

April 2008

FOR STAFF AND FRIENDS OF UNIVERSITY HEALTH CARE

Research Sherpa Performance on Top of the World

Nearly one year ago, **Scott McIntosh**, M.D., M.P.H., spent a few minutes on top of the world—literally. McIntosh, assistant professor of emergency medicine, summited Mount Everest last May while conducting physiological research with the SuperSherpa Expedition.

“Our role was to look at the Sherpas’ physiology and why they are so good at what they do at high altitudes,” he said. Sherpas are native to the Himalayan Mountain region of Nepal and are legendary for their strength and stamina on the 29,035-foot ascent up Everest, the world’s highest peak.

Stacie Wing-Gaia, Ph.D., R.D., principal investigator and assistant professor of nutrition, said the study results of this first all Sherpa expedition provide a starting point for more study. Next month, she plans to submit a case study for publication in an altitude-related journal.

The researchers suspected that the Sherpa’s aptitude had something to do with their history of inhabiting the Himalaya region for 25,000 years, genetically predisposing them to better performance at higher altitudes.

“If we took anyone from here and put them on the summit of Everest, they would be unconscious in about two minutes and dead in five minutes,” explained McIntosh. Everest contains about one-third of the oxygen at sea level. Attempting to summit the mountain requires three weeks’ acclimation for most climbers. Sherpas need only 10 days.

Prior to the expedition’s departure, the chief subjects of the study, Apa Sherpa and Lhakpa Sherpa, two of the world’s most accomplished Everest mountaineers who now live in Utah, underwent tests for strength, physical fitness, body composition, respiratory and heart rates. The results weren’t particularly impressive, according to McIntosh. But as soon as the team reached Base Camp (elevation 17,800 feet), the Sherpas began to stand out.

Apa Sherpa, Lhakpa Sherpa, and Scott McIntosh, M.D., summited Everest on May 16, 2007. McIntosh believes one reason Sherpas are so adept at high altitudes is they’ve lived in the Himalayan region for 25,000 years.

See **SHERPAS** on reverse



Collaboration New Fetal Therapy Program Performs Utah’s First EXIT Procedure

PHOTOS BY KRISTAN JACOBSEN

Elizabeth Sanders, 25, and her baby, Scarlett, 3 months old, underwent Utah’s first EXIT procedure in January. The complex procedure, performed in Utah for the first time at University Hospital, involved faculty and staff from several clinical departments, as well as physicians and staff from three other hospitals. The U’s new Fetal Therapy Program is designed to improve care for babies with birth defects, genetic conditions, and other problems associated with complicated pregnancies.

Elizabeth Sanders was 20 weeks pregnant when she and her husband learned during an ultrasound that something was wrong with their baby. The images showed a mass around the baby’s neck, possibly a tumor, that could make it impossible for the girl to breathe after delivery.

Sanders, a resident of Sandy, Utah, was referred to a maternal fetal medicine specialist at St. Mark’s Hospital who delivered even more bad news—the procedure that provided the baby with the best chance for survival had never been done in Utah.

At the direction of the referring physician, Sanders found her way to **Jan Byrne**, M.D., associate professor of obstetrics and gynecology and director of the University’s Fetal Therapy Program. After reviewing the case and meeting with Sanders, as well as the referring physician and colleagues from five other departments, Byrne gave the expectant mom some much-needed good news: the University, with help from Primary Children’s Medical Center, Intermountain Medical Center, and St. Mark’s Hospital, had the resources and expertise to perform the complicated procedure.

“I don’t know that anyone ever wants to be the first to undergo a procedure,” said Sanders. “But I felt very comfortable knowing that so many committed people were going to be part of the delivery.”

Known as an Ex Utero Intrapartum Treatment, or EXIT, the procedure involves partially delivering a baby via Cesarean section, and then intubating the baby to secure the airway before completing the delivery and cutting the umbilical cord. Only a handful of hospitals in the country perform the procedure.

On Jan. 14, two surgical teams, one for Sanders and one for her baby,

performed the EXIT procedure in University Hospital’s Labor and Delivery operating room. The operation went as expected and the baby was passed through the window connecting the operating room to the Newborn Intensive Care Unit. Once the baby was stabilized, she was transferred to Primary Children’s Medical Center.

“We had more than 20 people representing three different hospitals and five different specialties involved in this procedure, so we had to make



“No one practices medicine at the University in a vacuum,” says **Paula Woodward**, M.D., professor of radiology. “Everything we do is a combined effort.” Woodward, above left, with **Anne Kennedy**, M.D., professor of radiology, and **Jan Byrne**, M.D., associate professor of obstetrics and gynecology, are part of the U’s new Fetal Therapy Program, which includes specialists from maternal-fetal medicine, pediatric surgery, pediatric cardiology, radiology, neonatology, and genetics.

sure everything was well-scripted,” said Byrne. “Both teams had practiced beforehand and we all felt very comfortable about our roles.” One week later, another EXIT procedure was successfully performed.

Byrne says this collaboration is what makes the Fetal Therapy Program possible. “No one hospital, or health system could do this alone. As faculty members, we’ve always had collaborative relationships across specialties,” she

said. “But this new program, which is a collaboration between the maternal-fetal medicine programs at University Health Care and Intermountain Health Care, formalizes these relationships and, ultimately, makes it easier for patients with complex pregnancies to access our services.” Byrne also expects this collaboration to expand research questions and projects.

While EXIT procedures are the most complex surgical intervention the program coordinates, there are other postnatal surgical procedures for conditions such as diaphragmatic hernias and neural tube defects. Fetal dysrhythmias and Rh disease are treated in utero. Care of patients with fetal cardiac defects is coordinated with the Fetal Cardiology Program. Twin-twin transfusion syndrome is an area of active research, although laser treatment is not currently available at the University. The program also manages pregnancies with known birth defects and abnormalities where there is no surgical intervention possible.

Ultimately, the new Fetal Therapy Program serves as a resource to help coordinate the complexities of prenatal and peripartum courses for parents such as the Sanders. “We evaluate each case individually and bring together all our resources to do what’s best for the mom and the baby,” she said.

Scarlett Sanders is now 3 months old and doctors have determined the neck mass was not a tumor, but lymphatic cysts. During the next year, doctors at Primary Children’s Medical Center will try to shrink the cysts with injections of a mixture of antibiotics and alcohol.

“We had so many worries before she was born, but everything turned out so much better than we expected,” says Sanders. “She’s the most precious, little baby and we just love her so much.”





Ad Campaign

Who is University Health Care? Campaign Promotes Our Comprehensive System

DEE BREWER

Assistant Vice President, Marketing

You've probably heard the ancient parable where a maharishi leads six blind men to an elephant and asks them each to describe it.

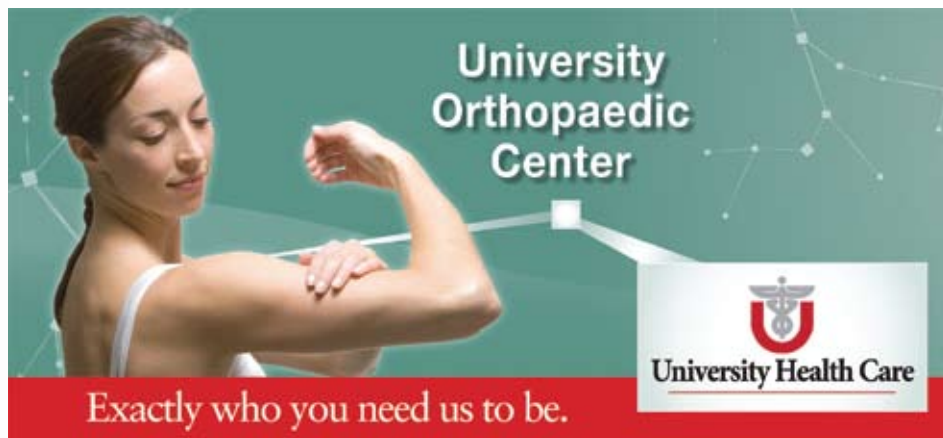
One man, with his arms around a massive leg, imagines it to be like a tree. Another, running his hand across the elephant's broad side, insists it is like a wall. Another, feeling the trunk, says it is very much like a snake.

Each of the men experiences a part of the elephant and forms an opinion based on his limited perspective. None fully appreciates the magnificence of the elephant.

We have a similar challenge explaining University Health Care to people who have only experienced a part of who we are. They may see us as just a hospital, a cancer institute or a neighborhood health center. Or maybe they think of us as a training ground for doctors.

According to our market research, most people don't understand the relationship of our parts and therefore don't appreciate the whole. But that research also tells us that when people do understand a fuller picture of who we are, they are much more likely to choose University Health Care services.

That's why we are raising our voice with advertising and news media public-ity—to render a fuller picture of who we



University Health Care's current ad campaign connects the dots to express who we are and how we collaborate for our patients' benefit.

are. It's a mammoth task.

The market research informed strategies for expanding people's view of University Health Care. The current campaign relates our individual parts to the whole and, quite literally, connects the dots of who we are. It also reinforces the point that, because of our comprehensive services, we are exactly what patients need when they have health-care issues.

Among the mass media tools we use to render our image are television and radio commercials, billboards, bus boards and print advertisements (See examples at healthcare.utah.edu/adcampaign/). We also place hundreds of news media stories each year to add greater depth to our image.

We measure the campaign's effective-

ness through regular telephone surveys of Wasatch Front households. The research tells us that we are having a positive impact. For example, survey participants were asked—before and after the first year campaign—to name an excellent health-care system. Those who answered "University Health Care" increased 8 percent after the first nine months of the campaign. Other measurements also indicate a growing public understanding of our system.

Strengthening University Health Care's brand identity is one of the top five strategic priorities in Health Science's Clinical Enterprise Strategic Plan. We will continue raising our voice with a persistent campaign keeping in mind another African proverb: *how do you eat an elephant? One bite at a time.*

Government Affairs

2008 Legislative Wrap Up

KIM WIRTHLIN

University Vice President, Government Relations, & Associate Vice President, Health Sciences Public Affairs & Marketing

"Just because you do not take an interest in politics doesn't mean politics won't take an interest in you." —Pericles, 430 B.C.

At the end of every legislative session, I'm reminded of how timeless this Pericles quote is. During this year's 45-day legislative session, more than 1,100 bills were filed and 436 of them passed, creating roughly 300 new laws for us to follow and allocating a \$12 billion budget.

So what interest did the legislators take in health care this year?

- Though we thought that the health care reform debate would take center stage, as the session approached it became clear that there was too much disagreement around the strategies and tactics to reach a consensus. Rep. David Clark successfully sponsored HB 133 Health Insurance Reform that created an 11-member task force charged with developing a strategic plan for the following legislative session.

- As in past years, there were several



MICHAEL DUNN

"any willing provider" bills that would require health insurers to contract with any willing and qualified health-care provider, but all failed to pass.

- A bill was passed that requires the Department of Health to keep enrollment in the Children's Health Insurance Program open year-round and designated non-lapsing appropriations to fund the program.

- After a four-year struggle, it is now required that a driver provides a proper restraint device, e.g. a booster seat, for any child younger than 8 years old, with exceptions based on a child's height.

- There was an inflationary increase for Medicaid funding, including 2.7 percent increase for inpatient care, 3.3 percent increase for outpatient care, and 2.5 percent

increase for physicians.

- Medicaid adult dental services received \$2 million in one-time funding.

It's important to note that next fall, every member of the House and half of the Senate are up for re-election (as well as the governor and three congressmen). As Pericles suggested nearly 2,500 years ago, politics will take an interest in you, so take a moment to find out who your state representatives are. Visit Legislator Lookup at <http://le.utah.gov/maps/amap.html> or call your county clerk.

SHERPAS *continued from cover*

McIntosh and co-investigator **Staci Nix**, R.D., instructor of nutrition in the U's College of Health who was stationed at Base Camp, monitored the Sherpas to measure their total energy expenditure, weight, hydration, body composition, oxygen saturation, and heart and respiratory rates. McIntosh was monitored for comparison purposes.

Early in the climb, the Sherpas' oxygen saturation levels measured in the mid- to high-70s while McIntosh was in the low 60s. An Emergency Department patient who arrived with a saturation level below 90 would be put on oxygen and rushed to the Surgical Intensive Care Unit, according to McIntosh.

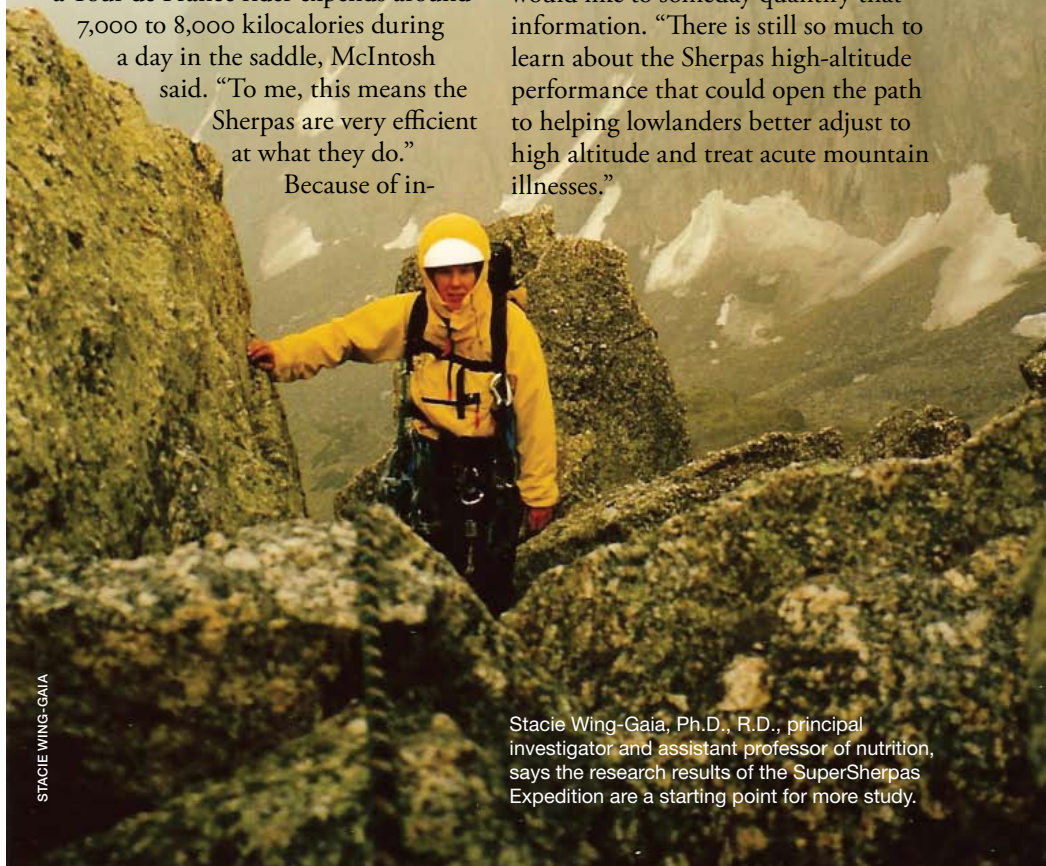
They also found the Sherpas used 3,600 kilocalories a day. By comparison, a Tour de France rider expends around 7,000 to 8,000 kilocalories during a day in the saddle, McIntosh said. "To me, this means the Sherpas are very efficient at what they do."

Because of in-

testinal illness, loss of appetite, dehydration or other problems, the average Everest climber loses 20 percent of body weight. But none of the Sherpas lost weight and, in fact, one guide gained weight. This could be related to their resting metabolic rate, which is believed to play a role in altitude-induced weight loss. Most Everest climbers' resting metabolic rate increases 7 percent to 28 percent, but the Sherpas' resting metabolic rate did not rise.

The Sherpas did show significant dehydration. Yet they didn't exhibit the usual symptoms—headaches and nausea.

Because of language barriers and cultural differences, the team was unable to measure the Sherpas' appetite and dietary intake, and Wing-Gaia would like to someday quantify that information. "There is still so much to learn about the Sherpas high-altitude performance that could open the path to helping lowlanders better adjust to high altitude and treat acute mountain illnesses."



STACIE WING-GAIA

Stacie Wing-Gaia, Ph.D., R.D., principal investigator and assistant professor of nutrition, says the research results of the SuperSherpas Expedition are a starting point for more study.

a note from david entwistle



STEVEN LEITCH
David Entwistle,
CEO, University Hospitals & Clinics

Potentially Facing \$25 Million in Medicaid Cuts, Hospitals and Clinics Must Operate More Efficiently to Make Up Lost Funds

Dear Colleagues:

A few weeks ago, it looked almost certain that a new rule regarding federal reimbursement for Medicaid patients, which would go into effect May 25, would cost our hospital \$25 million a year in revenue. Losing that much income—equal to the hospitals and clinics annual profit—would force us to change the way we do business.

For some time we've been looking at different ways to cut costs to make up the lost revenue. These are hard decisions. In the meantime, our institution joined others across the country in a lawsuit that a California hospital filed against the Centers for Medicare and Medicaid Services to place a moratorium on the new rules. New developments in the past few weeks have given us some hope those cuts may be delayed. A committee in the U.S. House of Representatives voted unanimously to delay implementing the rule for a year. But, there still would need to be action by the full House as well as the Senate and the President before such a delay becomes law.

We are somewhat optimistic about this recent action by the House, but won't know for a few weeks whether the entire Congress will pass a bill to place a moratorium on the cuts. Even if this legislation is successful, Medicaid reimbursements are likely to be cut drastically in a year.

Regardless of what happens, this process has made clear that we must operate more efficiently and lower our costs, and we are committed to doing this. We do not expect to cut staff, but every other avenue to reduce expenses or increase revenue is open to

consideration: from providing fewer Medicaid-funded elective procedures to growing the most profitable service lines.

One of the first places we'll focus on is reducing supply costs. Our hospitals and clinics spend \$18 million a year more on supplies than similar academic centers nationwide.

Regardless of cuts in Medicaid reimbursements, we've must do better in buying, managing, and using supplies. We are making institutional changes in our supply system, but as I've said in other messages in Pulse, every UUHC employee can make a difference, whether it's in patient satisfaction or, in this case, saving money on supplies. We must work together to accomplish a major reduction in supply costs.

Other areas we'll look at include our service lines: profitable ones will be grown, and we'll do our best to help unprofitable ones start making money. We'll also consider leaving selected unfilled jobs vacant.

As a teaching and "safety net" hospital and clinics system, we're proud of our role in training tomorrow's doctors and in treating those in our community who don't have health insurance or other resources to pay for their medical care. But, ultimately, a cut in Medicaid revenues may mean UUHC will not be able to care for as many of these patients as we traditionally have done.

I have mentioned only a couple of the areas where we could save money, but I hope they give you an idea of the challenge that lies ahead and where you might be able to help. Challenges sometimes come with opportunity, and ours is this: To remain financially strong, we must learn—without compromising care—to operate as efficiently as possible in every aspect of our hospitals and clinics. In the long run, that will make us even stronger."

David Entwistle

Awards

Old Mill Moran Eye Clinic Wins First Outpatient Satisfaction Award

For the staff at the Old Mill Moran Eye Clinic, it's the little things that count: sending a card for a patient's birthday or a significant life event, or lending an ear to a patient waiting to see the doctor.

Lead Technician Wendy Mitchell credits the staff's friendliness and attention to detail for receiving the Outpatient Satisfaction Award, the first granted by University Health Care's Outpatient Satisfaction Team. "It's the little extra things that let the patients know we care," she said.

Like the Pillar Award granted by University Hospital administration, the Outpatient Satisfaction Award is based on survey responses, and a new honoree is chosen quarterly. The Old Mill clinic will showcase a trophy for the next few months. The staff also received a certificate for finishing in the 95 percent quartile or higher nationally for two consecutive quarters.

John A. Moran Eye Center Executive Director Wayne Imbrescia believes the Old Mill clinic sets a good example for others to follow. "There are other departments that could learn a lot from the way you do things here at Old Mill," he said during the award presentation on March 11.

The Old Mill Moran Eye Clinic, located at 6360 S. 3000 East in Salt Lake City, is an outpatient clinic specializing in cornea and routine vision care. Patients also go to the Old Mill clinic for initial surgery consultations, and then are referred to the John A. Moran Eye Center for surgery.



Outpatient Patient Satisfaction Survey Results for the 4th Quarter 2007 Most Improved Award: Surgery Clinic. Positive Trend Award: Surgery Clinic, Transplant Clinic, Cardiovascular Clinic. Top Quartile Award: Infusion Clinic, Old Mill Moran Clinic, Surgery Clinic

Quality Improvement

Critical Tests and Critical Test Results

When Communicating Critical Test Results, Time is of the Essence

It seems like a simple task to receive a critical test result and then immediately communicate it to the licensed independent practitioner (LIP). But with the constant demands of a typical workday, it's easy enough to get distracted and forget to make the call. Unfortunately, there are many tragic stories that have resulted from people forgetting to close that critical communication loop.

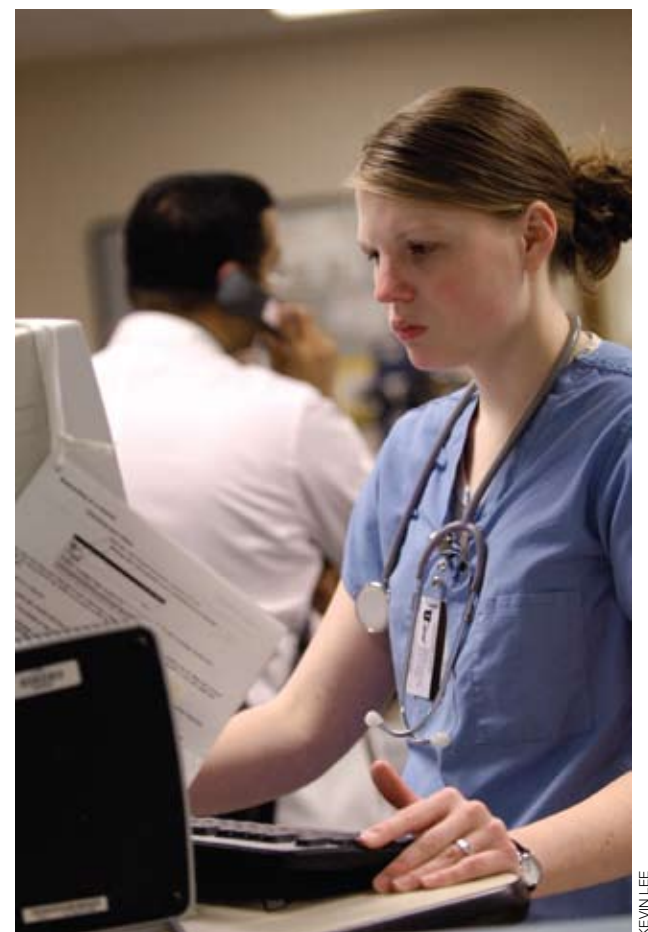
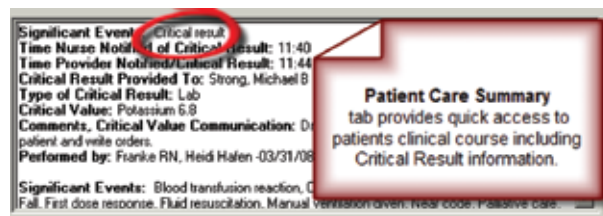
The Joint Commission has identified the problem as a serious threat to patient safety and established communication of abnormal results to a licensed care provider as a national patient safety goal. The reason is simple: to ensure prompt treatment of the condition, which could be life-saving.

The terms "critical tests" and "critical results" apply to all diagnostic tests including imaging studies, electrocardiograms, laboratory tests, and other diagnostic tests that University Health Care (UHC) has determined are critical. Critical results are findings, even if from a routine test, that require rapid communication to the LIP. Even if the results of a critical test are normal, they still need to be immediately communicated to the referring provider.

UHC clinical departments also have established acceptable time reporting limits. One measure is taken from the time a test is ordered to the time the licensed care provider receives the critical test result. As you can imagine, this can vary from test to test. Another measure considers the time lapse from when a nurse receives the critical test result to the time the result is received by the LIP. The target time for this step is 45 minutes or less. Again, the goal is to make the best treatment decisions based on this information.

For more information about critical tests and critical test results, or any patient safety standards, please contact Carol Hadlock at 587-3793 or carol.hadlock@hsc.utah.edu.

Critical results are now documented in Power Chart under "Summary of Clinical Course." Documentation provides written communication between shifts and a record of the timeliness of the critical event. It's also important to remember that any critical test result should be written down and read back to the person providing the information. This is a national patient safety goal.





STEVEN LEITCH

Amy Wilson, left, a graduating medical student who matched in a psychiatry residency at the University of Washington, announces the news to classmates as fellow senior Chris Sadler looks on. Wilson and her fellow classmates each placed a red dot on the map in the background to indicate the city and program where they'd matched.

School of Medicine It's a Match!

If the pressure of final exams and end-of-semester class work wasn't enough, graduating School of Medicine students also had to deal with the uncertainty of not knowing where they would live for the next several years.

On March 20, the Class of 2008 gathered, as did cohorts from medical schools across the country, for the annual Match Day. Having ranked their preferred residency programs, the soon-to-be-doctors were moments away from finding out where they will serve their residencies. At the assigned Academy Award-like moment, they eagerly tore open envelopes that revealed where they had "matched."

Eighty-seven graduating medical students matched to programs across the country in a wide range of specialties.

Wyatt Rivas (emergency medicine) and **Chris Sadler** (pediatrics), two graduating seniors who also are planning their wedding on top of it all, were happy to announce they matched together at Bay State in Springfield, Mass. **Becky Kroll** (family medicine), a single mother who raised three children before attending medical school, is heading to Salinas, Calif., and **Joshua Brinkerhoff** (family medicine) is going to Ball Memorial in Muncie, Ind. "It was our first choice, so my wife and I are very happy to have matched there," he said. Brinkerhoff, who hails from Bicknell, a small town in Wayne County, someday would like to practice family medicine in or near his hometown.

Class of 2008 Student Matches by Specialty:

- 14 each in family medicine and internal medicine
- 12 in anesthesiology
- 8 in emergency medicine
- 7 in ob/gyn
- 5 in general surgery
- 4 each in pediatrics and physical medicine and rehabilitation
- 3 each in orthopedic surgery, pathology, and psychiatry
- 2 each in pediatric internal medicine, neurology, ophthalmology, and radiology
- 1 each in plastic surgery and radiation oncology



STEVEN LEITCH

Gerald Gleich, M.D.

A Healthy U Surviving Allergy Season

Spring is in the air. So are airborne allergens from grass to weed to tree pollens. This means your allergy symptoms—itchy, watery eyes, and a stuffy nose—are here to stay for the next eight to nine months. In Utah, the allergy season begins in mid-March and lasts through the first frost in October or November.

Some of the most common seasonal allergens are grass, tree, and weed pollens. Other allergens such as pet dander, dust mite, and rodents can cause symptoms year-round. If you're among the 25 percent of the U.S. population affected by allergies, there are three things you can do to provide much-needed relief this season, according to **Gerald Gleich**, M.D., allergist and research professor of dermatology.

- **Take preventative measures.** This usually means avoiding the allergen, which is useful for pet dander, but difficult for seasonal allergies. Keeping windows closed, washing your face and hands after being outdoors, or even changing clothes to remove pollen can help.
- **Medications.** Antihistamines and decongestants, such as Claritin and Zyrtec, are very effective for relieving symptoms. If you prefer to use steroid or non-steroid medications, such as nasal sprays, begin taking them before the allergy season begins because they aid in blocking allergens from causing symptoms.
- **Allergy vaccines,** or allergy shots, are 80 percent effective and are also beneficial for allergy-related asthma.

Want to know what you're allergic to? Have an allergist perform a skin test, which Gleich says is a "quick, inexpensive, painless and accurate way to diagnose specific allergies." If you're interested in having a skin test done or have questions about treatment options, schedule an appointment with Gleich through Clinic 3 (581-6465) or the new Allergy Center at the Greenwood Health Center (213-9400).

mark it down

calendar of events

Seeds of Remembrance

Tuesday, May 13, 7 p.m.,
College of Nursing Auditorium

People who have lost a friend or family member will have an opportunity to commemorate the memory of their loved one at Caring Connections' annual Seeds of Remembrance program Tuesday, May 13. The program, which is free and open to the public, will feature speakers Gloria Horsley, Ph.D., and Heidi Horsley, Ph.D., co-hosts of the syndicated radio show "Healing the Grieving Heart."

For more information, call 585-9522.



Connecting Women to Health

Thursday, May 15, 5:30 p.m. to 8 p.m.,
Madsen Health Center

Statistics show women in Utah do not regularly participate in preventive health care, and the U's Center of Excellence in Women's Health wants to change that. On May 15, the Center is hosting the Women's Health Fair at the Madsen Health Center, 555 S. Foothill Blvd. Women of all ages are invited to this free event to gather information on 13 key health issues and learn simple steps for improving physical and mental health and preventing disease.

For more information, call 585-9971.



Patch Adams

Friday, May 16, 7 p.m.,
Kingsbury Hall

Laugh and you'll heal faster: it's a simple prescription that Patch Adams, M.D., has been dispensing for 30 years. Next month, the physician-clown, who was portrayed by Robin Williams in the popular movie *Patch Adams*, will be on stage in Salt Lake City presenting "Living a Life of Joy." Tickets are \$25 for general admission and \$10 for students, seniors, and children ages 5-12.

Adams's visit is sponsored by the Arts in Caring Council, a new nonprofit organization in Utah dedicated to supporting the role of the arts in the healing process and to integrating the arts into health-care environments across the state.

For ticket information call 581-7100 or visit www.kingsburyhall.org



Employee Benefits Your Spring To-Do List

☑ Choose Open Enrollment Benefits

Deadline: Wednesday, April 30

Open enrollment is the one time this year you can make changes to your existing benefits for the upcoming fiscal year (July 1, 2008 to June 30, 2009), so you don't want to miss it. HR has made it simple and fast to enroll and make changes at <https://gate.acs.utah.edu>, but you must make them by Wednesday, April 30.

- Change your health care plan option. (If you'd like to continue in same plan you don't need to do anything.)
- Enroll in a Flexible Spending Account Plan (FSA) to allocate pre-tax dollars to pay for eligible health care and/or dependent care expenses. You must make a new FSA election each plan year as elections *do not* roll over from one plan year to the next.
- Enroll in or cancel group legal plan.
- Enroll spouse or dependents in life insurance program without providing evidence of their good health.

If you have questions, call the Benefits Department at 581-7447 or visit www.hr.utah.edu/ben

☑ Nominate a Colleague for a 2008 District Staff Award

Deadline: Monday, May 5

Now's the time to take a moment and formally nominate your amazingly dedicated and inspiring colleague to receive a District Staff Award. Not only will they receive the recognition they well deserve, but they also could be chosen as one of the six Staff Excellence Award finalists, who will each receive \$5,000. Nomination forms for each District are available at www.hr.utah.edu/etc/psa/.

For more information contact Thuy Nguyen at nguyen.t@utah.edu.