Welcoming Families at the Bedside

New ED Initiative Made all the Difference for Husband and Wife

Andy Dean was next to his wife in bed when she awakened at their Smugglers’ Notch vacation condo feeling faint and weak. She worried she was suffering seizures or possibly a stroke. Lauren Mistretta was just 38, healthy, and had hiked the ridgeline of Mount Mansfield the previous afternoon. Perplexed and afraid, Dean called 911, sent their two kids across the hall to be with their uncle, and boarded the ambulance for a fast ride to the UVM Medical Center.

Dean, of Brookline, Mass., hoped to stay by his wife’s side when they reached the emergency department (ED), but didn’t know what to expect. TV dramas typically show panicked loved ones being ushered to the waiting area while the patient is whisked away by a swarm of doctors and nurses to perform all manner of life-saving interventions. And until two years ago, that’s what might have happened.

But in the fall of 2017, the ED began a new patient-and-family-centered care initiative to welcome family members of adult patients at the bedside, in the same way that the parents or guardians of pediatric patients have always been welcomed, even during invasive procedures, trauma and resuscitation. A key component of the initiative is ensuring the presence of a family liaison, either a social worker or nurse, to support them.

Within moments of their arrival in the ED, Dean was met by Deb Robinson, RN, and social worker Emily Reed. They stayed with him, interpreting the medical proceedings while Dean watched Kalev Freeman, MD, and the rest of the team get to work assessing and treating his wife. Within 10 seconds, the team deduced she was not suffering seizures but was fainting from dangerous cardiac arrhythmia.

“Andy came in and I put my hand on his shoulder to try to reassure him. I asked him if he ever watched medical dramas showing the paddles used to shock the heart,” says Dr. Freeman, who is also an associate professor in the department of surgery at Larner College of Medicine. “I explained that this appeared to be a problem with the ‘wiring’ in her heart, and if so, we may need to administer a shock to help reboot her circulation.”

Mistretta’s heart continued beating erratically even after dozens of shocks. Each time, her blood pressure plummeted, cutting off blood supply to her vital organs, and she passed out over and over again. It was a dramatic case, even by ED standards.

Tests confirmed there was no blockage in Mistretta’s heart, so the cause of the problem had to be with its electrical system, which is responsible for making and conducting signals that continued on page 2
trigger the heart to beat. Robinson, the ED nurse, drew a picture of the heart on her hand as she explained the problem to Dean.

“What was amazing was that Deb and Emily were there for me, holding me while I was crying and explaining to me what was going on.” Dean recalls, adding: “I was very scared and sad but I think it would have been a lot harder if I weren’t in the room and seeing what was happening.”

Amanda Young, RN, a nurse educator in the ED who led the initiative, says that Dean echoes the feedback of other patients’ loved ones. “Having families at the bedside has been better for the department, staff morale and patient relationships than our original research prepared us for.”

Mistretta’s story has a happy resolution. From the emergency department, she was transferred to the cardiac catheterization lab where she was stabilized. She spent three days in the ICU and then was transported by helicopter for surgery closer to home at Massachusetts General Hospital. Her rare and previously undiagnosed congenital condition required a complicated surgery, and a pacemaker.

In August, she returned with her husband to the emergency department—this time for a planned visit—so she could meet and thank the team who saved her life and supported Dean through the worst day of his.

“The fact that he had that support was critical to him making it through this traumatic experience,” she says. “It really put him on solid ground to support me for the rest of this journey.”

Read the full story here

Our Margin, Our Mission
A Conversation with CFO Rick Vincent

Dr. Leffler recently sent an email to all employees outlining the financial challenges this organization—and our network—is facing. In that communication he referenced the fact that, for the first quarter of the 2020 Fiscal Year at UVM Medical Center, we missed our margin by $5 million. He also emphasized the importance of us taking the steps needed to meet our margin. So, what exactly is a margin, and why is it so important? We sat down with Rick Vincent, Senior Vice President, Chief Financial Officer, to ask a few questions.

Q: Can you describe in simple terms what a margin is?
A: If you look at your own personal finances, there are certain large one-time things you have to plan to spend money on in the future—maybe you know you’ll need a new car in five years; maybe you want to renovate your upstairs bathroom soon. For a non-profit organization, a margin is essentially the money you need to make after covering your routine expenses to be able to afford these future large one-time needs. In our case, our margin helps us pay for our future needs in our facilities, our technology, our equipment and our people.

Q: What are some things that UVM Medical Center has paid for with our margin?
A: The big buckets of what we spend our margin on are facility upgrades, such as our Miller Building, technology needs, such as the Epic implementation, and routine replacement and upgrades of equipment.

Q: What happens if we don’t meet our margin?
A: We are here to serve the needs of our community. That means we need to have the people, the equipment and the facilities to deliver the highest quality care. If we do not meet our margin, that starts to chip away at our ability to serve our patients and families. Or, to put it even more simply—no margin, no mission. It’s absolutely critical that we have the funds to invest in our future and our community.
Innovations with Heart  
Kathy Getty, RN, Enjoys Front Row Seat to Cardiology Advances

The first time Kathy Getty showed up at the Medical Center Hospital of Vermont she was, well, a newborn. She debuted in what was then called the Mary Fletcher Hospital in 1954.

14 years later, she was back here as a candy striper. What she saw inspired her: “I saw the nurses dealing with these children and families who were so frightened. And knowing that the little bit that I was doing was making a difference, I thought: I want to be a nurse.”

Five years later, she was back here with her nursing degree. Her first job was in cardiology—and 45 years later, she’s still there.

As a cardiac catheterization lab specialist, Kathy is responsible for helping cardiac patients understand what they need to do to prepare for and recover from a cardiac catheterization, and provides support for those who are coming in to have a pacemaker or defibrillator implanted. She also makes sure that information from patients who have suffered what’s called an ST elevation myocardial infarction (STEMI)—a very serious type of heart attack—goes into a national registry of STEMI patients.

Kathy says she loves the fact that there are always new procedures and new technologies to learn in her work. One transformative example has been trans-aortic valve replacement (TAVR), for which she’s had a front row seat. TAVR is a relatively new procedures that makes it possible to replace the aortic valve without open heart surgery. “Just watching that program progress—over 1000 patients later—has been really exciting,” she says.

Kathy’s work to supporting patients and their families is a source of pride and satisfaction in her work. “I love helping them through this feeling of ‘oh my goodness, it’s my heart and I will be okay.’”

But most of all, she appreciates the impact that she and the team have. With our STEMI program, patients who have suffered heart attacks go right in for their cardiac catheterization, saving heart muscle in the process. She helps people through those first harrowing hours. “We open that artery and the minute it opens, most patients are pain-free. You look at their faces and they are just so thankful. It gives me a thrill every time to see the transformation from when the artery is totally blocked—and the next minute it’s wide open.”

Kathy also really values the collaborative spirit of her team. “Everyone is so talented. We all listen to each other—and we all really, really care about our patients.”

Today, Kathy enjoys bringing her perspective, her work ethic and her appreciation for the value of what we do to her team and her patients. “It’s been a wonderful journey—and I feel very blessed that I could be a part of it for all these years.”

Calling All Car Lovers: Employee Discount at Kleentech

Kleentech would like to offer all UVM Medical Center employees a 15% discount on the following services:

- Gold/Platinum Level Detailing
- Rustproofing
- Window Tint

Please bring your employee ID. To learn more: kleentechvt.com or call (802) 598-0038.
Make All the Difference  
**UVM Medical Center volunteers change lives in Rwanda**

“It’s people like Frankie that make all the difference.”

Dr. Leavitt has spent more than 30 years at UVM Medical Center. He’s also a professor at Larner College of Medicine, where he is chief of the Division of Cardiothoracic Surgery.

**HELPING A VULNERABLE POPULATION**

Dr. Leavitt’s involvement with Team Heart started when he met Morton “Chip” Bolman, MD, who along with his wife, Ceeya Patton-Bolman, founded Team Heart in 2006 while working in Boston. Dr. Bolman—who also was a professor at Larner College of Medicine—created Team Heart so that volunteers could offer open-heart surgery to the vulnerable people of Rwanda.

Dr. Leavitt lays out that vulnerability in stark terms: “Rwanda has 12 million people and four cardiologists and no standing heart surgery program,” he says. Making matters worse, Africa has a high prevalence of rheumatic heart disease, which stems from untreated streptococcal infections and damages heart valves.

Rheumatic heart disease is relatively rare in the U.S., because it’s common practice here to treat strep throat with penicillin. But Rwanda lacks the medical infrastructure for reliable, widespread primary care, says Dr. Leavitt. And in those cases, tragically, strep throat can lead to a life-threatening heart condition.

Every year, volunteers with Team Heart travel to Rwanda to perform heart surgeries that save lives. In 2020, those surgeries will be spread over four trips, but in past years, Team Heart has done 16 operations in one eight-day span.

Those procedures happened in a hospital with four operating rooms and unreliable infrastructure. “The air conditioner worked only about half the time,” says Dr. Leavitt. “The power would go out once in a while. Toilets didn’t work in the hospital all the time. And they had virtually no supplies for heart surgery. So we had to bring everything, including chest tubes.”

Dr. Leavitt praises UVM Medical Center’s consistent willingness to donate drugs and supplies for Team Heart trips. Sometimes, those donations have come in a pinch: Last year, Dr. Leavitt learned shortly before departure for Rwanda that there were no operating room packs containing vital equipment for surgeons. “Our hospital donated 16 packs. So last year, I went to Africa with 29 trunks of material. This hospital has been incredibly supportive of Team Heart.”

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**Last year, Frankie was a 14-year-old Rwandan with a million-dollar smile and a death sentence.**

Suffering from rheumatic heart disease, the teen crossed paths with volunteers from the medical nonprofit Team Heart, including Cardiothoracic surgeon Bruce Leavitt, MD—and his life changed.

Dr. Leavitt put two donated heart valves into Frankie’s chest, and today the boy sends text messages about football and school. Dr. Leavitt says Frankie is a perfect example of why he and other UVM Medical Center staff return to Rwanda every year.
A TEAM EFFORT

Just as important has been the support of UVM Medical Center staff. Those who have made the Team Heart trip include Drs. Patrick Bender and Marc Tischler; Drs. Mayo Fujii and Alexander Riveron, both surgical residents; nurses Rebecca Austen, Grace Lynch, Mark Sgantas, Carroll Maxwell, Missy Stabach and Vanessa Lake; perfusionist Jennifer Wheel; pharmacist Michele Corriveau; Tom Buley, biomedical engineering specialist; and Jean Roberts, biomedical equipment technician.

Dr. Leavitt’s wife, Anne Leavitt, a librarian by trade, also has gone on several of the trips to participate in a reading program for grade school children called “Kigali Reads” and to support Team Heart.

Given the sometimes-unpredictable operating conditions in Rwanda, Dr. Leavitt said having a familiar team makes a big difference. “You just have this level of comfort when everybody around you knows each other from UVM. It just takes away one of the unknowns.”

Team Heart plans to double the number of surgeries performed in Rwanda this year. There also are plans to increase educational efforts, as the goal is for the country to have a freestanding heart surgery program.

MAKING PERSONAL CONNECTIONS

There may come a time when Team Heart won’t have to make frequent trips to Rwanda. Until then, volunteers are sustained by stories of the patients they’ve helped.

For Dr. Leavitt, who’s performed about 50 surgeries in Rwanda, there are many such stories. A recent example is a 25-year-old woman who was so weakened by heart disease that she couldn’t walk up a hill to get to her job in a grocery store. The woman underwent heart surgery but suffered complications and had a stroke after the operation.

“I go back a year later, and there she is sitting there, shook my hand, total recovery,” Dr. Leavitt said. “She walks up the hill to go to work every day. I went back last year, and there was a baby on her back. That tells it all.”

And, of course, there’s Frankie. Dr. Leavitt proudly displays photos of himself and the smiling teen. “Somehow,” he says, “when you’re over there in Africa saving a 14-year-old’s life, with all the help from the people here, it just really clicks—what you’re doing, and how you and your UVM colleagues can make a difference in people’s lives.”

How to Prevent Heart Disease at Any Age

Preventing heart disease means making smart choices now that will pay off for the rest of your life.

Lack of exercise, poor diet and smoking habits take a toll on your body over the years. Anyone, no matter your age, can take simple steps to keep their heart healthy during each decade of life. It all starts with one small thing.

FOR ALL AGE GROUPS—EAT HEART HEALTHY

Choose a healthy eating plan. The foods you eat may decrease your risk of heart disease and stroke. High blood pressure and high cholesterol are two key risk factors for heart disease.

Choose foods low in saturated fat, trans-fat, and sodium.


Limit eating red meat. In general, red meats such as beef, pork, and lamb, have more saturated fat than chicken or fish. The American Heart Association recommends that people limit lean meat, skinless chicken and non-fried fish to 5 ½ ounces per day, total.

LEARN MORE ABOUT HEART DISEASE

How can you reduce your risks of developing heart disease? Hear from our experts.
2019 Novel Coronavirus—What You Need to Know  
A Conversation with Cindy Noyes, MD

Q: First things first: can you talk about our general preparedness for the 2019 Novel Coronavirus?

A: We follow CDC guidance very carefully, and we have enacted their recommendations for travel and sick contact screening at our points of contact—particularly in our highest risk contact points, including urgent care, ED, and urgent care ambulatory care sites. We are also making sure that we are not only are able to identify sick patients early, but that we have the proper type of isolation rooms and adequate personal protective equipment (PPE) supplies.

Q: What about our PPE supplies?

A: We have PPE for the many different types of procedures and infectious organisms that we encounter every day, including the 2019 Novel Coronavirus. Because of the increased demand for these supplies, and because they are almost exclusively made in China, there is concern that, worldwide, supplies will be impacted in the near future. Manufacturers are carefully monitoring, purchasing and ordering, and at this point, we feel comfortable that we have the supplies we need. The CDC and FDA are also helping to assess supplies nationally.

Q: What about our preparedness as far as training for staff goes?

A: We’re sending refresher information on the use of PPE for our clinical staff. Particularly for our people in the ER, ambulatory care and urgent care, we want to be sure that people feel comfortable with the donning and doffing of PPE. We’re also making sure people are refreshing their FIT testing.

Q: If someone calls into their doctor at Milton Family Practice and says, “I was just recently in China. I have a headache and a fever and a cough,” what should happen?

A: The two-part screening, focusing on the person’s travel history and symptoms is really important here. Ideally a nurse in triage phones the person back: what exactly are their symptoms, where were they, what were they doing, and did they have exposure to sick contacts? When was their last date in that country? And if there is risk suggested by their answers, we would suggest that the clinician get in touch with Infectious Disease. We also work really closely with the Vermont Department of Health to then do a little bit more investigation to determine if this person warrants diagnostic testing.

If people can stay home we’re advising them to do so, so that we can prepare if we need to evaluate them. The advice from the Department of Health has been if you do start to develop symptoms, we want you to stay where you are and call us, as well as your primary care physician, before going anywhere to get care.

If someone’s ill and they need emergency care, the CDC has drafted recommendations for EMS services and those have been disseminated with all of the health advisory notifications from the Department of Health. I know our ER, Urgent Care and Ambulatory sites are carefully screening people.

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Q: Is there anything else you want to emphasize in terms of preparedness?
A: First, this is an epidemic in process. Every day, every week, there is evolving information. That said, we have a system in place that we can flex as needed. Every week, we get all of the stakeholders around the table and check in on status, discuss CDC updates, review questions and really try and understand how people are doing. This group includes people from industrial hygiene, infection prevention, leadership, infectious disease, nursing, supply chain and more. Everyone’s sitting at the table, so that we can make changes as needed.

Q: What advice would you give for people who provide direct patient care?
A: First, make sure you understand the PPE you need—N95 respirator, gown and gloves, face shield—and that you are comfortable with donning and doffing. And of course, practice vigilant hand hygiene. This is really important: if you are sick, stay home.

Q: And for all of us?
A: We don’t have coronavirus in our community, and while we are prepared for the possibility that it will arrive here, we need to remember that influenza and other respiratory viruses are the bigger threat, both nationally and locally. On average, 30,000 Americans die from flu every year.

Find updates and information about staff resources here.

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Delivering “Meds to Beds”

A key collaborative effort involving our pharmacy, nursing and case management is addressing barriers like drug cost and patient education, while improving our patients’ experience.

The Bedside Medication Delivery Program, or “Meds to Beds,” as it is informally called, is being piloted in our Miller building. How it works is pretty simple: before a patient is discharged, a pharmacist or pharmacy tech visits the patient’s bedside to give them their medication, discuss side effects and answer any questions.

The project debuted on Miller 5 in October of 2019, and has since been introduced in Miller 3, 4 and 6. So far 2000 prescriptions and 540 deliveries have been handled through the program. Plans for now are to continue to expand the approach through FY 20 throughout the hospital.

The program offers great benefits for our patients:
- More efficient discharge home through bedside delivery
- Direct access to pharmacists for counseling
- Increased patient safety, especially for patients with complicated medication management
- Streamlined approach to removing barriers to patients getting the medications they need, such as prior authorizations and access to UVM Medical Center’s drug cost assistance program

The goal of the program is to lower the barriers to obtaining medication and to improve patient outcomes. “Ultimately,” says Doug Franzoni, supervisor, Outpatient Pharmacy, “we hope this program will lead to lower readmission and complication rates for our patients.”

For staff, the program has been a big positive. Says Sarah Gilroy, RN, Miller 3, “It is really helpful to have the medication at bedside to go over with discharge instructions. That way if a medication has complicated dosage the patient is visually able to see it. The pharmacist goes over the medications as well, so the patient receives additional education.”

“For our patients and our staff, this has been a win-win,” says Franzoni, “it alleviates a lot of the patient’s stress when they can get context about what drugs they’re going home with, and in the end, it’s better for their overall health to understand what they are taking.”

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“Meds to Beds has revolutionized how we do care on Miller 5”

—JEN HAUPTMAN
CASE MANAGER
Providing Culturally Humble Care

Marissa Coleman, PsyD, Shares Perspective on Providing Care for the Black Community

Wherever we work in health care, it’s our responsibility to meet each person who comes to us with a perspective that is unclouded by internal bias or prejudice.

In recognition of Black History Month, we checked in with Marissa Coleman, PsyD, who is a Staff Psychologist within the Department of Psychological Services. Her role includes providing clinical care, as well as training focused on Equity, Diversity, and Inclusion.

Q: You mention history playing a role in how African Americans are treated in the health care environment. Can you elaborate?

A: Absolutely. Historical oppression and medical trauma are woven into our country’s history. The effects of these experiences continue to impact how Black communities interact with the medical field.

Q: Such as?

A: The Tuskegee Study of Untreated Syphilis is an infamous example. It was an unethical clinical study conducted between 1932 and 1972 by the U.S. Public Health Service to observe the natural history of untreated syphilis in African American men. After being recruited by the promise of free medical care, 600 men originally were enrolled in the project. The participants were primarily sharecroppers, and many had never before visited a doctor. Of the men enrolled in the study, 399 had latent syphilis and 201 didn’t have the disease. The men were told that the study was going to last six months, but it lasted 40 years, and even after the funding ran out, it was continued without informing the men that they wouldn’t be treated. None of them were told they had syphilis and none were treated with penicillin, even after it was proven that the antibiotic could cure them. As a result of the Tuskegee experiment, many African Americans developed a lingering, deep mistrust of public health officials and medical providers.

Another example is Henrietta Lacks, an African American woman whose cancer cells were cultured to become the first immortalized human cell line for medical research in 1951—without her and her family’s consent.

“When there is systemic harm done to a community there will be a deep sense of mistrust and posttraumatic effects.”

Notably, these experiences were not that long ago and the mistrust from the Black community is often passed down through generations.

Q: Can you be a little more specific about how that is?

A: Well, quite understandably, when there is systemic harm done to a community there will be a deep sense of mistrust and posttraumatic effects. I see this surface in my work related to how therapy is underutilized by the Black community. Research also demonstrates that medical care is also underutilized by Black individuals. This is not because of noncompliance or disinterest in our own well-being and health. I believe it is a direct result of historical trauma and a lack of acknowledgement and healing between the Black community and the medical field.

Q: How can we as health care professionals address this?

A: We have an amazing opportunity to right this ship and facilitate healing—both physically and psychologically. I believe that the work starts with ourselves. Once we educate ourselves about the effects of historical trauma and raise our consciousness about our own implicit
biases, then we can provide culturally humble care to our patients. This would impact how we perform intake assessments, view differential diagnosis, recommend treatment options, and ultimately build rapport.

Q: Can you give an example?
A: Yes, the language we use and the questions we ask hold a lot of power. As providers, we set the tone for how clinical interactions unfold. For example, asking a patient, “What barriers are you experiencing with keeping our appointments or taking your medication as prescribed?” opens up the door for honest and non-judgmental communication. I try and make a point to ask each of my patients what information they believe is important for me to know about them versus taking the position of an “all knowing” provider. The latter just perpetuates the power hierarchy that has caused harm to many communities. Lastly, taking a thorough trauma history and discussing a patient’s past experiences with medical and psychological providers profoundly contextualizes a patient’s presenting problem.

Q: Have you noticed other providers being open to this dialogue?
A: Yes! That is one of the most encouraging things I have experienced working at this hospital as a Black woman. I do believe we have a lot of work and challenging conversations ahead of us but the desire and energy behind Equity work at UVM Medical Center is growing. I see it with my interactions with other providers. I am a member of the Equity, Diversity, and Inclusion Steering Committee and when Dr. Steve Leffler joined us for a meeting it was hopeful to hear him discuss the impact of implicit bias and his investment to diversify our workforce. I feel so fortunate to be in a department, under Dr. Marlene Maron’s leadership, that values culturally humble care and is invested in our multicultural learning and growth. Thank you for providing a platform to continue these crucial conversations!

**COMPLIANCE & PRIVACY DEPARTMENT INFORMATION**

The UVM Medical Center has established a confidential disclosure mechanism through its Compliance and Privacy Hot Line, a toll-free telephone line, to enable employees, residents, staff and patients to report instances of noncompliance and/or make inquiries on compliance issues. The Compliance Hot Line can be reached at: (800) 466-7131 or (802) 847-9430, or via email at ComplianceOfficer@uvmhealth.org.

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**Preventing Respiratory Viruses**

Flu has hit our region, and we all can play a part in preventing the spread of illness:

- Cover your mouth and nose when coughing and sneezing—sneeze into your elbow or use a tissue.
- Discard tissue and perform hand hygiene.
- Keep your hands away from your face (eyes, nose and mouth).
- Perform hand hygiene (soap and water or alcohol-based hand rub) frequently – before and after patient care.
- Clean and disinfect frequently touched surfaces.
- If you have a cough, wear a mask.
- If you haven’t been vaccinated against the flu, get vaccinated.
- For visitors who have a fever or cough, consider not visiting.
- For visitors who are actively coughing, provide them a mask.
- Educate visitors to perform hand hygiene.

Questions? Contact Infection Prevention, (802) 847-6468.
We’ve Got Your Back  
Safe Mobility Program Update

Starting in January, UVM Medical Center initiated an organization-wide effort to train nurses and other direct patient care providers on the use of equipment to move our patients safely. The program, which is rolling out in phases, includes teams from across the organization in Respiratory, Support Services, Nursing, Radiology and the Cath Lab.

This work reflects an organization-wide effort to reduce staff injury and improve our patients’ mobility. Prolonged stays in the intensive care unit and mechanical ventilation are associated with functional decline and increased mortality and length of stay. Studies show that an early mobility program can improve outcomes. Further, according to OSHA, health care workers providing direct patient care are seven times more likely to sustain a musculoskeletal injuries on the job compared to all other industries.

“Aimee Wilson, RN, who has been helping to coordinate the training, says that attendance has been robust—in fact, virtually every class has been full, and there’s been a positive response to the

Some of the new equipment includes the Combilizer, which can set ICU patients in a sitting or even standing position. Says Wilson, “This is one of several pieces of equipment that encourages early mobility.” Also part of the training is the new Patient Mobility Assessment Tool, (PMat), which is meant to give a common language for patient mobility and helps nurses assess their patients earlier on, even before PT and OT arrive.

“This new equipment reduces staff injury and improves patient care,” says Aimee. “It’s definitely a win-win.”

Safe Mobility Training By the Numbers

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<tr>
<td>270 outpatient</td>
<td>112 outpatient</td>
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*approximately

“The Safe Mobility Program will provide the training we need to reduce injuries and help patients when they can’t move themselves.”

PEG GAGNE
Big Change Roundup Supports Child Life

Going to the hospital for any reason can be very intimidating for everybody, young and old.
Child Life Specialists work in myriad of ways to provide support, information and normalcy to help reduce the understandable anxiety a hospital can bring for children and their families. Child Life is one of the many departments within our organization that is supported by the Big Change Roundup. Here, two members of our Child Life team talk about why they went into this field and why they believe it’s important.

SIERRA SCHELLER
“After college I was very interested in working with children and education—but initially I was a financial recruiter. It took me working in several different positions, that weren’t the right fit, to push me in the right direction and find the career path that would make me happy. Child Life happened to be a good combination of my interests and felt like the right career path. From there, I earned my master’s degree in Child Life from Wheelock College and have worked in Emergency Medicine and Pre-Op throughout my career.

The best part of my job, in the Pre-Op and OR, is seeing the difference that education and communication can make on the overwhelming journey patients and families have to travel. Knowledge and the inclusivity of families can dramatically help minimize anxiety during the hospital experience. It’s amazing to witness.

Our work benefits the parents beyond just what we do for their child. It’s very helpful when we collaborate with caregivers and identify a role they can play on the day of surgery. In so many ways, you feel like you don’t have control in the health care setting—we work hard to give families the information they need to feel in control.

We also provide both formal and informal staff education through inservices and/or daily interactions with residents, medical and nursing students. If we can provide current and future medical staff with some successful strategies that can be placed in their toolboxes and incorporated into their own practice, we’ve made a lasting difference in the lives of many children.”

JENNIFER EDDY
“I was an early childhood education and human development major at UVM. After graduation, I taught elementary school, worked for the VNA and volunteered with the Child Life department. I loved teaching, but also loved caring for community members with health needs. While volunteering, I witnessed the blend of my two passions and fell in love with the Child Life career.

I began my journey in the Children's Specialty Center, but now I'm full time in The Comfort Zone, a pediatric sedation area. For me, the best part of my job is creating individualized plans with patients, families and the rest of the health care team. Every patient, every family is unique, and there’s a lot of creativity in the collaboration with them to make the experience easier. For example, if a child comes in for an endoscopy, I help the child and family assimilate to the staff and environment, discuss the flow of the day, provide developmentally appropriate education and preparation, allow an opportunity for questions and help alleviate misconceptions. I might use a doll or super hero to demonstrate what the IV process will be like. I can’t tell you how many times caregivers will be listening just as closely as the children, gaining knowledge and in turn having anxiety diminished.

Also rewarding—and challenging—is the diversity of our work. On any given day, we may be working with a family and their active two-year-old, reinforcing the importance of play, or helping an anxious teenager develop coping skills to use throughout the hospital experience and beyond. Again, this is where being creative and thoughtful really come in handy.

While Sierra and I have different roles in Child Life, I think we’d both agree that there are tremendous emotional rewards in helping children and their caregivers better cope with their hospital experience.”
An Ambassador at our Front Doors  Garret Sullivan Provides Special Service for Patients and Families

You can see it on their faces when they walk through our doors: fear, joy, uncertainty... let’s face it: hospitals can be scary places. Sitting at our front desk on the Main Campus, Patient and Family Ambassador Garret Sullivan makes it his business to understand how our patients and visitors are feeling—and provide the support and guidance they need.

It wasn’t at all clear that the high school student interested in history would end up working in health care, but Garret’s trajectory somehow makes sense. At UMass Amherst he became interested in Chinese language and literature, which ultimately led to a scholarship in Taiwan, and in turn serendipitously led him to his future wife. Eventually he came to Vermont, where his mother and sister were living, and before he knew it he was a freight train conductor based in St. Albans.

Turns out train travel was not Garret’s life calling, so he took a job in Facilities at Saint Michael’s College, and spent 11 years there working in special events before taking a job at UVM Medical Center as a materiel handler and truck driver. His precious cargo included dialysis materials, and he found great satisfaction in knowing the good he was doing making sure our units and patients were getting what they needed.

And that’s what led him to UVM Medical Center: the desire to do good. As a Patient and Family Ambassador, he is there to help them with wayfinding, to answer questions, and in the process to address the smaller things that can affect our patients’ experience. “You see people come in and you read how they look. You don’t want to overwhelm them, but they’re dealing with a lot of anxiety and stress. I’m there to show a friendly face and help them navigate the system.”

Sometimes that means walking a patient or family member part of the way to their destination. Sometimes it means remaining calm when a family member is frustrated. He can remember a few times when, on their way out, they’ve thanked him for his patience with their frustrations.

Of course there are plenty of challenges to this work. You have to be a sort of detective, he says, when people think they’re going somewhere—but actually they need guidance to a different location. “People will say they have an appointment in Neurology in the East Pavilion, but if it’s a diagnostic test it might be somewhere else,” he says.

When they walk through our doors, what our patients and visitors need is a kind and patient human being to help them understand where they need to go, so at least they don’t have to worry about ending up in the wrong place.

At the end of each day, even the difficult ones, Garret feels like he’s made a difference. “Helping people is what we all do, in so many different ways. I’m proud to be here, making people’s journeys a little easier.”

Learning to Let Go With Cancer

We can all learn from this personal experience with cancer.
Rebecca Bella, MD, Receives Good Catch Award

Rebecca Bell, MD, received a Good Catch Award for noting a discrepancy in the weight recorded for a patient. She saw that the patient’s weight was flagged in the vital sign section on the chart—the record weight was 9.9 kg, per the patient’s mother. Dr. Bell asked ED staff to weigh the patient; the patient actually weighed 5.4 kg.

Lauren Myer, RN, Receives Good Catch Award

Lauren Myer, RN, received the Good Catch award for identifying that our PYXIS machines didn’t have the “witness on waste” check box activated. She notified Pharmacy, and the correction to PYXIS has been made.

Cara Ladouceur, RN, Receives Good Catch Award

Cara noticed that an IV medication solution used during open heart surgery had been inadvertently delivered to Miller 4. Having this solution on a general unit posed a potential danger, so the medication was returned to the pharmacy, and Cara filed a SAFE report. As a result, new processes are now in place to minimize the risk of this occurring again.
Judy Schwenn, Receives Leadership Award
Judy Schwenn was recently honored with the UVM Medical Center Leadership Award in recognition of her support of the laboratory team. “Throughout all of the challenges given to her,” wrote the person who nominated Judy, “she resiliently led her team with grace, dignity, poise and humility.” Congratulations, Judy!

Please join us as we present Amy Stegner, Pharmacist with the Good Catch Award.
While trying to fill a stat request for calcium gluconate gel for a patient with an acid burn, Pharmacist Amy Stegner encountered a variety of systems issues. There was no efficient way to order the medication in Epic. The recipe was not readily available in the Pharmacy, and when the recipe was found, the Pharmacy did not have all of the necessary ingredients to prepare calcium gluconate gel. Despite these challenges, Amy was able to prepare the medication and it was delivered to the ED. Amy then completed a SAFE report, which resulted in the addition of a manufacturer prepared product to our inventory and an Epic enhancement that allows calcium gluconate gel to be easily ordered through Epic. Good Catch Amy!

Better Together Award Recognizes Courier Assistance with Medication Delivery
A multidisciplinary team was recently recognized with the Better Together Award for their efforts to address a patient safety concern for patients transitioning from our ED to a short-term stabilization and detoxification program in Burlington. A solution was proposed to have our courier service deliver the patients’ needed medications separately. A pilot confirmed that this approach was an improvement in patient safety, patient experience and patient flow. Congratulations to the team who helped bring this project to fruition.
Why Cybersecurity Matters

Networks are like petri dishes—all it takes is one small bit of malicious code to infect the whole thing. To keep our patients’ information private, we all need to be careful when we check our emails or surf the web.

Cybersecurity Best Practices

- Never share patient data online.
- Where possible, avoid exchanging patient information via email.
- Send only the absolute minimum amount of patient information via email, if necessary; remove the patient information from your mailbox immediately after sending.
- Treat all unknown and unexpected email senders as suspicious until proven otherwise.
- Avoid downloading attachments from or clicking on links within email messages from unknown or unexpected senders.
- Remember that phishing emails, or emails that attempt to obtain user data, can be very sophisticated and may appear legitimate.
- Verify identities before responding to requests for information—even from known senders.
- Use strong, unique passwords for each account and never share them with family, friends, or coworkers.
- Report suspicious emails to the Cybersecurity Team via the Report Message button in Outlook (or email to abuse@UVMHealth.org).

Cybersecurity & Privacy

We ask that you join us in securing and protecting sensitive and confidential data. If you think or know a policy has been violated, call the Compliance and Privacy Department at 7-9430 or email Compliance@UVMHealth.org or email Cybersecurity via Cybersecurity@UVMHealth.org.

Toni’s Story: My Son’s Leukemia

Our son was diagnosed with leukemia two days before his fourth birthday. In an instant, our world revolved around learning about his disease, treatments, medicine and test results.

The doctors and nurses at UVM Children’s Hospital were generous with their patience and knowledge as we asked the same questions over and over, trying to comprehend so much information through our emotional strain and while caring for our son, his sister and each other. The medical team respected our emotional state and worked with us closely to understand our child’s treatment and prognosis. They took the time to get to know our family.

We were fortunate that the treatment protocol for acute lymphoblastic leukemia is well-established, and that our son responded well to treatment. Families before ours had permitted their children to be studied and followed so that, later, children like us had shared personal experiences with the Patient and Family Experience team that helped our child with coping and thriving under treatment. I choose to give back as a Patient and Family Advisor because I know pieces of our experience will help the families who come after us.

Toni Josey volunteers as a Patient and Family Advisor at UVM Children’s Hospital.