April 23, 2009

PRIDEmatters

Read how Nursing "Super Users" are preparing the Medical Center for our giant step forward in automation, patient safety and collaboration: Computerized Provider Order Entry. To learn more, please visit the Medical Center intranet CPOE Home Page and view Custom Tip Sheets and Go Live Check Lists.

The central and frontline role of nurses in UCMC strategic initiatives was highlighted last week during preparations for the May rollout of Computerized Provider Order Entry (CPOE) – the Phoenix Project software that allows medication and procedure orders to be entered directly in a computer.

Several specially-trained nurses – called Super Users – were available around the clock in early April when CPOE was installed in select units. They worked on the frontline as the Medical Center deploys innovative technologies that support the consistent delivery of safe, effective, efficient and patient-centered care.

Their hands-on experience is helping fine tune the software so patient safety benefits, such as automatically screening for drug interactions and not having to interpret physician handwriting, are optimized when CPOE goes live throughout the Medical Center May 12. Entering all orders directly into a computer will also enable more effective collaboration among multidisciplinary care providers, as everyone on the care team will see all the information at the same time.

"It's been a very smooth transition," said Davina Pillai, NICU staff nurse and CPOE Super User. "We are helping make sure we know where to find all the information so the entire roll out proceeds smoothly."

sharingNEWS

The University of Chicago ranked first in U.S. News & World Report's special issue of Best Graduate Schools for ecology/evolutionary biology. The Pritzker School of Medicine ranks thirteenth in the nation for research-focused medical schools. The University also ranks in the top 20 for Biological Sciences.

Brown Bag Lunch Seminar: Financial Planning to Achieve Your Goals and Dreams. Learn valuable tax, retirement and other financial planning tips. The seminar will be held Tuesday, April 28 at 11:00 a.m. in Room L-131. To register, contact Tedi Cohen at 4-9191 or tedi.cohen@uchospitals.edu.
"We are dedicated to justice and equality" was the ceremonial blessing for the Chicago Family Health Center (CFHC), a new Urban Health Initiative--staffed bilingual health center site in Chicago's East Side community. It opens this summer.

On April 7, the Chicago Family Health Center (CFHC) held a board-breaking ceremony for a new bilingual center site in Chicago's East Side community, slated to open in August 2009.

CFHC chief executive officer Warren J. Brodine welcomed nearly 100 board members, community members, administration and clinic staff to the 6000 square foot space at 106th and Ewing streets that will house six medical exam rooms, three dental operatories and behavioral health suites.

"We are dedicated to justice and equality," said board member Reverend Mark Brummel, as he delivered his blessing of the site. The new space will help CFHC realize its mission to ensure that every patient, regardless of their race, religion, language, gender, age, income or their ability to pay receives high quality, comprehensive healthcare.

CFHC staff will include Urban Health Initiative doctors Umang Sharma and Kohar Jones, both assistant clinical professors with the University of Chicago's Department of Family Medicine.

Bernard Ewigman, MD, Chairman of the Department of Family Medicine, will assume that same position at NorthShore University Health System, overseeing departmental clinical, educational and research efforts at both the NorthShore and Hyde Park campuses.

bestPRESS

Eric Whitaker, MD, executive vice president for strategic affiliations and associate dean for community-based research, writes in the Chicago Tribune how "We can make the South Side a model for health-care reform."

By Eric Whitaker
April 23, 2009

I was born in a legendary Chicago hospital that has nearly disappeared.

Michael Reese Hospital was once a showcase of the South Side, a first-class research center that served as a beacon for people from many walks of life. Scientists there helped develop electrocardiography, found new links between cholesterol and heart disease, and did groundbreaking work on insulin. When my mother studied to be a nurse, Reese and Cook County Hospital were the only teaching hospitals in town that welcomed black trainees.

Once I dreamed of practicing medicine at Reese. Now the hospital is bankrupt and will close soon. The last time I drove past, all the lights were out.

Reese's fate gives a sense of the vast health-care challenges in underserved areas like
the South Side. Tight financial resources here can make it difficult to sustain advanced-care centers such as Reese and the University of Chicago Medical Center, where I work. Yet my home community desperately needs the best care available. We contend with widespread poverty and some of the nation's highest rates of chronic disease -- diabetes, hypertension, asthma.

We don't have to accept a future of declining community health and struggling hospitals. If we take the right steps now, the South Side could become a national model for how to build an innovative and sustainable health network. We'll need to put aside institutional turf and accept that no single medical center can meet all of our patients' needs.

The best strategy would combine the strengths of many South Side centers and treat them as one "virtual hospital," which patients can access in different locations depending on their medical needs.

Such an approach makes economic as well as medical sense. It would sustain the area's network of community hospitals and clinics, and connect low-income patients with the primary care they need to prevent serious complications of chronic conditions. My hospital has worked on this through the Urban Health Initiative, which strives to match patients with local clinics and physicians.

But we will not reach any of our goals without restoring trust within the community. Our patients don't always trust that if we refer them to a different institution, they will still get care of the highest quality. And hospitals often distrust each other, fearful that the patients they refer elsewhere will never come back.

The hospital where I work has not always been a good partner for this kind of collaboration. The U. of C. has been seen as detached from its medical neighbors and at times arrogant and overly competitive.

I think we can change those views and build a true partnership on the South Side. More faculty and residents from my hospital are fanning out to smaller centers where they are sharing knowledge and helping new groups of patients. Many of our patients who voluntarily transfer to those centers report greater satisfaction than they had at our hospital. That's humbling, and a sign that we can learn a lot from our neighbors.

Together we can learn more about our patients' unique health problems. The health disparities that exist between rich and poor are a huge problem for Chicago, yet we still don't know enough about why they persist. For example, why are diabetic adults on the South Side nearly three times more likely to be hospitalized than diabetes patients in the rest of the state? We suspect that diet, genetics and a lack of preventive care all play a role, but we don't know the specifics -- or how to correct the problem.

That's why a coalition of groups from around the city will soon embark on the South Side Health and Vitality Study, an ambitious effort to understand and begin remedying these glaring gaps in health outcomes. We want to create a resource that patients and researchers will draw on for decades, much as the Framingham Heart Study in Massachusetts has shaped ideas about cardiovascular disease.

No single hospital will solve the South Side's health disparities by working within its own four walls. And no center here can thrive without strong affiliations -- that's one lesson of Reese's demise. But if we learn to trust one another and work together, we can help our patients and prevent more hospital lights from flickering out.

Dr. Eric Whitaker is executive vice president for strategic affiliations and associate dean for community-based research at the University of Chicago Medical Center.
Mark Ratain, MD and Richard Schilsky, MD, are featured in a Chicago Tribune story covering how new drugs are changing cancer treatments and offering patients new hope.

**Chemotherapy advances targeting specific cells with fewer side effects**  
By Deborah L. Shelton  
Tribune reporter  
3:37 PM CDT, April 23, 2009

When Glen Farkas learned he had late-stage colorectal cancer in 2003, his chance of surviving five years was almost nil.

Trying to beat the odds, he chose to undergo radiation, surgery and painful five-hour-long infusions of a cocktail of chemotherapy drugs. The treatments held the cancer at bay for about a year, but the cancer returned with a vengeance, invading his liver, bone and lungs.

The second time around, a drug called Avastin was added to his chemotherapy regimen. Not widely available in 2003, Avastin required only 10 minutes to transfuse, was painless and didn’t cause side effects, Farkas said. As an added plus, he got his chemo in pill form, instead of intravenously.

The Los Angeles ophthalmologist has been cancer-free since December 2006. "In my opinion, [the addition of Avastin] turned my case around and saved my life," Farkas said.

Today's anti-cancer drugs are a far cry from medicine's first chemotherapy -- a form of mustard gas -- developed at the University of Chicago and two other universities and approved 60 years ago last month by the U.S. Food and Drug Administration.

Thanks in part to advances in genetic science, chemo is becoming more effective and far less grueling, and is transforming treatment for many cancer patients. The array of cancer-fighting medications is growing, and they are aided by new drugs that help treat nausea, minimize pain and boost levels of white cells to fight infection.

More than half of all people diagnosed with cancer are prescribed chemotherapy, a general term for drugs used to stop cancer cells from growing. Its advantage over surgery and radiation is that drugs can wage war on cancer cells wherever they are in the body.

Older chemotherapy drugs caused many difficult side effects because they couldn't distinguish between healthy and cancerous cells and attacked other fast-growing cells in the body, including hair and blood cells. The newer drugs are tailored to specific types of cancer and target particular types of cancer cells.

"These drugs are certainly less toxic and more effective than they used to be, in some cases, dramatically more effective," said Dr. Thomas J. Smith, professor of medicine and palliative care at Virginia Commonwealth University Massey Cancer Center. "A handful of cancers are controllable now that weren't controllable 5 or 10 years ago."

The drug added to Farkas' regimen, Avastin, is an example of this relatively new type of "targeted" cancer therapy. It includes monoclonal antibodies, laboratory-produced molecules that are engineered to attach to specific defects in cancer cells. The antibody makes the cancer cell more visible to the immune system, blocks chemicals that signal the cell to grow, delivers radiation to cancer cells and allows anti-cancer drugs to
penetrate into the cells.

Avastin is also an anti-angiogenesis drug, meaning it interferes with the vessels delivering blood to cancer cells. Without a plentiful blood supply, tumors can't grow.

Despite the advances, chemotherapy is still far from perfect, and the risk of debilitating side effects remains. Some people tolerate the drugs better than others, and some cancers respond better than others.

Suzanne Lindley, who lives in Texas, has experienced a range of side effects from chemo, from rashes to loss of feeling in her extremities.

"I think there's still a big communication gap between patients and physicians about how those side effects affect the person," said Lindley, diagnosed with advanced colon cancer that has since spread. "It's one thing to see the side effects on paper. We have to live with them. It's a matter of quality of life."

As the field advances and cancer treatment becomes more complex, experts say doctors and patients will have to communicate better about the best course of action. That's especially true for patients whose conditions are terminal and who do not want medical intervention that might do more harm than good to their quality of life.

Physicians are coming around to the idea that chemo should not be the default position, Smith said.

"It's very hard to sit across from someone and tell them that medical science does not have a way to make them live longer," Smith said. "It's a lot easier to just give another round of chemotherapy. But that has to change -- and it is."

Increasingly, however, genetic tests are making it possible to tailor care so patients with treatable cancer receive drugs that are most likely to help them while avoiding the side effects of drugs that won't.

"It used to be, we gave everybody the same dose of chemotherapy and watched what happened and then made adjustments as necessary," said Dr. Richard Schilsky, a U. of C. Medical Center oncologist who is president of the American Society of Clinical Oncology.

"We are now moving into an era where we can test people, for at least some of the chemotherapy drugs, to see if they will be able to tolerate the standard dose or not, so we can begin to make dose adjustments right from the start," he said.

For example, cancer specialists now agree that patients with advanced colon cancer should get a particular genetic test before taking two of the leading treatments. Oncologists adopted the change in February after studies found that two pricey drugs, Erbitux and Vectibix, were ineffective in 40 percent of patients.

One breakthrough in targeted cancer therapy was the development of the drug Gleevec, which works by turning off specific proteins in cancer cells that cause the cells to grow and multiply. It targets a cancer protein that causes a type of chronic myeloid leukemia, and another cancer protein, called Kit, that is the suspected cause of gastrointestinal stromal tumors.

"Gleevec is an example of a drug that hits a target and is well-tolerated," said Dr. Maurie Markman, vice president of clinical research at the University of Texas' MD Anderson Cancer Center. Over the next 10 to 20 years, he said, we will see many more examples
of drugs like that.

Smith said some drugs being tested in phase III clinical trials appear to work even better than the chemotherapies currently available. Also on the horizon are greater advances in tailoring chemo to the biology of an individual's tumor.

Schilsky said the new-generation drugs are moving patients further away from the image many people have of chemotherapy.

Years ago he regularly observed chemo patients hovering over a wash basin and vomiting during treatment. By contrast, he recently peeked in on a patient tethered to an IV who was undergoing chemo as he ate a sandwich.

John Bailey, 58, who was diagnosed with cancer nine years ago, has been taking Nexavar for three years to treat non-secretory neuroendocrine tumors in his liver. Cancer cells migrated there from his duodenum, part of the small intestine.

The tumors have shrunk somewhat, he said, and side effects of the drug, which he takes in pills, have been minimal.

"When people see me they can't believe I have cancer," Bailey said. "They say I look so healthy."

The main side effect for Bailey has been minor calluses on his fingertips and feet. That is a big change from the experiences of friends whose cancers were diagnosed years ago. Prescribed early-generation chemo drugs, they "seemed to wither away," he said.

"I feel fantastic," said Bailey, a regional international sales manager for UPS. "I haven't missed a day of work. I'm out the door by 5:30, 6 o'clock. I'm one of the first to arrive and many nights I turn out the light."

Dr. Mark Ratain, who oversees a clinical trial of Nexavar at the U. of C., where Bailey receives the drug, urged people to participate in research so they can gain access to promising new treatments.

"We're stuck fighting a war on cancer when we should think in terms of arriving at a truce," Ratain said. "That's what this drug allows: You don't bother me and I don't bother you."

Robert Schmidt, MD, professor of radiology, is featured in this WTTW Channel 11 discussion about metastatic breast cancer.

Donald Liu, MD, is featured in a Chicago Sun-Times article about a pediatric patient who was diagnosed and treated for an abnormal alignment of the bowels that can cut off blood flow to the intestines.

April 21, 2009
BY MONIFA THOMAS Health Reporter

When Dianna Green's 2-month-old son started vomiting "pretty much after every feeding," doctors at first told her not to worry.
But Green did.

"Every time I asked about it, the doctors said, 'Oh, babies spit up,' or 'Oh, babies have colic,' but you kind of know your own gut feeling," says Green, 22, of Carbondale.

She asked that her son, Jaylen O'Brien, be given an ultrasound. The test confirmed that Jaylen had an abnormal alignment of the bowels that can cut off blood flow to the intestines.

Green, too, had been born with the condition, called malrotation, though it wasn't diagnosed until she was 14.

Malrotation occurs in an estimated 1 in 500 live births -- about the same frequency as cerebral palsy. Most cases are diagnosed within the first year of life.

Yet treatment is often delayed because parents and pediatricians mistake the symptoms for those of other, less serious conditions, says Dr. Donald Liu, a pediatric surgeon at the University of Chicago Comer Children's Hospital.

"They think acid reflux or simple things, but it's just not that rare," Liu said. "The reality is, most cases we see in a children's hospital are flown in to the emergency room because they were ignored."

The condition can be deadly if blood flow to the intestines is cut off for too long. Undiagnosed cases that result in death or intestinal failure are one of the top reasons for pediatric malpractice suits, Liu says.

"For a relatively uncommon disease, it's surprising how often you see it in litigation," says Steven Goren, a medical malpractice attorney in Michigan.

While occasional vomiting is normal for young children, projectile vomit that is yellow or green is usually a tell-tale sign of malrotation, Liu says.

Bloody stool is also a late indicator that the bowels are twisted abnormally, and immediate medical care should be sought.

It's unclear what causes malrotation, which begins during the early stages of fetal development. Children with congenital heart or liver defects and those with Down syndrome are more likely to develop it. Sometimes, as with Jaylen and his mother, it runs in the family.

Surgery to untwist the bowels is the only treatment. While Green has a 6-inch scar from her operation nine years ago, Jaylen, now 5 months old, had a minimally invasive procedure at the University of Chicago that left only a few small puncture wounds.

"He won't even know he had surgery unless I tell him," Green says. "It's definitely a blessing that he won't have to go through the pain that I did."

Leah Durst, MD, medical director of the Friend Family Health Center, and Eric Whitaker, MD, executive vice president for strategic affiliations, are quoted in a Crain's Chicago Business article about plans for a South Side health care network.

Leaders of some of Chicago's largest hospitals and clinics are exploring plans to form a network to improve medical access for poor residents on the South Side.
The idea is to stitch together affiliation deals that would help funnel patients to the most appropriate — and least costly — places for treatment. Talks involve about 20 clinics and hospitals, including University of Chicago Medical Center, Rush University Medical Center, Cook County’s health system and three hospitals owned by Advocate Health Care.

Jump-starting the effort was a study completed last month and funded by the foundation of the late Gary Comer, the Land’s End founder and South Side native who donated more than $80 million for U of C’s children’s hospital. The study offers a prescription for fixing the most common problems on the South Side and near south suburbs: jammed emergency rooms and months-long waits for appointments to see scarce specialists like neurologists.

The effort comes amid growing local and national debate over how to divvy up responsibility for fixing a frayed health safety net. U of C, for example, has for years sought partnerships with nearby hospitals and clinics to send them routine cases so it can focus on complex care like cancer treatments. But critics — including some of its own doctors — have accused the Hyde Park hospital of sending poor patients away so it can focus on the well-insured.

Yet local health leaders involved in plans for the South Side say coordination among clinics and hospitals to route patients to the most appropriate provider would actually improve access.

"If you can manage these patients in the appropriate venues, it's better for everyone's bottom line," says Leah Durst, medical director at Friend Family Health Center in Hyde Park, who has been involved in the talks. The tendency of patients to seek routine treatment at emergency rooms rather than less costly clinics "is like buying a shirt at Nordstrom when you can get the same one at T. J. Maxx."

South Side hospital executives have discussed one-off partnerships for some time. The 64-page Comer report, by Chicago-based consultancy Health Management Associates Inc., has provided a starting point for formal talks to create a network that would cover 1.4 million people — 40% of whom are either uninsured or on public aid. Still, most are reserving judgment on its specific recommendations — an indication that it won't be easy getting longtime competitors to agree on the fine details.

"Any partnerships have to be mutually beneficial and sustainable," says Eric Whitaker, the U of C executive vice-president in charge of building ties to other medical providers. "We're all struggling with how to create a delivery system out of a non-system."

IMPROVING ACCESS

The report focuses on expanding access for pregnant women and children, who generally have Medicaid coverage, though backers view it as a blueprint for improving access for the uninsured, too.

One example: It urges U of C to join with Friend Family to open an urgent-care center near the hospital’s jam-packed emergency department. Patients showing up with non-emergencies — a big problem for U of C — could be redirected quickly to the clinic and its primary care doctors. Drs. Whitaker and Durst say the idea has been discussed, but there’s no concrete plan.

It also suggests U of C send pregnant women and children with less complex needs to the nearby county-run Provident Hospital, which needs the revenue and has the capacity to double its volume of those cases. Dr. Whitaker says that idea has been discussed but
hasn't gained traction because of leadership turnover at the county health system, which gets a new chief, Bill Foley, next month.

Another suggestion from the report: Rush and Mount Sinai Hospital could jointly serve as a hub for specialty care for kids and pregnant women on the Southwest Side, which the report says is plagued with "health care dead spots." The hospitals' CEOs have discussed the prospect of a joint specialty outpatient center and how they might share hard-to-find specialists like pediatric neurosurgeons.

"We're trying to flesh out what the roles and investments of the institutions could be," Rush CEO Larry Goodman says.

The study was commissioned by Stephanie Comer, the foundation's president and daughter of Mr. Comer. She says she is ready to donate money toward capital projects or other plans that may hatch from the effort.

"Some of these providers have never spoken to each other before," Ms. Comer says. "It's exciting to get them all in one room and have them at least acknowledge there's a problem."

"Path to Progress 5k," UCMC sponsored American Brain Tumor Association Annual walk is Saturday, April 25 at 8 am. Please come support our efforts to fund research to cure brain tumors.

UCMC will celebrate National Nurses Week from May 6 through May 12.

The Annual Spring Benefit for the University of Chicago Celiac Disease Center is Wednesday, May 6. Purchase Tickets.

The 63rd Annual Senior Scientific Session is Thursday, May 7. The session will be held in the Biological Sciences Learning Center from 1 - 6 p.m.

Sign-up to volunteer at the Day of Service and Reflection, on Saturday, May 16. Call 800-378-9675.

The 2009 American Cancer Society Walk and Roll is Sunday, May 17. The University of Chicago Team will walk, skate or bike on Chicago's Lakefront. Register here.

The Friends Against AIDS Inaugural Golf Classic is Monday, June 8. Join us for a beautiful day of golf to support the Comer Pediatric & Adolescent HIV/AIDS Program. To register, contact Michaela Brothers 2-3816.

Check out the University of Chicago Campus Calendar of Events.

Find this week's national health observances.