Study finds direct link between sugar and diabetes

Does eating too much sugar cause diabetes? For years, scientists have said, “Not exactly.” Eating too much of any food, including sugar, can cause you to gain weight; it’s the resulting obesity that predisposes people to diabetes, according to the prevailing theory.

But now the results of a large epidemiological study suggest that sugar may also have a direct link to diabetes. Researchers examined data on sugar availability and diabetes rates from 175 countries over the past decade. They found that increased sugar in a population’s food supply was linked to higher diabetes rates, independent of obesity rates.

“It was quite a surprise,” said Sanjay Basu, MD, PhD, an assistant professor of medicine at the Stanford Prevention Research Center. “We’re not diminishing the importance of obesity, but these data suggest that there are additional factors that contribute to diabetes risk besides obesity and total calorie intake, and that sugar appears to play a prominent role.”

The findings do not prove that sugar causes diabetes, Basu emphasized. But more sugar was correlated with more diabetes, and diabetes rates dropped over time when sugar availability dropped.

Emergency department streamlines patient services

There was no obvious reason why patients flooded Stanford’s emergency department on Jan. 25. No major traffic collisions had occurred; the flu wasn’t on the rampage, as it was on the East Coast.

But over the course of that day, ED physicians and staff treated 206 people—a 40 percent increase over last year’s average daily number of patients and an all-time high. The department was able to achieve that record because of two new programs, Fast Track and Team Triage, designed to provide speedier, more efficient service to patients in the ED.

Since those programs were introduced eight months ago, the median door-to-doctor time has dropped from 45 minutes to 18 minutes. The number of patients who leave without being seen has dropped from the industry average of 2 percent to 0.65 percent.

Stanford’s ED is like that of most other hospitals that still offer emergency medicine. It’s contending with spiraling growth in demand fueled by powerful forces. The number of people without insurance is steadily increasing, while the number of emergency rooms is steadily decreasing. Nationally, emergency room visits leaped from 114 million in 2003 to 124 million in 2008 to 136 million in 2009. Since Stan-
"Soon data will be integrated with medical records and people will have 24/7 access to their whole genomes through mobile devices, like they do for their financial information today. That future is not so far away."
—Euan Ashley, MD, assistant professor of cardiovascular medicine, on the emergence of personalized medicine as the new standard of care. Feb. 14

"Giving this intervention—exposing kids to less adult television, less aggression on television and more pro-social television—will have an effect on behavior."
—Thomas Robinson, MD, MPH, professor of pediatrics, on a recent study from the Center for Child Health, Behavior and Development at Seattle Children’s Research Institute that found violent programming affects children’s behavior. Feb. 18

"For just about everything in medical science, we’re still very male-focused. Our basic understanding is missing a key ingredient, and that is the sex difference."
—Marcia Stefanick, PhD, professor of medicine, on the need to include more females in scientific research. March 5

"The worst thing would be [for people to think], ‘I can take aspirin and that justifies me doing indoor tanning.’ That is not the right message."
—Jean Tang, MD, PhD, assistant professor of dermatology, on a new study showing women who took aspirin on a regular basis reduced their risk of developing melanoma. March 11

30 years of science lead to valuable cancer drug
One gene, many researchers, future hope

Three years ago, 101-year-old Winnie Bazurto noticed a strange growth on her lower eyelid. She didn’t worry about it initially, but in 2012 it started getting bigger, fast—doubling in size every two weeks and growing into the orbit of her right eye, restricting her vision.

It was diagnosed as basal cell carcinoma, the most common skin cancer. Her main concern was that the painful growth would infiltrate the eyeball, possibly causing blindness. Bazurto’s options for treatment did not look good. Although she is still healthy, her age meant she was not a candidate for the eight-hour surgery necessary to remove the growth or the alternative, six weeks of radiation treatment. But she was reluctant to lose the sight in her right eye and, along with it, much of her independence—not to mention her ability to watch a fastball on television.

Then a third option emerged: a new drug approved by the U.S. Food and Drug Administration in January 2012 called vismodegib (brand name Erivedge) to treat inoperable basal cell carcinomas.

Like most patients prescribed a new drug, Bazurto knew little about its origins. The Genentech-developed drug is the first class of drugs approved by the FDA that works by inhibiting one of the key regulators in human development: the hedgehog molecular signaling pathway.

The hedgehog connection
This approach is considered a landmark in cancer treatment, and it’s hoped that there will be many more hedgehog-inhibiting drugs to come for the treatment of other invasive cancers, including pancreatic, esophageal and ovarian cancers.

“That’s the exciting part about this drug,” said Anthony Oro, MD, PhD, professor of dermatology at Stanford, who was part of the original hedgehog cancer studies. “Now, hopefully, we will develop more of these types of drugs for other cancers in a faster cycle time.”

Faster is the key word here, considering that more than 30 years of painstaking scientific research lie behind the development of the little pink-and-gray pills offered to Bazurto by her Stanford dermatologist Jean Tang, MD, PhD, assistant professor of dermatology. Both Oro and Tang were involved in the first clinical trials testing vismodegib on basal cell carcinoma tumors.

The drug’s origins date back to a scientific quest in the 1970s to answer a crucial question of developmental biology. Scientists knew that a developing embryo started out as a ball of identical cells, but nobody yet understood how these cells knew when or where to grow body parts, such as arms and legs.

Rooted in research
Through fruit fly studies scientists were able to identify more than 50 genes needed to control the formation of the embryo, including one they named hedgehog. The hedgehog gene was found to regulate the organization and pattern of fly body parts. Remarkably, other researchers identified a similar gene in humans and other vertebrates, indicating it had been present in common ancestors more than half a billion years ago.

These major discoveries triggered a new round of research to determine exactly how genes control the growth of animals. One of those scientists, who would prove to be a key player in the history of hedgehog research, was Matthew Scott, PhD, Stanford professor of developmental biology. Sixteen years after the fruit fly discoveries, in 1996, Scott and a team at UC-San Francisco made another huge discovery that connected the hedgehog pathway and certain cancers. They discovered that defects in hedgehog or related genes were present in two cancers: basal cell carcinoma, the most common human cancer, and medulloblastoma, a highly malignant pediatric brain tumor.

“These genes, discovered first in flies, tell the cells of a growing embryo when and where they should divide,” Scott said. “If the system breaks down, cells will divide when they should not, and that’s cancer.”

A new round of research took off. Scientists set out to discover therapies that could treat certain cancers by blocking the hedgehog pathway when it had gone awry.

Sixteen years later, in April 2012, Bazurto, who lives in San Mateo, started taking the drug.

Taking things in stride
Bazurto has seven grandchildren, nine great-grandchildren and two great-great-grandchildren. She’s survived the Depression, the recent recession and three husbands. She took the new treatment for skin cancer, and its potential side effects, in stride. Her appetite dampened a bit; she had some leg cramping. Most disturbing for her was some hair loss. She also developed an undocumented side effect—a squamous cell cancer, another type of skin cancer.
After more than half a century, the rooftop of the Hoover Pavilion is once again graced with a finial, an architectural ornament akin to the cherry on a sundae.

On a cold and overcast morning last fall, a crane hoisted the 500-pound aluminum sculpture more than 105 feet off the ground. It was then lowered onto a cube-shaped concrete stack, sheathed in copper, atop the pavilion’s tower and bolted into place by construction workers. The undertaking capped a 14-month, $50-million renovation of the Art Deco building, which stands at the corner of Quarry and Palo roads on the Stanford campus.

Building’s new role

The building now serves as headquarters for several Stanford primary-care clinics: coordinated care, internal medicine, family medicine and senior care. “Hoover Pavilion is the flagship site for Stanford’s new primary care system,” said Sang-ick Chang, MD, MPH, assistant dean for clinical affairs, referring to Stanford Medicine’s initiative to expand and strengthen its primary care services.

The pavilion also houses the Stanford Center for Integrative Medicine, an extension of the dermatology clinic, the neurology clinic, a medical pharmacy, the offices of about a half-dozen community physicians, a station for drawing blood samples and a café.

The main branch of the Stanford Health Library, which provides free scientifically based medical information to help people make informed decisions about their health and health care, is located on the second floor.

Many community residents were born in the building, which originally opened in 1931 as the Palo Alto Hospital. “Hoover Pavilion has always played an important role in our community’s health, and we’re excited about its new role as a destination for leading-edge and coordinated primary care,” said Amir Dan Rubin, president and CEO of Stanford Hospital & Clinics.

Renovations and repairs

The Pavilion is a local Art Deco landmark. Designed in the style of a ziggurat—a terraced pyramid built by denizens of ancient Mesopotamia—its south wing and east wing, added in 1939, are each four stories and connect to a five-story tower, atop of which sits a sixth-story penthouse.

“This was Palo Alto’s skyscraper in 1931,” said Laura Jones, PhD, director of heritage services and university archeologist at Stanford. However, the edifice became dilapidated over the decades. Before renovation work began in 2011, the façade was faded and dirty, with air-conditioning units protruding from windows.

And while the original, decorative terra-cotta paneling that covers portions of the building’s façade remained in remarkably good shape, the same couldn’t be said of the steel-reinforced concrete making up the building’s floors, said Rachel DeGuzman, a senior project manager at Stanford Hospital & Clinics who oversaw the renovation project. Decades of remodeling required extensive patching of the slabs, she said.

Some repair work also needed to be made to the exterior walls and relief panels, said Erin Ouborg, a designer and materials conservation specialist at Page & Turnbull, the architectural firm in charge of restoring the building’s historic façade. In addition, the clay tiles on the sloping roof of the tower were replaced.

The final touch

Now the roughly 82,000-square-foot building has been restored to its former glory on the outside and refurbished to accommodate modern medicine on the inside.

As for the finial that once stood atop the tower of the old hospital? The original adornment, made of iron, consisted of a spherical object—a cross between a gyroscope and an armillary sundial—on a pole supported by a four-pronged base. But it was removed, possibly for use as scrap metal during World War II. Nobody knows for sure. The new finial is an exact replica, except that it is made of aluminum.

“Fortunately we had significant documentation to show what it originally looked like,” Ouborg said. “We had the original construction drawings with all the details.”

“It’s an interesting building without the finial,” Jones added. “But with the finial, it’s just superb.”

For more information about the Hoover Pavilion renovation, visit sumcrenewal.org.
A vision for Stanford Medicine

Lloyd Minor, MD, an inner ear specialist and surgical innovator, became the dean of Stanford University School of Medicine on Dec. 1, 2012. Minor changed the field of otolaryngology by identifying a new disease and developing a treatment that has benefited many patients. He previously served on the faculty of Johns Hopkins University for nearly 20 years, the last three as the school’s provost.

What are your priorities as dean?
As I consider the future of Stanford Medicine, I am guided by three priorities: advancing innovation, empowering future leaders and transforming patient care. To advance innovation, we must seek to protect the high-risk, high-reward science that Stanford is known for. To empower future leaders, we must provide students and trainees with the skills needed for a changing biomedical landscape.

To transform patient care, we must deliver health care that is accountable, coordinated, and patient centered.

One of the ways that we are working towards these priorities is through the Campaign for Stanford Medicine, which I am leading on behalf of the school and Stanford Hospital & Clinics. The campaign provides an opportunity for us to collectively plan our future around these priorities.

You have said that your experiences growing up in Little Rock, Arkansas, during the 1960s and ’70s had a profound impact on your views on diversity. Can you tell us about your perspective?
As part of a court-ordered desegregation plan, I was bused to a formerly African American junior high school in 1971. I immediately learned that what was billed as “separate but equal” was separate but certainly not equal. There were very few books in the library, and the books on the lower shelves had their covers eaten away by rats. Banisters were missing from stairwells. Plaster was peeling from the walls.

It was eye opening to see this injustice, and it had a profound effect on me and on my aspiration for what I hope to accomplish as a leader. At institutions like Stanford I think there’s a lot we can do to promote diversity and be an agent for social change.

What do you think are the factors that will drive future innovation in medicine?
I believe that innovation is driven by what I call the 3 C’s—combination, collaboration and chance. Researchers must be given time to fail over the short term and the freedom to experiment and go where their research leads.

At Stanford, our scientists are exceptionally innovative. But in the current tough funding climate, we will have to work harder to give them the time and freedom they need to pursue the visionary science that can transform our lives.

How do you hope to leverage Stanford’s research programs to turn them into treatments that will benefit patients?
Stanford is committed to training the physician scientists who will translate fundamental research into improvements in patient care. We graduate four times as many MD/PhDs as the average medical school, and nearly all our medical students do research. This means that we have a unique opportunity to train and nurture the career development of innovative scientists who will be poised to have a significant impact on the translation of discoveries from bench to bedside.

As an otolaryngologist, you are known for having discovered a syndrome and developed a surgical procedure to correct the problem. Can you tell us more about this?
As a young physician at Johns Hopkins, some of my first patients were referred to me by the hospital’s psychiatrists. One man said he got dizzy when he sang in the shower. Another said he could hear the sound of his own eyes moving. I later discovered that these patients were experiencing symptoms coming from inside their heads—but not in the ways others might have supposed.

They had superior canal dehiscence, a debilitating disorder characterized by sound- and pressure-induced dizziness, caused by tiny holes in a bone overlying the inner ear. The surgery I subsequently developed to correct this problem is now practiced around the world and has brought benefit to hundreds of patients.

What role has basic science played in your career?
Basic science has played a central role in every step of my career. I spent several years as a postdoctoral research fellow, and as a faculty member at Johns Hopkins I did basic research in my lab while seeing patients in the clinic. In fact, my discovery of superior canal dehiscence syndrome and subsequent development of a corrective surgery would not have been possible had it not been for my basic research on the physiology of the vestibular system.

Creation of new knowledge through basic sciences research is essential to the improvement of human health. That’s why I have set a $70 million goal for the basic sciences in the Campaign for Stanford Medicine.

How do you collaborate with your colleagues at Stanford Hospital and Lucile Packard Children’s
Stroke Center consolidates expert care for rare brain disease

For several months, Theresa Rodriguez struggled with recurrent episodes in which she would temporarily lose the ability to move or speak. One moment, she would be feeling fine; the next, the left side of her body would go numb. Her left hand couldn’t grasp, and she couldn’t rouse her tongue to form words. She was seen four times at two different hospitals and received only partial answers. “I had a spot on my brain,” she remembers physicians telling her. “They were baffled. All I could do was cry, ‘What is going on with me?’”

Rodriguez finally was referred to Stanford Hospital & Clinics’ Stroke Center, where she was evaluated by a full team of specialists. Their diagnosis: Those repeated moments of disconnection were strokes caused by moyamoya disease, one of the rarest cerebrovascular conditions known to medicine.

Fortunately for Rodriguez, Stanford has one of the nation’s foremost experts in moyamoya disease. Moreover, its 20-year-old Stroke Center is now the first in the nation to be certified as a comprehensive stroke center by the Joint Commission.

Standards of accreditation

The designation came after a team of experts from the Joint Commission, the nation’s largest health care accrediting organization, spent two days at the hospital in the fall, evaluating all aspects of its stroke program. They assessed compliance with the new comprehensive stroke center standards and requirements, such as advanced imaging and treatment capabilities, the 24/7 availability of specialized treatments, participation in research and the staff with the unique education and competencies to care for complex stroke patients. The surveyors found the hospital met or exceeded all required standards.

“We knew from the very start that the most effective way to battle complex stroke cases was to create a truly coordinated, multidisciplinary team that united specialists from every related field—not just in neurology, neurosurgery and interventional neuroradiology, but also experts in nursing, rehabilitation, emergency medicine and pharmacy, among others,” said Amir Dan Rubin, president and CEO of Stanford Hospital & Clinics. “This approach has improved patient outcomes and pioneered significant advances in stroke diagnosis and treatment.”

Nearly 1 million people in the United States were hospitalized by stroke in 2009, according to the federal Centers for Disease Control and Prevention. An estimated 7 million Americans have had some form of stroke. It was the fourth-leading cause of death in the United States in 2010.

Theresa Rodriguez’s symptoms baffled most physicians until she was diagnosed by experts at the Stanford Stroke Center with a rare condition called moyamoya disease.

Stanford established its stroke center in 1992. “What we recognized from the start was that the best care would come from going beyond issues about turf,” said Michael Marks, MD, the center’s director of interventional neuroradiology and one of its three founding physicians. “We have been blessed to work with people who are open-minded and interested in a common goal: taking care of patients by using their individual areas of expertise.”

The Stanford Stroke Center’s founding philosophy is the key to its success, said Greg Albers, PhD, one of the center’s co-directors and founders. “To partner neurosurgery, neurology and interventional neuroradiology seemed sensible,” he said, “but it was a unique concept then.”

Combined expertise

The center also gained strength from the continuity of its leadership. “Our three original leaders are still together 20 years later,” said neurosurgeon Gary Steinberg, MD, PhD, co-director of the center and one of the founding members. “That’s unprecedented in stroke centers. What keeps us here is our shared enthusiasm for innovation and discovery—and our shared passion for helping patients.”

Fortuitously for Rodriguez, Steinberg is also one of the world’s leading experts on moyamoya and has treated more than 830 patients with the disease. Using a surgical technique he pioneered, Steinberg created a new set of arterial pathways in Rodriguez’s brain to bypass the areas blocked by her disease.

She was home three days later, ready to resume care of her four children and her first grandchild. Rodriguez said she still gets occasional headaches, but doctors have told her those will eventually subside. “I am very blessed,” she said. “Other people don’t get diagnosed for months or years. I’m already healing.”

For more information about the Stanford Stroke Center, visit strokecenter.stanford.edu.

Hospital?

I am fortunate to have the opportunity to work with two outstanding CEOs, Amir Rubin of Stanford Hospital & Clinics and Chris Dawes of Lucile Packard Children’s Hospital. Together we share not just a common mission to improve human health but a common future.

I am delighted that they share my commitment to transforming patient care at Stanford Medicine by bringing the very best science to the treatment and prevention of disease, by focusing on the health and well-being of each patient who receives care through our system, by communicating our knowledge and advances to others so that we are a leader in the transformation of health care and by training the leaders who will have an impact.

How does primary care fit in your overall vision of delivering care to the community?

Academic medical centers have historically focused on providing specialized care, but our mission is broader than that. I believe that we must enhance our focus on primary care if we are to be accountable for the overall health of our patients and provide them with the coordinated care they need in an otherwise fragmented health-care system.

Stanford has broken ground to rebuild and expand both hospitals. What will be the significance to patients?

Stanford Medicine already provides preeminent care to the community. With the renovation and expansion of the hospitals, made possible by the Campaign for Stanford Medicine and the Lucile Packard Foundation for Children’s Health, we will be able to provide preeminent care in preeminent facilities. But more than just buildings and technology, the renovation and expansion will allow us to transform patient care by implementing new models of integrated care built around the needs of patients.
EMERGENCY DEPARTMENT FROM PAGE 1

ford’s current ED opened its doors in 1976, visits have risen between 5 and 10 percent each year. It was built for 17,000 patient visits annually. Last year it tallied close to 54,000 visits.

Evaluation and assessment

In response to this rising tide, the ED has taken steps to improve the efficiency of patient evaluation and treatment, most recently borrowing strategies from the business philosophy of lean management. Lean management aims to eliminate any expenditure of energy or resources that does not create value for customers—or in this case, patients. ED staff conducted a careful evaluation of their operations, down to the smallest detail. For example, they took a hard look at what paper forms were needed and where they were kept, how patients were informed of delays, and what the discharge process required. They used this information to make improvements. Another key step was to analyze the medical needs of ED patients to determine whether changes might be made to speed appropriate care for each type of patient.

First came Team Triage, inaugurated a year ago. In the same area as the waiting room, big bronze-colored letters that spell “triage nurse” are affixed to a dividing wall, behind which patients are evaluated by a team of doctors, nurses and ED technicians. Apart from trauma patients brought in by ambulance to receive the highest-priority care, everyone who comes into the ED passes through the Team Triage area. Minor injuries are classified as 4 or 5, the most critical as 1.

“For this level 3, said Patrice Callagy, RN, patient care manager in the ED, “They might have abdominal pain or broken bones.” Team Triage also allows for earlier diagnosis of time-sensitive conditions, such as stroke.

An analysis found that 40 percent of the hospital’s patients were sick enough to have been admitted through the ED. It also showed that 12 to 13 percent of the ED’s patients were 4s and 5s, who did not require hospitalization. Yet their relatively minor medical issues meant that they were waiting the longest, starting with how long it took for them to see a doctor.

“We knew we needed dedicated resources,” said Grant Lipman, MD, clinical assistant professor of emergency medicine and an ED physician. “The less time someone stays in the waiting room, the better it is for everyone. It’s common sense and good medicine.”

—Grant Lipman, MD
Clinical assistant professor of emergency medicine

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Enter Fast Track, a dedicated team composed of doctors, nurses and ED technicians whose job is to treat patients with less-severe health problems as rapidly as possible. “We treat you and let you get on with your life,” said Lipman, Fast Track’s medical director. “You’re the least sick, so we’ll treat you the fastest.” The median length of stay for Fast Track patients is 65 minutes, well under the original goal of 90 minutes. For 3s whose evaluation and treatment times might take longer because of tests or other requirements, another portion of the ED’s waiting room has been partitioned and furnished with comfortable treatment chairs and other basic medical equipment. In this area, clinicians can treat pain, for instance, with intravenous medication. “Treating pain makes a huge difference,” said ED physician and Team Triage Director Nounous Taleghani, MD, PhD.

Improved efficiencies

The benefits of these changes have been abundant, the emergency medicine team says. Overall, the ED staff is less stressed, Callagy said, because they can handle the higher patient counts so much more efficiently. And, as shown in surveys returned by discharged patients, the change in wait time is clearly appreciated: The likelihood of patients to recommend the ED overall has risen from the 55th percentile to the 95th percentile since the changes were instituted.

“It’s not rocket science,” said Marlena Kane, director of business development for patient care resources at Stanford Hospital. “It’s bringing the right people together and getting them engaged. We want to make Team Triage and Fast Track permanent parts of the way we do business.”

Dads of Daughters: The Joys and Challenges of Raising Teen Girls
Presented by Packard Children’s Hospital
Speaker: Julie Metzger, RN
Founder, Great Conversations and Heart-to-Heart
Date: Thursday, April 18, 7 pm
Location: Community Programs Classroom, 4100 Bohannon Drive, Menlo Park
Fee. Register online at calendar.lpch.org or call 650-724-4601.

Caregivers Workshop
Presented by Cancer Supportive Care
A skills-based class designed to provide support, education and resource materials to caregivers
Date: Thursday, April 18, 4–7 pm
Location: Stanford Cancer Center, 875 Blake Wilbur Drive, Stanford
To register, call 650-725-9456.

The Princess and the Pee: What Every Parent Wants to Know About Bed-wetting and Incontinence in Children
Presented by Packard Children’s Hospital
Speaker: William Kennedy, MD
Chief, Pediatric Urology
Date: Monday, April 29, 7 pm
Location: Packard Children’s Auditorium, 725 Welch Road, Palo Alto
Register online at calendar.lpch.org or call 650-724-4601.

Forgive for Good
Presented by Stanford Center for Integrative Medicine
A series that offers insights into the healing powers and medical benefits of forgiveness
Speaker: Fred Luskin, PhD
Course Instructor, Health Promotion Services
Date: Tuesdays, April 30–May 21, 6:45–8:40 pm
Location: Stanford Hospital Health Library, Hoover Pavilion, 211 Quarry Road, Palo Alto
Fee. For registration and more information, please call 650-498-5566.

Preparing for Multiples
Presented by Packard Children’s Hospital
Date: Saturday, May 4, noon
Location: Community Programs Classroom, 4100 Bohannon Drive, Menlo Park
Fee. Register online at calendar.lpch.org or call 650-724-4601.

Grandparents Seminar
Presented by Packard Children’s Hospital
Date: Monday, May 6 or June 10, 6 pm
Location: Community Programs Classroom, 4100 Bohannon Drive, Menlo Park
Fee. Register online at calendar.lpch.org or call 650-724-4601.

Walking Tour of Stanford University Medical Center
Date: Wednesday, May 8 or June 12, 2–3 pm
Location: Meet at the fountain by the Stanford Hospital main entrance
Registration required. Register by calling 650-725-4589 or emailing LaneAskus@Stanford.edu.

Living Well with Chronic Conditions
Presented by Stanford Aging Adult Services
A workshop to teach people with chronic conditions how to communicate with physicians, develop an exercise program, manage medications and deal with stress
Date: Thursdays, May 16–June 20, 1:30–4 pm
Location: Stanford Hospital Health Library, Hoover Pavilion, 211 Quarry Road, Palo Alto
To register, call 650-498-7826.

Heart-to-Heart Seminars
Presented by Packard Children’s Hospital
For Boys Only: Mondays, June 10 and 17, 6:30 pm
For Girls Only: Thursdays, June 20 and 27, 6:30 pm
Location: Packard Children’s Auditorium, 725 Welch Road, Palo Alto
Fee. Register online at calendar.lpch.org or call 650-724-4601.

Events are free unless otherwise noted. Space may be limited, so please call to register in advance.
Parents of sick newborns need clear, immediate access to information about their baby's condition. While conversations with the physician or nurse are essential, Packard Children's has found another way to keep families in the loop.

Each morning, parents of newborns in the hospital's neonatal intensive care unit (NICU) receive a printout, called Your Baby's Daily Update, which is placed at the baby's bedside. It provides a personalized snapshot of key items from the electronic medical record, including lab results, nutritional status and any changes in the baby's condition over the past 24 hours.

The daily reports became possible after the NICU switched from paper-based files to electronic medical records, making it easier for caregivers to maintain and share medical information with each other. The next step was to extend this information to the other vital members of the care team: parents. A group of physicians, nurses, parents and informatics specialists then designed a template that could be personalized and printed out for each infant.

"The team had a good sense of what needed to be included on the printouts based on what parents wanted to know about their child each day," said Jonathan P. Palma, MD, MS, a neonatologist and member of Packard Children's medical informatics services. "The update empowers parents with the knowledge to contribute to medical decisions regarding their infant and creates a meaningful connection."

When Shannon Maher's son, Aiden Kuwayti, was born 10 weeks early, the updates helped Maher communicate with her husband about the baby's condition. Because the family had an older child at home, they took shifts at Aiden's bedside, catching each other up on his condition by phone. But the stress of their son's fragile state made it difficult for Maher to recall specific details of his care. Instead, she gave her husband information from the printed updates each time they talked. "It really helped to have some numbers to give him," she said.

Since it was introduced in 2010, the update has been translated into Spanish and the distribution process has been expanded and streamlined. Based on the NICU's experience, other Packard Children's departments are beginning to offer similar updates for families of their patients, too.

"The update includes all the basics that a parent wants to know and is a starting point for more in-depth conversations," said Heather Keller, a member of the team that developed the project. "It's also a wonderful tool for parents new to the NICU who face a tremendous learning curve about their child's care and condition."

In a study designed to evaluate Your Baby's Daily Update, recently published in the *Journal of Participatory Medicine*, parents reported that they found the printout very useful, and more than 95 percent said that they "always" liked receiving it and felt more competent to manage information related to the health status of their babies.

Parents rated the quality of the update as highly as information from their conversations with doctors and nurses, and more highly than many other information sources, such as NICU bulletin boards or the Internet. Many considered the report to be "refrigerator worthy," taking it home for display, as well as posting it on family blogs and Facebook.

The document also has proven to be useful for nurses and physicians in the NICU, Palma said. "There is a large number of patients, and we don't always have a chance to talk to each parent every day. It's become an important part of how we deliver care."
You won’t find deep-fried French fries, bacon cheeseburgers, or sugar-sweetened sodas in the cafeteria at Packard Children’s. Instead, hungry visitors and employees can choose whole-grain pasta, frozen yogurt and lots of fresh fruit and vegetables.

The change is part of a wide-scale initiative to make Packard Children’s one of the healthiest children’s hospitals in the country. The plan involves introducing healthy practices throughout the hospital, from encouraging the use of stairs to revamping the cafeteria menu.

“As a children’s hospital, we have the responsibility to model the healthiest environment possible for our patients, their families and the community,” said Karen Kemby, administrative director of strategy and business development. “We take that responsibility seriously, and we are leading the way in making children’s hospitals healthier places.”

Putting healthy options first
Packard Children’s was one of the first children’s hospitals in the country to eliminate sugar-sweetened drinks from its menu. (Each 12-ounce serving of a carbonated, sweetened soft drink contains the equivalent of 10 teaspoons of sugar.) Packard Children’s is also one of only 10 children’s hospital systems among 155 hospitals signing on with the nonpartisan, nonprofit Partnership for a Healthier America, which is working with the private sector and Honorary Chair First Lady Michelle Obama to end childhood obesity in the U.S.

The cafeteria now features healthful options like whole-grain breads and pasta, low-fat dairy and meat products, vegetarian selections and seasonal fruits and vegetables. All offerings are assessed in terms of fat, sugar and salt content as well as portion size.

“It’s hard for families to be in the hospital when their children are ill, and we should do whatever we can to make our environment healthier for them.”

—Stephen Roth, MD, MPH
Chief, pediatric cardiology

We tend to eat more than we need, especially at stressful times,” said Stephen Roth, MD, MPH, chief of pediatric cardiology and medical director of the Children’s Heart Center. “It’s hard for families to be in the hospital when their children are ill, and we should do whatever we can to make our environment healthier for them.”

But healthy does not mean boring. Packard Children’s cafeteria rates an average of four out of five stars on Yelp, with kudos for its grilled cheese, turkey burgers and egg dishes.

Similar changes are under way at Stanford Hospital, where the Market Square Café began making major changes more than five years ago. It added more vegetarian selections, eliminated trans fats, reduced salt in food preparation and offered baked chips, rather than fried. Administrators also began increasing the percentage of fresh foods that are organic and purchased from local farmers who follow sustainable production practices.

Sugar cutbacks
Plastic utensils and trays have been replaced by compostable materials; recycling of food waste has also become a foundation of the café’s operations. The kitchens have been renovated and seating and food distribution areas upgraded to accommodate the changes.

Some of the more radical alterations made at Packard—such as removing deep fryers and replacing them with ovens—are planned for the adult hospital, said Florence Fong, administrative director of hospitality. But when SHC removed all the sugared sodas, its cafeteria customers complained so much that two brands were brought back, she said. In the meantime, the hospital is working to find new vendors to replace the cafeteria’s sugary desserts.