobial Stewardship Program
- Wai-Ying Lam, Clinical Pharmacist, Infectious Diseases
- Dr. Diana Nguyen, Pediatric Infectious Diseases specialist
- Natalie Williams-Bouyer, Associate Professor of Pathology, Division of Clinical Microbiology; Co-director of the Microbiology Laboratory
- Scott Ferren, Clinical Pharmacist, Infectious Diseases
- Renee Kearby, Senior Quality Management Specialist
- Dr. Janak Patel, Professor in the Department of Pediatrics; Director of the Division of Infectious Disease and Immunology; Director of Healthcare Epidemiology
- Robert Starkweather, Business Analyst, Department of Healthcare Epidemiology
- Morgan McClure, Systems Analyst, Clinical Information Services Projects
- Mary Feldhusen, Administrative Director, Communications Strategies, Health System

**CHOOSING WISELY**

Avoid prescribing antibiotics for upper respiratory infections. The majority of acute upper respiratory infections (URIs) are viral in etiology and the use of antibiotic treatment is ineffective, inappropriate and potentially harmful. However, proven infection by Group A Streptococcal disease (Strep throat) and pertussis (whooping cough) should be treated with antibiotic therapy. Symptomatic treatment for URIs should be directed to maximize relief of the most prominent symptom(s). It is important that health care providers have a dialogue with their patients and provide education about the consequences of misusing antibiotics in viral infections, which may lead to increased costs, antimicrobial resistance and other adverse effects.
LABORATORY STEWARDSHIP

About 30 percent of inpatient laboratory testing is considered unnecessary. Choosing Wisely initiatives from numerous professional societies have identified repetitive laboratory testing in the face of clinical stability as low-value care. Although laboratory expenditure often represents less than 5 percent of most hospital budgets, the impact is far-reaching given that laboratory tests influence nearly 60 to 70 percent of all medical decisions.

Patient safety is at the forefront of the laboratory stewardship effort, because growing evidence suggests that routine laboratory testing is associated with preventable harms such as hospital-acquired anemia, false positive results, interruption of badly needed patient sleep and patient discomfort. Additionally, diagnostic testing without reasonable pretest probability can lead to a cascade of additional interventions, including more-advanced laboratory studies, particularly if abnormalities are discovered.

Led by Dr. Todd Masel, the goal of UTMB’s Clinical Laboratory Stewardship program is to increase patient safety by emphasizing selection of the right tests, at the right time for each patient. Audit and feedback on the appropriateness of both common and expensive laboratory orders will be a key focus, as well as promoting accurate test interpretation.

CHOOSING WISELY

Don’t transfuse more units of blood than absolutely necessary. Each unit of blood carries risks. A restrictive threshold (7.0-8.0g/dL) should be used for the vast majority of hospitalized, stable patients without evidence of inadequate tissue oxygenation (evidence supports a threshold of 8.0g/dL in patients with pre-existing cardiovascular disease). Transfusion decisions should be influenced by symptoms and hemoglobin concentration. Single unit red cell transfusions should be the standard for non-bleeding, hospitalized patients. Additional units should only be prescribed after re-assessment of the patient and their hemoglobin value.

CHOOSING WISELY

Don’t perform repetitive CBC and chemistry testing in the face of clinical and lab stability.

Hospitalized patients frequently have considerable volumes of blood drawn (phlebotomy) for diagnostic testing during short periods of time. Phlebotomy is highly associated with changes in hemoglobin and hematocrit levels for patients and can contribute to anemia. This anemia, in turn, may have significant consequences, especially for patients with cardiorespiratory diseases. Additionally, reducing the frequency of daily unnecessary phlebotomy can result in significant cost savings for hospitals.
IMAGING STEWARDSHIP

Medical imaging technology plays an essential role in the timely diagnosis and management of many conditions. However, one major factor contributing to the growth of health care cost nationally is the increased use of diagnostic testing to identify the cause of a patient’s symptoms.

An estimated 20 to 50 percent of imaging is considered unnecessary. Imaging is also the single largest source of per capita radiation exposure. Over the years, the use of imaging has grown in part because there have been so many advances in high-tech equipment that have rapidly proliferated the health care industry. Additionally, many patients insist on having certain types of imaging tests. Another contributor to wasteful practice is duplicate testing, which often occurs when a patient changes physicians.

For example, lower back pain is one of the most common reasons people seek emergency medical care. Choosing Wisely suggests that unless red flags are present like fever, weight loss or neurological deficits are present, imaging for lower back pain is usually unnecessary. This common condition usually resolves on its own in approximately four weeks and can be treated with over-the-counter medications and through physical therapy, massage or other forms of care. Even in patients without pain, imaging of the lower back is likely to detect “abnormal” findings which could lead to unnecessary procedures.

The goal of UTMB’s Imaging Stewardship program, led by Dr. John Heymann, is to ensure patient safety while reducing the use of imaging that is not evidence-based or may not be appropriate according to criteria established by the American College of Radiology. Other goals include reducing duplicative testing when appropriate. The initial focus will be on Abdominal and Pelvic CT scans and Lower Back Pain imaging.

TEAM

- Dr. John Heymann, Assistant Professor, Radiology; Director, Imaging Stewardship Program
- Dr. Alok Dabi, Assistant Professor, Department of Neurology; Director, Neurosciences Critical Care Program
- Dr. John Hagedorn, Assistant Professor, Orthopaedic Trauma
- Dr. Gary Horn, Assistant Professor, Radiology
- Dr. Robert Kaale, Emergency Medical Group, ED Medical Director
- Dr. Leah Low, Assistant Professor, Internal Medicine; Associate Program Director; Medical Director John Sealy Hospital Units 7A and 7B; Lead Physician Advisor
- Dr. Rex McCallum, Vice President & Chief Physician Executive; Associate Dean for Clinical Affairs
- Dr. Angelica Robinson, Fellowship Director, Department of Radiology; Director, Breast Imaging
- Dr. Stephen Williams, Assistant Professor, Urology; Director of Urologic Oncology
- Winston Chan, Biostatistician
- Morgan McClure, Systems Analyst, Clinical Information Services Projects
- Mary Feldhusen, Administrative Director, Communications Strategies, Health System

CHOOSING WISELY

Do not obtain spinal imaging for patients with acute low-back pain during the six weeks after onset in the absence of red flags.

In the absence of red flags, evidence-based guidelines do not support the routine use of spinal imaging for patients with acute back pain of less than six weeks duration. Red flags include history of cancer, fracture or suspected fracture based on clinical history, progressive neurologic symptoms and infection, as well as conditions that potentially preclude a dynamic thrust to the spine, such as osteopenia, osteoporosis, axial spondyloarthritis and tumors. Unnecessary imaging incurs monetary cost, exposes the patient to radiation, and can result in labeling patients with conditions that are not clinically meaningful, creating a false sense of vulnerability and disability. Indeed, several studies have shown that the routine use of radiographs in the care of low-back pain may result in worse outcomes than without their use.

LABORATORY STEWARDSHIP TEAM

- Dr. Todd Masel, Interim Vice Chair of Clinical Affairs, Assistant Professor, Neurology; Director, Laboratory Stewardship Program
- Dr. Matthew Mrazek, Assistant Professor, General/Internal Medicine
- Chad Botz, Asst. Professor, Pathology
- Dr. Luba Frank, Director Cardiothoracic Imaging
- Juan David Garcia, Administrative Director, Lab Services
- Mohamed Morsy, Assoc. Professor, Internal Medicine/Cardiology
- Tho Nguyen, Manager, Laboratory Services

- Judy Trieu, Resident Pgl-2, Internal Medicine
- Amy Davis, Asst. Administrative Director, Lab Services
- Elizabeth Rodriguez, Patient Services Specialist, CBC League City Family Medicine
- Mayukh Sarkar, Medical Lab Scientist, Lab Services
- Barbara Bowers, Decision Support Analysis
- K. Nicole Young, Nurse Manager, Internal Medicine
- Morgan McClure, Systems Analyst, Clinical Information Services Projects
- Mary Feldhusen, Administrative Director, Communications Strategies, Health System

continued from page 3 | Best Care: promoting patient safety and creating value for our patients

continued on page 5
March is Colorectal Cancer Awareness Month

Colorectal cancer is the second leading cancer killer in the United States and is expected to cause more than 50,000 deaths in 2018. However, it is one of the most preventable types of cancer and is often curable when detected early. Colorectal cancer and precancerous polyps don’t always cause symptoms. You may look healthy and feel fine, and not know there may be a problem. It may take 10 to 15 years for a polyp to develop into colorectal cancer.

Screenings for colorectal cancer are recommended for all adults beginning at the age of 50. Screenings can help prevent colorectal cancer by finding and removing polyps before they turn into cancer.

For more information or to request a screening appointment at a location near you, call:

**Angleton:** (979) 848-9111
**Galveston:** (409) 772-4798
**League City:** (832) 505-1800

Don’t be a statistic. Learn more about risk factors and screenings at utmbhealth.com/colorectal
Do no harm: Patient event reporting critical in improving patient safety

“First, do no harm,” may be one of the most widely recognized phrases from the Hippocratic Oath and a revered ethical code for those who work in health care. Unfortunately, despite the best intentions and preparations, “to err is human,” as Alexander Pope once wrote, and mistakes are sometimes made.

This is why UTMB is ramping up its Patient Safety and Event Reporting Program so that care providers can more efficiently report any quality or patient safety-related event they witness – whether the report is about something that needs improvement or something that is working well, the goal is to improve systems and processes for the benefit of patients, visitors and staff.

Patient event reporting is valuable, because it not only promotes accountability, but provides opportunities to learn from potential errors and adverse events. It is also a chance to celebrate “Great Catches.” Most often, reports are received from front-line staff and personnel who are directly involved in a near-miss or the actions leading up to an event, such as a nurse who identifies an incorrect dosage on a prescription.

The Patient Safety Net (PSN) reporting system is currently used at UTMB to document safety events. When a report is submitted, it is reviewed by the Safety Event Action Team, often referred to as SEAT, and assigned a risk rating of 1 (lowest risk) to 10 (highest risk). The team then makes recommendations for improvements in order to avoid similar errors in the future.

This spring, the current PSN event reporting system will be replaced with a new and improved reporting tool, the Midas+ Juvo Patient Experience and Event Reporting System. In addition to capturing information on near misses and adverse events, the new system will allow users to report positive patient experiences. It will also provide real-time data and scorecards. Implementation of the new system comes in response to physician, resident and staff concerns that the current system was complicated to use. Stay tuned for more information about the new Midas+ Juvo Patient Experience and Event Reporting system in the coming months!

Generally, there are three types of events that are reported: adverse events, near misses and unusual events:

- **Adverse events** include preventable errors, unexpected incidents, therapeutic misadventures or other adverse occurrences directly associated with care or services provided.
- **Near misses** are unplanned events that could have resulted in harm, but did not, either by chance or timely intervention. Near misses are especially critical to report, because they often precede adverse events.
- **Unusual events** are incidents that aren’t necessarily directly related to a patient harm event or a near miss, but still impact the quality and safety of care. These incidences may include technological malfunctions, equipment defects and packaging errors.

According to The Joint Commission's 2016 Sentinel Event Data Summary, some of the most common examples of adverse events include:

- Wrong patient/wrong site/wrong procedure
- Unintended retention of a foreign bodies
- Patient falls
- Delay in treatment
- Medication errors
- Failure to make a timely diagnosis or institute the appropriate therapeutic intervention
- Adverse reactions to a treatment
- Procedural errors/complications

The following is an example of a “near miss” and why speaking up about concerns is so important. Last month, Mirna Gloria, a senior imaging library representative in Radiology, noticed a discrepancy in a patient’s mammogram files. Upon further investigation, she discovered that this patient shared a name, birthdate and even a hometown with another UTMB patient. The typically reliable two-step patient identification verification process (name and date of birth) was not sufficient in this instance. Based on the commonalities in both patients’ medical records, it was clear that they potentially could receive the other’s test results and documentation. Mirna
notified her supervisor about her discovery and both patients’ files were assigned additional identification information. For these two patients, Mirna’s near miss report likely prevented future medical errors.

**Unusual events** aren’t limited to incidents of patient harm or near misses. These events also have an effect on patient care and should be reported:

- Instructions/labeling/packaging errors
- Software problems
- Failure to work as intended/malfunction
- Interactions with other devices
- Equipment/supplies device failure or defects
- Unusual events that occur to employees resulting in injury

Sometimes, care team members may see an adverse event or a near miss take place, but feel unsure of whether or not they should report the incident. A good rule to live by is, “**If you see something, say something!**” Even if an incident report does not result in the need to change practice, supplies or equipment, it is always better to speak up about a concern or incident than to say nothing!

To report an adverse event, near miss or unusual event, a link to the PSN is available on the iUTMB homepage or you may visit [https://utmbpsnprd01.utmb.edu/datix/live/index.php](https://utmbpsnprd01.utmb.edu/datix/live/index.php).

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**Health Care Innovation Lecture Series**

If you could imagine the future of health care – a future without boundaries – what would it look like? If you could change any rule to create a better care experience for patients or staff, what would it be? How would you cure a disease or improve patient access to the system?

Join us as the Health System and Academic Enterprise kick off the new Health Care Innovation Lecture Series hosted by Chief Medical and Clinical Innovation Officer, Gulshan Sharma.

On April 23, Futurist Garry Golden will explore **“The Health Care Delivery System of the Future.”** As an academically trained Futurist, Garry helps organizations bring structure and discipline to exploring the implications of long-term change. He helps organizations close the gap between the pace and direction of change happening outside their organization while advising on the changes happening within an organization. Golden teaches leaders and teams how to tap their inner futurist and develop the right habits of mind to anticipate and lead change.

April 23, 2018 | 11:30 a.m. - 1:00 p.m.
Levin Hall Main Auditorium
**Tough and Tiny Pediatric Weight Loss Clinic**

The Departments of Pediatric Surgery and Pediatric Gastroenterology are proud to announce the jointly managed “Childhood Weight Loss Clinic” for children 3-11 years of age with a Body Mass Index (BMI) greater than the 95th percentile. In an effort to target children at their most impressionable age, the program will provide nutrition education to parents, guardians and caretakers, while the children take part in structured fitness activities with a certified fitness instructor. All eligible participants must receive a referral from a UTMB provider. The clinic will meet on the second and fourth Thursdays of each month from 4:30 to 5:30 p.m. at the Bay Colony Pediatric Center in League City.

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**Jennie Sealy Hospital Medical Intensive Care Unit Achieves One Year CAUTI free**

The Jennie Sealy Hospital Medical Intensive Care Unit (MICU) completed one year of zero catheter-associated urinary tract infections (CAUTI) on Feb. 19. This is the first time since the Department of Health Care Epidemiology began tracking CAUTI in 2005 that it has achieved a full year CAUTI-free.

In 2016, the MICU implemented a nurse-driven, evidence-based CAUTI reduction program to eliminate infections. This process included an assessment of the necessity of indwelling urinary catheters (based on CDC indications), CAUTI-prevention measures and care for patients requiring catheters and shift rounding to assist staff with identifying opportunities for preventing catheter-associated urinary tract infections.

Congratulations to the MICU nurses, physicians, staff and the Hospital-Acquired Infections (HAI) Prevention Team for your hard work and dedication to Best Care!

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**MICU HAI Prevention Team**

Robert Starkweather, business analyst, Health Care Epidemiology
Christina Drake, nurse clinician, MICU/CCU
Maria Minerva, nurse clinician, MICU/CCU
Estrella Ofquila, nurse clinician, MICU/CCU
Rachel Taylor, nurse clinician, MICU/CCU
Scott Woodby, nurse clinician, MICU/CCU

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**SHOUT OUTS!**

I would like to give a shout out to Dr. Hassan Harirah of Maternal Fetal Medicine. He helped my family during an unfortunate situation. My brother and his wife received bad news about their pregnancy and he, Nurse Maxine Aguilar, and the tech were awesome.

I had no fear or concerns before my amputation. Dr. Vinod Panchahavi was so calm, reassuring and very educated in his specialty. He has a passion for his profession and shows compassion for each person in his care. (Orthopedics)

My family was very impressed by the attentiveness of everyone involved in my care. They received regular updates from nurses and Dr. Charlie Cheng took time with them to explain the procedure. (Vascular Surgery)

My nurses, Shannon Clark and Dyana Leteff, were with me for several days and they made all the difference in my stay! (League City Campus Labor, Delivery, Recovery & Postpartum)

My Labor and Delivery nurse, Tempie Soell, made me feel very comfortable with her knowledge and care during my birth experience. Thank you! (Angleton Danbury Campus Labor & Delivery)

Michaele Osterhout (lead neurodiagnostic tech) was kind, attentive and overall, just exceptional! (Neurology)

Dr. Erin Hommel is the best physician I have ever had. She is so knowledgeable, communicates with genuine concern for my well-being, is an excellent listener and follows through completely! (Internal Medicine, Geriatrics)

Dr. Susan Easley is the best physician I have seen in my 81 years. All doctors could learn from her! (Family Medicine)