How the 2001 Anthrax Scare Led to 24/7 Preparedness

Nancy Donegan, RN, director, Infection Control; Glenn Wortmann, MD, director, Infectious Diseases; Mark Smith, MD, director, MedStar Institute for Innovation; Ligia Pic-Aluas, MD, hospital epidemiologist and Chris Wuerker, MD, director, MedSTAR Transport, outside the Emergency Department entrance at MedStar Washington Hospital Center.
A recent “good catch” for a surgical patient and what happened after that good catch, resulted in our being more vigilant about something that hasn’t always concerned all of us in the past.

The patient was scheduled for surgery. In the OR, when the team was reviewing the final questions before anesthesia, the patient mentioned that she had a nickel allergy. The process immediately stopped, and the surgery was cancelled and rescheduled for a later date.

The Perioperative Services leadership team has used this story as a teaching moment for all teams who work in the ORs. Inquiring about metal allergies is now part of the routine for surgical patients. In the past, metal allergies weren’t a consideration, but today, stainless steel, nickel alloys and other metal-containing alloys are used extensively for surgical implants, medical tools, health care equipment and fixtures, and dental tools and implants.

The transparency surrounding this good catch might have been considered an embarrassing mistake in previous years. But as a hospital committed to deliver the highest levels of quality and safe care to our patients, we are all on MedStar Health’s journey to become a High Reliability Organization (HRO).

- We want to prevent failures in safety protocols and processes, to keep our patients safe as we provide excellence in care for them.

- We want to identify quality and safety concerns before any harm can occur.

As part of our Good to Great journey, all areas of MedStar Health strive to become an HRO. Our StarPort site lists what we need to incorporate in our daily work:

- Transparency involves open and honest communication between leadership, caregivers, staff, patients and families in all areas of care, including publishing all outcomes data.

- Patient engagement involves understanding patients’ needs, values, preferences and goals around care, and finding ways for patients to take an active role in their care.

- Reporting of events that cause harm, as well as near misses and unsafe conditions, are a key to HROs. Reporting allows for open and honest reflection, feedback and mindful awareness of areas in need of improvement. The Patient Safety Event (PSE) Management System lets everyone report real or potential safety issues, including patient harm, near misses and unsafe conditions. Please make every effort to report real or potential safety issues in the PSE Management System.

“Transparency involves open and honest communication between leadership, caregivers, staff, patients and families in all areas of care, including publishing all outcomes data.”

- Interprofessional teamwork and collaboration is vital to the success of an HRO, as it supports the six other characteristics. HROs employ team approaches in all they do, and successfully level the hierarchical “playing field.” A non-hierarchical organization embraces a non-punitive response to error, an important milestone in becoming an HRO.

- Measurement allows us to benchmark our success and outcomes. HRO cultures use health information technology to measure everything. They know where they stand relative to the best, and act on it.

- Respect and support is necessary, as we work to become an HRO. We must take time to celebrate and appreciate successes along the way. In an HRO culture, the positive work of team members and individuals is noticed, recognized, appreciated and rewarded.

- Leadership is the seventh characteristic of HROs. Leaders of HROs possess an innovative spirit that is driven by ideas, vision and action. They are fearless, and have an obsession for improvement. They are committed to helping their associates understand and achieve the milestones necessary for reaching their goals.

Transparency in healthcare doesn’t refer only to what we want our patients and their families to know. All providers on each care team need to share our experiences and learn from each other, to improve the quality and safety of the care we give to every patient, every day.

Gregory J. Argyros, MD, MACP, FCCP, is sr. vice president, Medical Affairs and Chief Medical Officer at MedStar Washington Hospital Center. You can contact him at gregory.j.argyros@medstar.net or 202-877-5053.
Like many other high school seniors, this time of year finds Stephen Bonacci happy to be celebrating his graduation. But unlike others in his class, Stephen got to his high school commencement after navigating care from numerous physicians, and believing that his mood swings, irritability, inability to focus, spatial disorientation and vertigo was his “new normal.”

Recent statistics show that one in five high school athletes can sustain a concussion during each sports season. As a freshman on his school’s lacrosse team, Stephen had a direct blow to the head. He was diagnosed with a concussion, and received care from many different physicians. But after 13 months, all of his symptoms remained, worrying his family.

Enter serendipity. At a social event, Stephen’s parents met Dennis Fitzgerald, MD, Otolaryngology, a senior attending at MedStar Washington Hospital Center. After hearing about Stephen’s ongoing problem, Dr. Fitzgerald suggested a consultation.

Dr. Fitzgerald’s primary practice is in the Otolaryngology subspecialty, Neurotology, which focuses on the treatment of the inner ear conditions, and hearing and balance disorders. His practice includes working with many other MedStar physicians, including neurosurgeons, neurologists, physiatrists and rehabilitation experts.

While Stephen had seen many other specialists, after an initial exam and subsequent specialized testing, Dr. Fitzgerald suspected that Stephen had a rupture of the inner ear, a perilymphatic fistula (PLF). PLFs are little known outside of Otolaryngology, but this topic is one in which Dr. Fitzgerald has considerable experience. He has published in peer-reviewed journals, reporting his personal experience, as well as reviewing the literature on the pathophysiology, diagnosis, treatment and prognosis for PLFs.

“The continuing, unrelenting symptoms in a young person who had a concussion makes you suspicious of an inner ear disturbance,” says Dr. Fitzgerald. “One of four tests we gave Stephen was abnormal. We like to see all four with abnormal results for a positive conclusion, but that one pointed me to which side the problem existed.”

PLF has been a controversial disorder for more than 40 years. Otolaryngologists can never prove that someone does or does not have an inner ear rupture. For many years, every paper on the topic declared the gold standard for the diagnosis was based on fluid discovered during surgery.

“But only 70 microliters of fluid exist in the inner ear,” explains Dr. Fitzgerald. “If there is a leakage, it’s only one or two millionth of a liter. To depend on visual identification of this amount of small fluid is almost impossible. Inner ear surgery includes bleeding and mucosal adhesions, weeping of tissue, so a clear fluid leak is near impossible to detect during these procedures.”

Dr. Fitzgerald recommended surgery for Stephen. When Stephen and his family agreed, Dr. Fitzgerald performed an autogenous tissue graft repair of the oval and round windows, the small, thin membranes between the middle and inner ears, which restored the barrier between the two.

He harvested loose tissue from under the scalp, just superior to the external ear. Using an operating microscope, an incision was made in external ear canal skin, and the eardrum was lifted by up. Denuded areas were covered by extremely small pieces of tissue, and packed into place with gel foam. Stephen’s eardrum and canal wall skin were put back into their normal positions, and his external ear canal was filled with antibiotic ointment.

Stephen’s response to the grafting was typical of uncomplicated PLF, and his symptoms were resolved quickly. Within 18 months of the surgery, Stephen’s school performance was back to normal and his balance was restored, as was his pre-injury personality. He is playing competitive golf, but will not take part in contact sports, for fear of being hit in the head again and reopening fluid leaks.

Dr. Fitzgerald would recommend a Neurotology consult for any patients with unrelenting symptoms of dizziness, motion intolerance following head injury, and especially anyone with those symptoms who also has an accompanying hearing loss in one ear.

For any questions from referring physicians, Dr. Fitzgerald can be contacted at 202-877-4342.
How the 2001 Anthrax Scare Led to 24/7 Preparedness

As the first cases of Ebola were being diagnosed in West Africa last fall, MedStar Washington Hospital Center was preparing to care for any patients in the nation’s capital suspected of having contracted the dangerous disease. Every step, from patient identification and transport, to establishing isolation areas and treatment regimens, had been carefully strategized, rehearsed and critiqued, to ensure quality care for patients and a safe work environment for caregivers.

As of the end of March, the Hospital Center had handled only two suspected Ebola patients, both of whom tested negative for the disease. Yet while the outbreak’s gradual abatement worldwide has eased concerns among the public, the Hospital Center remains prepared to act at a moment’s notice for any new cases of Ebola—or any other bio-emergency—thanks to a detailed protocol for preparation and response more than 15 years in the making.

Warning Signs

The appearance of anthrax-tainted letters on Capitol Hill and the Brentwood Post Office just weeks after the September 11, 2001, terrorist attacks confirmed what health professionals had long suspected—bioterrorism was a real threat for major cities such as Washington, D.C., and hospitals needed to be ready for them.

“There was no doubt the Hospital Center would be a major receiving facility for such an event, given our size, specialized capability and location,” says Mark Smith, MD, former chairman of Emergency Medicine, and now director of the MedStar Institute for Innovation.

Clinical protocols on handling patients potentially exposed to anthrax changed on a daily basis, in response to evolving information. The Hospital Center converted its Ambulatory Care Area (ACA) into a receiving area for patients who were concerned they could have been exposed. A concurrent educational program reassured caregivers concerned about working so close to potentially lethal agents. “It made it easier that anthrax could not be spread from person to person, unlike Ebola,” says Dr. Smith.

With the appearance of the severe acute respiratory syndrome (SARS) virus in Toronto 18 months later, it was clear that a generalized plan was needed, in order for the Hospital Center to be fully prepared not only for bioterrorism incidents, but also any droplet- or airborne-transmissible disease with epidemic or pandemic potential, known as Human Epidemic Respiratory Diseases (HERD).

To develop and continually refine this strategy, the Hospital Center formed a HERD committee, which included representatives from a variety of medical disciplines, administrative and support functions.

“Our fundamental plan can go only so far, because the response to every disease risk will be different,” explains Nancy Donegan, RN, the Hospital Center’s director of Infection Control and a committee member. “We continually track information from the Centers for Disease Control and Prevention (CDC) and other sources, to evaluate potential outbreak projections and adjust our plan as needed, to prepare for any likely impact on our area.”

Jennifer Brandt, PharmD, one of the Hospital Center’s clinical specialist pharmacists, adds that while preparing for bio-emergencies is an everyday practice, “a lot of it is learning and acting on the fly, which is why a team effort is important.” For example, Brandt is responsible for ensuring an adequate supply of medications is on hand both for patients and staff.

“If there is no protocol for a particular medication or dosing from the CDC or elsewhere, I have to research the best way to deal with it, including medications that may not be FDA-approved,” she explains. “That includes drug type, proper dosing and how it might interact with other medications.”
Myriad other details must be addressed as well, from communicating responsibilities for potential bio-emergencies to Hospital Center staff to the earliest possible screening for cases.

“We learned from SARS that the situation can be very dynamic, with information and guidelines changing daily, or even more frequently,” says Christopher Wuerker, MD, head of MedSTAR Transport. “Rather than repeatedly training and re-training large groups, we tasked specific clinicians to monitor and analyze the information, and provide relevant updates to the full staff as needed.”

The hospital’s Emergency Department (ED) has also been readied to support a comprehensive, scalable response to a bio-emergency. To limit the spread of infection, patient rooms have been fitted up with negative pressure ventilation systems, individual toilets and showers, antimicrobial paint and flooring, and elimination of wall and surface corners where germs can collect. The rooms are also designed to be quickly converted into isolation areas for as many patients as needed, using specially designed removable biocontainment walls.

Donegan notes that while bio-emergency preparedness has driven these design enhancements, “it’s important that these ED areas be available for routine use, so we can make improvements as needed, and not limit our day-to-day operations. It’s not like we just open an empty warehouse when a bio-emergency happens.”

**Ebola Enters the Picture**

During the past decade, the HERD response plan has been implemented for potential outbreaks of avian and swine flu, Middle East Respiratory Syndrome (MERS) and other diseases. But the fact that Ebola is transmitted by human-to-human contact, and only when symptoms are present, added a new dimension to the response strategy. For example, caregivers would need to be thoroughly trained in putting on and taking off protective gear, and working in those suits for long periods.

“While we strive to protect caregivers, you simply can’t make mistakes when taking off the equipment,” says Ligia Pic-Aluas, MD, the Hospital Center’s epidemiologist. “In addition to following the CDC-provided guidance and protocols, we also drew on what other hospitals were doing, as well as the perspectives of our own people who would be working in the gear the longest.”

Repeated practice drills using a scale mock-up of an Ebola biocontainment unit (BCU) in the ED Ready Room did more than familiarize physicians, nurses and other caregivers with the various equipment protocols. It also alerted the HERD committee, now the BCU committee, to a needed facility modification.

“In addition to the ‘hot’ room where the patients would be, we also needed a ‘warm’ anteroom for caregivers to put on and remove their gear,” says Glenn Wortmann, MD, director, Infectious Diseases and the lead physician for the BCU. “We solved that issue by adding a secure door between the areas.”

Dr. Wortmann adds that the practice also honed the team’s skills in setting up the BCUs. “We could have the walls up and be ready to handle a patient in as little as 30 minutes,” he says.

The BCU committee’s comprehensive preparation efforts resulted in the Hospital Center being named among the first 35 hospitals designated as Ebola treatment centers by the CDC. And despite having only those two cases as “real-life” drills, the extensive training and preparation effort nevertheless provided immensely valuable lessons learned for the future.

“Ebola tops the list for contagious diseases,” says Dr. Pic-Aluas. “This will prepare us for any future disease that’s transmissible by contact.”

“We are always learning and implementing into daily practice,” adds Dr. Brandt. “For example, our flu clinics have taught us how to more efficiently dispense medications to the entire staff quickly. So if there is an emergency, we know how to get things done quickly.”

Dr. Smith is particularly pleased that some of the facility design decisions made during the early phases of preparing for bio-emergencies have proven to have long-lasting utility.

“We made a fair number of correct decisions as to what was needed for emergency response, both in terms of facilities and procedures,” he says. “It’s good that our baseline assessments were correct, but there are always things we can do to improve, and different scenarios to plan for.”

Dr. Wuerker agrees, noting that the Hospital Center is one of only a few hospitals in the country to have experienced multiple biological events.

“That’s provided us a great deal of experience and knowledge, which we’ll need,” he says. “Being the largest and most capable hospital in the nation’s capital, we’re going to be involved, whether we want to or not.”

—Jim Parsons
An avid traveler, Karen Jerome, MD, likes nothing better than an “adventure” vacation. Not one to passively observe the sights, she prefers hiking, ziplining and even rappelling her way through exotic locales.

Turns out, this preference makes her a perfect fit for her new job, as Vice President for Quality, Safety, Risk & Resource Management at MedStar Washington Hospital Center. After a vacation in Costa Rica, she started her new job in early March, and already finds it “a great new challenge.”

Her job description involves every aspect of quality patient care. “Basically, I’m the vice president of almost everything,” she laughs.

Dr. Jerome spent the last eight-and-a-half-years at Holy Cross Hospital, where she worked on many of the same issues that she is charged with at the Hospital Center. But the big difference is that now she is tasked with setting the agenda, rather than implementing someone else’s choices. “I was ready to do this at a higher level,” she explains.

She appreciates the size of the Hospital Center—twice that of Holy Cross—and the breadth of its tertiary care services. “There seems to be a lot of opportunity here to make a real difference,” she says.

Before joining Holy Cross, Dr. Jerome spent a decade as an internist in private practice in Silver Spring, where she enjoyed her close daily contact with patients. So what caused her to make the leap to hospital administration?

“I was finding that insurance companies were posing a real challenge,” she says. “I was spending more and more of my day filling out forms and jumping through hoops, leaving me less time with patients. I was frustrated. Rather than help one patient at a time, I decided to pursue a more global approach to the problem.” This led to her first job with Holy Cross as a physician advisor.

“It was great to start really understanding the business of health care, how hospitals function. Having an impact on so many patients was very rewarding for me.”

Her background in primary care stands her in good stead for her new duties. “We’re trained to see the big picture,” she notes. She chose internal medicine because of its broad reach. As an undergraduate at Brown University in Providence, R.I., she majored in mathematics, studied abroad in Spain and took a wide variety of courses to obtain a well-rounded education. When she continued at Brown as a medical student, it made sense to continue that holistic approach to learning.

She traces her interest in patient care back to her parents, who were both teachers and then guidance counselors in the New York City public schools. A Brooklyn native, she decided to pursue a career in medicine “at the ripe old age of eleven.”

Currently a Montgomery County resident, she and her husband—a college-level teacher of screenwriting and film history—are contemplating a move closer to the Hospital Center. Their 20-year-old son is now in college, and they are ready for another new adventure.

For now, they are spending their leisure time watching movies. Also, they are resting up for their next big vacation. “We like adventure vacations,” she says. “If I’m not bruised afterwards, it hasn’t been a real vacation.”

— Catherine Avery
Ira Rabin, MD, the new vice president of medical operations at MedStar Washington Hospital Center, started his new job in late January at the height of the snow and ice storms that hit the metropolitan area. It’s too bad his new job kept him so busy, as he is an avid ice hockey player in local leagues.

That’s not the only surprising fact about Dr. Rabin. He taught himself to read at age four, so he could scour the sports pages.

“I would loved to have been a professional athlete,” he remembers. “When I realized that it wasn’t going to happen, I gravitated toward medicine. There are a lot of doctors in my family, including my father.”

After graduating from the University of Pennsylvania and completing Jefferson Medical College in Philadelphia, he pursued a career in internal medicine, with a residency at UMDNJ/Robert Wood Johnson in nearby New Jersey.

“My impression was, the hardest thing to do in medicine is to be a very thorough general internist, and that became my calling. There is an old joke that the internist knows everything, and does nothing. The first part must be true; the second part should not be.”

When it came time to set up practice, he concluded that he preferred working in the hospital arena. “You deal with so many other specialties and case management,” he states. He also preferred the level of acuity seen in the inpatient setting. “There’s a lot to keep you on your toes.”

He worked as a hospitalist for Kaiser Permanente for nearly 10 years, where he developed an interest and expertise in metrics. “It was a natural progression from hospitalist to administrator,” Dr. Rabin notes. “We spent a lot of time with patient satisfaction, core measures and length of stay, which helped me be more thorough in my clinical practice.”

In 2013, he made the move to the Hospital Center, where he served as a physician adviser. This role had him focus on throughput, quality, resource utilization and performance improvement.

“I was a resource for doctors, nurses and social workers, to help with issues that can delay patient care,” he explains. “I helped make sure that testing was done in a timely manner and patients were transferred to the next level of care, as well as smoothing over communication breakdowns.”

As to his impression of the Hospital Center, he says, “There’s some amazing talent among physicians. When you surround yourself with excellence, you learn something every day.”

His new role will be an expansion of his previous duties. “I view my role as breaking down barriers,” Dr. Rabin says. “Contact me for utilization issues, clinical issues; I’m all yours.” Dr. Rabin will still continue clinical duties as a teaching attending on “A” medicine.

He sees the biggest challenges in hospitals to be capacity and throughput management. “In medicine today, the consumer wants everything done, done immediately, and at minimal expense and minimal inconvenience,” he says. “But medicine can only go at its own pace. The challenge is to give quality excellent care, provide empathy and maintain realistic expectations.”

Dr. Rabin believes that the Hospital Center is more than up to the challenges ahead. “We have a very robust clinical resource management department, excellent clinicians who are very responsive and a great Medical Affairs department that puts patients first. We also have the added resources of legal and ethics.”

A native of Silver Spring, he now lives six blocks from his childhood home. He and his wife, who is an attorney, have three children, ages 12, 9 and 6. In addition to playing ice hockey for a local league, he plays piano. In his house, someone is almost always on the piano, unless the Washington Capitals are on TV.

“If we can continue to provide excellent, compassionate and efficient care, and the Caps win the Stanley Cup, I will be a very happy camper.”

— Catherine Avery
Emergency Response Operation

On the ground level of the hospital, the main command center is the central eyes and ears of the police force, answering on average 175 calls a day, ranging from requests to collect patient valuables to assistance with disorderly patients. Fifteen monitors also relay images from 250 cameras located inside and outside the hospital, allowing dispatchers to see any activity on campus from a multitude of angles.

The command center is staffed 24 hours a day, seven days a week, and has the capability of tracking every door that is opened or closed, with a special focus on certain areas that are alarm-controlled. Dispatcher Kurt Whitney-El notes one such area is the mother-baby unit, where all infants wear bands that trigger alarms if they come too close to a window or door. He notes in the event of a Code Pink, the command center can lock every door in the hospital, so no one can enter or leave.

Special Response Team

A specially-trained unit dedicated to responding to high-risk situations, the Special Response Team (SRT) handles potential active shooters on campus, barricade situations or aggressively combative persons. SRT works closely with Secret Service personnel and other law enforcement agencies in planning and overseeing high-level visits to the hospital.

Dressed in black uniforms, SRT members carry gas masks and trauma kits, in addition to the standard equipment all patrol officers keep. They have access to long guns, should they be needed for any scenario.


All are critical situations that need immediate action. MedStar Washington Hospital Center’s Police officers are the first responders to these campus codes, in addition to a wide range of less serious situations, such as a disruptive patient threatening violence or an unlocked door that needs securing.

Commissioned by the Metropolitan Police Department (MPD) and considered a special police force within the District of Columbia, all Hospital Center officers are fully-trained police officers. Officers carry 9 mm handguns and are equipped with ASP batons, pepper spray and handcuffs. They are licensed to arrest people and write tickets for the MPD, and can shut down the hospital campus, should there be any threat to safety.

Protective & Guest Services officers—those wearing a blazer instead of a blue or black police uniform—are also part of the force, and are strategically located at various points of entry across the hospital. They do not have a firearm, but do carry other police gear.

“All of our officers are extremely committed and dedicated,” says Police Chief Lawrence Harrington. “There is a great sense of pride and ownership, regardless of which area an officer is assigned to.”
Officer Derrick Anderson, SRT team lead, says members of SRT have intense, rigorous training—not only to qualify to join the team, but to maintain a spot on the team. Training includes ongoing physical conditioning and biweekly firearm and range training. The team also completes wound care and trauma training, and members are constantly preparing for different potential scenarios.

“We are always being proactive versus reactive,” Anderson says. “We have everyone's safety and best interest in mind, and people should feel assured they are in a secure environment.”

Traffic

Anyone who has driven on campus during high-traffic hours or shift changes knows entering and exiting parking garages and navigating the campus can be an exercise in patience. No one knows this better than Officer Darrel Johnson, a 22-year police veteran who helps direct that flow of traffic at key areas on campus. Currently stationed on Michigan Avenue, Johnson helps improve the morning traffic flow in light of the ongoing construction to the front of the hospital. Johnson, in addition to other traffic officers, also patrols all parking lots and offsite locations, either on bike or in a police vehicle, responding to calls as needed.

Patrol

Conflicts are the number one call for patrol officers. These calls be an elderly patient refusing to take medication, or a combative patient threatening violence. Regardless of the situation, Officer Fabian Simmons says it is all about establishing a connection, de-escalating the situation and coming to a mutual resolution. Ninety-eight percent of the time that works, he states.

“Usually when a conflict arises, it’s because a patient or a family member is frustrated,” explains Simmons. “The first thing I do is listen. Sometimes, it is as simple as sitting on the chair, and hearing their side of the story.”

For the rare times this doesn’t work, all patrol officers are equipped with necessary equipment if he or she needs additional measures. In his 15 years at the Hospital Center, Simmons says he has never had to use his gun, but he has used handcuffs to subdue an out-of-control person.

“Our main goal is to protect all medical staff and visitors,” Simmons notes. “And we are trained in a variety of tactics to do that.”

Honor Guard

Eight members of the Hospital Center police force are also members of the Honor Guard, a ceremonial unit that attends parades, events and funerals for fallen officers or other civil servants. All members are volunteers, and represent the Hospital Center, carrying a MedStar Washington Hospital Center flag during events.

“Anyone who joins the group is expected to treat it with the highest honor and respect,” says Sgt. Alan Saunders, an 11-year member of the force and long-standing Honor Guard member. “We train to become members of the Honor Guard. We learn positions and formation and how to call commands. It’s an honor to perform and to represent MedStar Washington Hospital Center.”

— Jenny Steffens

Safety is everyone’s responsibility.

All Hospital Center physicians and staff are encouraged to call x7-6188 if they see or suspect any potential issue that comprises safety. “We are first responders,” says Police Chief Lawrence Harrington.

“If there is any inkling of a problem, call us; no call will ever go unanswered.”
A perfectly-timed television commercial about MedStar Heart & Vascular Institute likely saved Estela Escobar’s life.

Escobar, an Arlington, Va., resident, had just been told she had a malignant cardiac sarcoma with a very dire prognosis. At age 66, she had recently undergone pericardiocentesis and a pericardiotomy, after doctors discovered pericardial effusion was the cause of her fatigue and shortness of breath. A cardiac MRI indicated a large mass was infiltrating the anterior wall of her heart. The news was devastating for Escobar, for her husband of 34 years and for her three adult children.

When she sat down in her living room that January day, Escobar was scared, confused and in search of a second opinion. Seeing the MedStar Health TV commercial was a message, she believed. Within hours, Escobar had gone online to request an appointment. A week later, she was meeting with Ana Barac, MD, PhD, director of MedStar Heart & Vascular Institute’s Cardio-Oncology program. The encounter would not only alter Escobar’s plan of care, but save her life in the process.

Dr. Barac, who specializes in non-invasive cardiology with a focus on cardiac imaging, reviewed Escobar’s imaging and recent medical history. She knew that cardiac sarcomas, while quite rare, are the most common heart malignancy. Still, she wasn’t convinced.

“I couldn’t yet prove it, but there were certain characteristics of the pattern and distribution of the tumor that suggested to me that this could be a lymphoma,” explains Dr. Barac, adding that primary cardiac lymphomas are even more rare and unlikely than sarcomas, but much more responsive to therapies.

Immediately, Dr. Barac ordered a CT of Escobar’s abdomen and chest, to ensure there was no metastasis elsewhere. After those results proved negative, Dr. Barac knew a tissue biopsy of the cardiac mass would be the only way to confirm her belief, and obtain a formal diagnosis.

Escobar, however, was reluctant to undergo another procedure. She met with cardiac surgeon Ezequiel Molina, MD, who explained to Escobar that while he was hopeful a tissue sample could be obtained in a minimally invasive procedure, if that proved difficult then a more invasive sternotomy would be required. After
discussing this again with Dr. Barac, who reiterated the importance of the biopsy to provide an accurate diagnosis, Escobar agreed.

In the operating room, Dr. Molina accessed the mass from a small incision in Escobar’s left side, despite having limited exposure to visual markers of the heart, due to the complexity of the tumor. Waiting nearby was Jayashree Krishnan, MD, a pathologist who prepared the tissue sample and invited Dr. Molina to look at the results as well.

“I knew it was a lymphoma as soon as I saw it under the microscope,” says Dr. Molina. “I knew this was abnormal tissue, and not normal heart muscle.”

After completing her formal cytologic evaluation, Dr. Krishnan confirmed the mass was a lymphoma, not a sarcoma. Now that the physicians knew they had a diagnosis of a primary cardiac lymphoma, there was not a minute to waste.

“Lymphomas grow extremely, extremely fast,” explains Dr. Barac, “but they are also very chemo-sensitive and therefore respond better than sarcomas.”

Escobar was quickly moved from the operating room to the cardiac care unit where she met Oncologist Joseph Catlett, MD. Soon thereafter, she received her first chemotherapy infusion, while being monitored in case any cardiac arrhythmias developed.

After the first cycle of chemo was complete, Dr. Barac repeated cardiac imaging, and was stunned to find the tumor was half its original size. “It was quite dramatic,” Dr. Barac says, adding that Escobar continued to receive chemo as an inpatient for five days. Six months of outpatient chemotherapy followed, with Escobar’s children and husband offering steadfast support and care.

Today, thanks to MedStar Heart & Vascular Institute’s Cardio-Oncology program, Escobar is cancer-free. She has MRIs every six months, and sees Dr. Catlett for follow-up visits every three months.

“This was a very rare case,” says Dr. Molina, noting that this was the first cardiac lymphoma he has seen in his professional career. “It is great that we can offer these services to treat unique patients. Very few hospitals can offer this.”

For Escobar, she is just grateful for her team of doctors. “Even though I was very sick, I was sure I was in good hands,” she says. “Dr. Molina is a wonderful person. Dr. Barac is extremely special. All of my doctors are simply one-of-a-kind.”

— Jenny Steffens

MedStar Heart & Vascular Institute Cardio-Oncology Program

MedStar Health’s Cardio-Oncology program evaluates, diagnoses and manages heart problems for patients who are being treated for cancer, or who have already completed treatment. Our cardiologists have a special interest in patients undergoing cancer treatment, and can also determine if a patient with cancer may be at risk for developing a heart condition before or during cancer treatment. Our cardiologists and oncologists work together, to provide comprehensive care and decide on the best possible treatment options.

For more information, please contact Ana Barac, MD, PhD, at 202-877-6925.

“This was a very rare case. It is great that we can offer these services to treat unique patients. Very few hospitals can offer this.”

— Ezequiel Molina, MD, cardiac surgeon

Fig 1. Short axis projection with late gadolinium hyperenhancement demonstrates diffuse contrast uptake in the entire basal anterior wall extending into the septum and lateral wall. Normal myocardial tissue (black) is replaced by the lymphoma in the area of the anterior and lateral wall as well as septum (arrow).

Fig 2. Short axis projection with late gadolinium enhancement after completion of chemotherapy, demonstrates complete disappearance of abnormal tissue in the myocardium with a thin layer of residual fibrosis (star). Normal myocardial tissue appears black.

Jayashree Krishnan, MD
**Viewpoint**

**Words ARE Data**

**Clinical Documentation: What You Write Matters**

by George A. Sample, MD, FCCP, physician champion, Clinical Documentation Improvement Project

The days of “whatever the doctor documents” are gone.

Improving our clinical documentation is a MedStar Washington Hospital Center, MedStar Health and national mandate. Better documentation provides better patient care through better communication, as well as improved quality scores, resulting in a better financial bottom line for the hospital.

Imagine this scenario. You check in on a new patient, and in your progress note, you write:

75 y/o presented with fever, leukocytosis, SOB with hypoxemia and altered mental status

There was a time when that narrative was acceptable, but no longer—and for good reason. As much as some of us may resent it, words have now become data. That data is used for many other purposes, by such agencies as the Agency for Healthcare Research and Quality (AHRQ), District of Columbia Department of Health (DCDOH), Centers for Medicare & Medicaid Services (CMS), HealthGrades, Solucient and the Department of Health and Human Services (DHHS).

This is the age of transparency, and the better we document, the better for everyone. There is some truth to the notion that there are too many watchdogs looking over our shoulders, but what you write matters. Statistics show better documentation improves patient care and outcomes.

This level of clinical documentation is also essential for the transition of care summary. We want that depth of documentation, so the next physician taking over is getting all the necessary information. From that perspective, this is huge for patients, and provides a seamless transition of care.

In the example above, the more appropriate way to write that progress note would be:

75 y/o with acute exacerbation of COPD and chronic respiratory failure, now complicated by acute pneumonia, probably Gram negative in view of age, underlying disease and recent hospitalization. Now presents with probable sepsis, with acute septic encephalopathy as well.

In this example, the note now includes information essential to coders:

- Co-morbidities and complications (CC)—chronic respiratory failure, acute exacerbation of COPD
- Major co-morbidity and complications (MCC)—pneumonia and encephalopathy
- Principle diagnosis—probable sepsis

As a result, the following improvements are made:

- Relative weight (RW)—has increased from 0.6822 to 1.8803
- Geometric mean length of stay (GMLOS)—has increased from 2 days to 5.2 days
- Severity of illness (SOI)—has increased from 2 (moderate) to 4 (extreme)
- Risk of mortality (ROM)—has increased from 2 (moderate) to 4 (extreme)

SOI and ROM affect the organization’s case mix index, outcome management and coding compliance. The data from our clinical documentation is reflected in your “report card,” as well as in the hospital’s financial bottom line. As of Oct. 1, these standards will be required for ICD-10.

To help facilitate these efforts, the Hospital Center has had a Clinical Documentation Improvement (CDI) Program for five years. Five Clinical Documentation Specialist (CDS) nurses are trained to perform concurrent review of medical records on selected patient care units. They have been working hard at this for the last year, in preparation for the changes looming ahead.

**New Acronyms We Need to Know**

**AHRQ:** Agency for Healthcare Research and Quality

**CC:** Co-morbidities and complications

**CDI:** Clinical Documentation Improvement

**CDS:** Clinical Document Specialist

**CMS:** Centers for Medicare & Medicaid Services

**DHHS:** Department of Health and Human Resources

**DCDOH:** District of Columbia Department of Health

**GMLOS:** Geometric Mean Length of Stay

**ICD-10:** International Classification of Disease 10

**MCC:** Major Comorbidities and Complications

**RW:** Relative Weight

**ROM:** Risk of Mortality

**SOI:** Severity of Illness
Leading our CDI program are Purvi Jani, assistant vice president, Revenue Cycle and Financial Reporting; Andy Markel, supervisor, Business Intelligence and Tedenekialesh (Judy) Solomon, director of Coding and CDI. Nineteen physicians have been tapped to serve as physician liaisons to the CDI.

The Clinical Documentation Specialist nurses review medical records, looking specifically at the SOI, closing the loop on all differential diagnoses, and helping to resolve cases with inconsistent, unclear, conflicting or missing documentation before the patients' records are coded. Concurrent reviews are key, because we want to capture valid clinical documentation while the patient is in house, not after the fact.

If a CDS finds a potential diagnosis that isn’t being picked up, or other inconsistencies, she’ll send a query to the physician, who has 72 hours to respond. The query process is essential to provide diagnostic specificity. The query may include a phone call, written note, email or fax. The CDS nurses cannot code, nor can they make suggestions. They can only query to improve the specificity and completeness of the data used to assign diagnosis and procedure codes. The physician needs to clarify, and make his or her own conclusions. This process transforms diseases into data ("reportable categories"), which are used to support requirements of reimbursement, statistical analysis and public health surveillance.

If the physician doesn’t respond within the given time, there is an escalation process that may eventually involve me or the Chief Medical Officer.

You may receive some queries in the next few months. Please remember that the queries generated today are also getting us to the ICD-10 detail level that will be required this fall. This process should be unobtrusive to your practice. It’s going to be a minor blip, and eventually, it won’t even be a blip.

### Physician Liaisons

**Behavioral:** Karen Johnson, MD/Stephen Peterson, MD  
**Cardiology:** Jonathan Patrick, MD/Khanh Decareau, MD/Allen Taylor, MD  
**Endocrinology:** Uzma Vaince, MD (Hospitalist service); Carmella Cole, MD (all other Medicine)  
**Gastroenterology:** Uzma Vaince, MD (Hospitalist service); Carmella Cole, MD (all other Medicine)  
**General Medicine:** Uzma Vaince, MD (Hospitalist service); Carmella Cole, MD (all other Medicine)  
**General Surgery:** Jack Sava, MD  
**Infectious Diseases:** Uzma Vaince, MD (Hospitalist service); Carmella Cole, MD (all other Medicine)  
**Nephrology:** Uzma Vaince, MD  
**Neurology:** Amie Hsia, MD  
**Orthopaedic Surgery:** James Tozzi, MD  
**Oncology:** David J. Perry, MD  
**Pediatrics:** Zacharia Cherian, MD  
**Pulmonary:** Uzma Vaince, MD (Hospitalist service); Carmella Cole, MD (all other Medicine)  
**Rehabilitation:** Fatemeh Milani, MD  
**Transplants:** Seyed Ghasemian, MD  
**Trauma:** James Street, MD  
**Urology:** Mohan Verghese, MD  
**Vascular Surgery:** Edward Woo, MD  
**Women’s Services:** Melissa Fries, MD

### Why It’s Important

**What’s in it for me?**
- Improvement in patient care
- Accuracy of data reported to state and other agencies
- Benchmark performance information

**Goals of the CDI Program at MedStar Washington Hospital Center**
- improves compliance with CMS and the federal coding guidelines
- achieves greater specificity of primary and secondary diagnosis
- captures precise Severity of Illness (SOI) and Risk of Mortality (ROM)
- improves patient care and outcomes
- improves quality scores and report cards

**Clinical Documentation Specialists**
- Olivia Baker, RN, BSN
- Valarie Coates, RN, MSN
- Sefanit Gizaw, RN, BSN
- Robin Livingston, RN, BSN
- Pauline Palmer-Williams, RN, BSN
**News & Notes**

**Doctor Days 2015** brought attendings, APCs, residents and fellows together to celebrate the clinical excellence and patient first service given by providers at the Hospital Center.

Ai-Hsi Liu, MD, Interventional Radiology, and Rocco Armonda, MD, Neurosurgery, enjoy lunch and a conversation.

Mohan Verghese, MD, chairman, Urology, signs the “Above All: Patients First” banner outside the Physicians Dining Room.

Arthur Weinstein, MD, Rheumatology; Etonde Musonge-Tarkang, MD, Cardiology hospitalist; Jessica Fields, MD, physician adviser, and Robert Laureno, MD, chairman, Neurology, gathered at one of the lunch tables.

Richard Benson, MD, PhD, associate medical director, Comprehensive Stroke Center, holds the Doctor Days gift, a Bluetooth® speaker.

**Kudos & Congratulations**

George A. Sample, MD, FCCP, Surgical Critical Care, received the Distinguished Service Award from the Society of Critical Care Medicine (SCCM). The Distinguished Service Award honors SCCM members for their exceptional leadership contributions that have furthered the vision and mission of SCCM over a period of time.

The Teen Alliance for Prepared Parenting (TAPP) and Executive Director Loral Patchen, PhD, have received a $100,000 grant for operational support, from the D.C. Teen Pregnancy Prevention Fund Establishment Act of 2014.
Welcome to New Members of the Medical & Dental Staff

Crystal Chappell, CRNP  Cardiovascular Disease
Alexa Gale, MD  Emergency Medicine
Charise Hasdorff, PA-C  Emergency Medicine
Alexander Lalos, MD  Gastroenterology
Filipa Lynce, MD  Hematology Oncology
Charlotte Yeomans, MD  Hospitalist, Cardiovascular Disease
Sathyabama Naidu, MD  Hospitalist, Internal Medicine
Meghan Gilleland, MD  Internal Medicine
Mary Richardson, NP  Internal Medicine
Vinita Singh, MD  Medical Oncology
Amjad Anaizi, MD  Neurosurgery
Vera Ibe, MD  Ob/Gyn
Saira Mir, MD  Ob/Gyn
Reshma Pachikara, MD  Ob/Gyn
James Pullano, MD  Ob/Gyn
Dana Smith, MD  Ob/Gyn
Kieu Smith, MD  Ob/Gyn
Angela Thompson, MD  Ob/Gyn
Shirley Van Milder, MD  Ob/Gyn
Therese Cermak, MD  Pathology
Adair Seager, MD  Pathology
Melissa Sinkiewicz, DO  Physical & Rehab Medicine
Zhen Xu, MD  Physical & Rehab Medicine
Jamie Chaffo, DPM  Podiatric Surgery
Erin O’Neill, MD  Radiology
Marc Margolis, MD  Thoracic Surgery
Tim Hopkins, MD  Urology

“The Doctor’s Lounge”

Every month, Chief Medical Officer Gregory Argyros, MD, MACP, FCCP, hosts an informal “lunch and learn” for members of the Medical & Dental Staff. With a different topic every month, “The Doctor’s Lounge” presents an opportunity for physicians to meet colleagues from different service lines. Physicians are welcome to suggest topics that they and others are interested in hearing. Each session is announced through an invitation sent through the DocsLink database. If you are not receiving the information, send an email request to marge.kumaki@medstar.net.

The March “Doctor’s Lounge” featured Certified Public Accountant Linda de Marlor, president, Tax-Masters, Inc. and Emergency Department Chair Jeff Dubin, MD, MBA, who spoke to physicians about taxes and investing.

Mobile App Speeds Treatment for Heart Attack Patients

A new study determined that a mobile app conceived at MedStar Heart & Vascular Institute at MedStar Washington Hospital Center is allowing heart attack patients to be treated more quickly, some an average of 30 percent faster—thereby reducing potential heart damage.

The CodeHeart app allows hospital interventional cardiologists to securely view a patient’s condition in real time, while simultaneously speaking with a physician at an emergency department that is referring the patient for further treatment. CodeHeart also allows physicians to view a live, secured video feed containing vital signs and test results, such as electrocardiograms. Previously, those test results were faxed, a process that could take 10 minutes or more.

“When it comes to treating a patient who appears to be suffering from chest pain or other heart attack symptoms, every second counts,” says Lowell F. Satler, MD, director of the Cardiac Catheterization Laboratory at MedStar Heart & Vascular Institute. “CodeHeart helps us provide optimal care as quickly as possible, and effectively treat every heart patient who comes to our facility.”

Using CodeHeart improved results for a key measure of the effectiveness of the treatment of heart attack patients with ST-segment elevation myocardial infarction, according to a recent study published in Cardiovascular Revascularization Medicine. The measure, called door-to-balloon time, tracks the time from a patient’s arrival at the hospital to the time he/she receives intervention, such as angioplasty, which uses a balloon to open up a blocked blood vessel. The longer the door-to-balloon time, the greater the chances of damage to the heart muscle.

The study found in cases where CodeHeart was used, door-to-balloon time was reduced from 149 minutes to 103 minutes. As a patient is in transit, the hospital team can guide first responders on interim care, as well as mobilize and prepare teams for treatment once the patient arrives.

The application has been in use for several years at the hospital, which was developed by Dr. Satler, through collaboration, first with AT&T™ and now with Vidyo. It is currently being used at 10 area hospitals that refer patients to MedStar Heart & Vascular Institute.

“This is an exciting advancement for MedStar Heart & Vascular Institute and our community,” added Dr. Satler who is the study’s co-author. “Through technology like this, we are able to save more lives and achieve faster treatment times than we could have imagined five or ten years ago.”

2015 Resident Match

MedStar Health and MedStar Washington Hospital Center did well in this year’s National Resident Match Program (NRMP). MedStar had 44 programs in the Match, with 305 available positions; 291 positions were filled in the match, with 14 unfilled during the Match but filled in the Supplemental Offer & Acceptance Program (SOAP).

At the Hospital Center, we will welcome the following number of new residents:

- 2 Dermatology
- 10 Emergency Medicine
- 24 Internal Medicine, Categorical
- 21 Internal Medicine, Preliminary
- 8 Internal Medicine, Primary Care
- 2 Internal Medicine, Dermatology
- 10 Ob/Gyn
- 5 Surgery
- 10 Surgery, Preliminary
- 1 Vascular Surgery

In Memoriam

James A. Curtin, MD, the first chair of Medicine at MedStar Washington Hospital Center, died in March.

A longtime member of the Medical & Dental Staff, Dr. Curtin was remembered by Neurology Chairman Robert Laureno:

“Dr. Curtin built a large, full-time staff, for the Department of Medicine, with chairs in all specialties, including Dermatology and Neurology, which later became separate departments. He accomplished this while welcoming participation of the private internists in the teaching program. The Medicine residency was considerably enlarged and strengthened during his long tenure. He nurtured residents interested in Infectious Diseases, and two of them succeeded him as Infectious Diseases division heads, Dr. Charles Levy and the late Dr. Margo Smith. I remember him as a fine and fair man.”

Dr. Curtin received his medical degree from the University of Buffalo Medical School. In addition to being chair of Medicine, he also served as director of Medical Education. His family has asked that memorial donations can be made to The Needy Sick Fund at the Hospital Center Foundation.
Please visit http://cme.medstarwashington.org for updated conference information or call 202-877-8200.
For Lorena LoVerde, chief resident of Ophthalmology, the memories of the first month of her residency remain forever seared into her brain.

A few days into her residency, Dr. LoVerde recalls being paged to the Emergency Department. A teenage girl had been stabbed right above her eye, and had developed a hematoma, one of the few ophthalmological emergencies.

“The ED doctors looked at me and said, ‘Oh good, Ophthalmology is here,’ and I remember panicking and calling for another resident, saying, ‘I need to do something quickly, but I don’t know how!’”

Three years and a chief residency later, Dr. LoVerde can laugh about that moment of panic, which now seems like a lifetime ago. Those visceral memories have afforded her the empathy to support incoming residents in any way she can.

“You can see the emotion on their faces—they’re so scared and just trying to absorb every word, and they come so far, so fast. For me, the most rewarding part about the chief residency is helping to see them through those first months of uncertainty.”

Dr. LoVerde attended The Johns Hopkins University as an undergraduate, and Stony Brook University School of Medicine for her medical degree. She entered medical school presuming she’d pursue Pediatrics or Internal Medicine, specialties where she saw the personal relationship that could develop over time between patient and doctor. That she found herself loving the surgical rotation caught her by surprise.

She spoke to a mentor and shared that she felt intrigued by surgery, but wanted a field with patient continuity, and the opportunity to develop a rapport. He advised her to consider Ophthalmology, telling her, “It sounds like everything you’re looking for.”

Dr. LoVerde took his advice, and spent a few weeks of an elective rotation in Ophthalmology. She found she clicked with the specialty even more than she’d anticipated. In addition, with the emphasis on patient relationships and opportunities for surgery, Dr. LoVerde found the diagnosis of pathologies challenging.

This July 1, she will begin a cornea fellowship at the Cincinnati Eye Institute. “I’m honored and excited to have been accepted,” she says.

Following that fellowship, Dr. LoVerde will return to the Washington, D.C., area, where her husband works. The couple married last year, just as she was onboarding for the chief resident role.

That meant that personal details, including a honeymoon, had to be postponed. Her husband must be very understanding, since she’ll be putting it off for at least another year: her fellowship start date offers no downtime, post-residency.

“But July 2016, it’s going to happen!” Dr. LoVerde says. ■

— Maggie Master
For Nnenna Oluigbo, MD, her training as an internist has been as much about “where” she’s practiced medicine, as it has been “what” she’s practiced. Having trained in her native Nigeria, in England and in the United States, Dr. Oluigbo—now an attending physician in Internal Medicine at MedStar Washington Hospital Center—learned three very different approaches to patient care. She has taken practices from each country to find her own path as an internist.

Dr. Oluigbo earned her medical degree from the College of Medicine, University of Nigeria. “Nigeria is a developing country, so there isn’t a lot of money for medical care,” Dr. Oluigbo explains. “If someone has a heart condition, you use your stethoscope to make a diagnosis, rather than getting an echocardiogram. Patients have to pay for every test, so doctors are trained to develop very good clinical skills.”

In England, where Dr. Oluigbo completed part of her postgraduate training, she found she could request an echocardiogram easily enough—if she could prove unequivocally the patient needed it. “We were taught to listen and feel with your hands. If you ordered a CT scan of the chest, it had to be absolutely necessary, even though everyone had access to medical care under England’s universal healthcare system.”

When Dr. Oluigbo came to the United States in 2008 to complete her residency at Saint Mary’s Hospital, a Yale-affiliated Internal Medicine program in Waterbury, Conn., she got a different perspective of medical practice. Investigations and tests were very readily available, but she also discovered a disparity of care existed, compared to the universal healthcare system in England.

“The actual practice of medicine wasn’t so different, with the focus in both England and Saint Mary’s on high-quality care. The change was that some patients had excellent insurance, and others didn’t have insurance at all. That sometimes made a difference as to when patients came to see us for help.”

For Dr. Oluigbo, the emphasis on clinical skills was always standard practice, regardless of access to resources.

“I prioritize getting a clinical history and performing a complete physical exam. I find that if I just listen to a patient I can get the story, by the time we’ve finished the exam, I’m two-thirds of the way to getting the diagnosis,” she says. “This would help reduce waste, in the form of needless exams and tests.”

Dr. Oluigbo came to the Hospital Center in 2013 from the Ohio State University Medical Center, where she was an attending physician and clinician educator/assistant professor in Internal Medicine.

“Coming from a smaller community-based teaching hospital without an electronic medical record to a large system with very specialized but accessible care was a shift. But having an inpatient and outpatient EMR helped tremendously with continuity of care for patients there.”

Dr. Oluigbo is passionate about medical education, and enjoys integrating teaching into patient care both at the bedside and in the clinic.

“I grew up in a teaching environment, as my father was a university professor of veterinary medicine, and I love working with residents and medical students. It’s important that we train the next generation to have a good medical foundation, not by only performing a good history and physical, but also showing empathy to our patients. There’s so much for them to learn and do at the Hospital Center.”

Dr. Oluigbo is also invested in patient health literacy and education. “We have many different levels of understanding among our patient population, and I enjoy helping patients understand why they need to take ownership of their health—why it’s important to keep appointments with us, to take medications as prescribed and to ask us questions, if they don’t understand something we’ve said.”

Dr. Oluigbo is the mother of two boys, ages 11 and 2. It’s another fulltime occupation that keeps her incredibly busy. When the family has some down time, they enjoy traveling, and have visited several cities in Scotland, England and Germany. Her older son recently visited Nigeria, where his grandparents live.

“It was a cultural shock for him,” says Dr. Oluigbo. “But it appears to have given him a better perspective on life.”

It’s likely the same perspective that continues to shape Dr. Oluigbo’s medical practice.

— Maggie Master
Physicians’ Perspective

From the Desk of…

K. Eric De Jonge, MD
Director of Geriatrics
Co-founder, Medical House Call Program

Promoting the health, comfort and dignity for frail elders is the heart of what we do. Since 1999, when the Medical House Call Program was established, we have provided primary care to more than 3,000 elderly patients in the comfort of their own homes. Currently, we have 620 active patients who live within a 25-minute radius of MedStar Washington Hospital Center. They range in age from 65 to 110, with an average age of 83, and are predominantly African-American and female. Criteria to be part of the program includes having multiple, serious chronic illnesses and a known difficulty accessing primary and acute care services.

There is consistent high demand for the Medical House Call Program. We enroll 15 to 20 new patients every month. Our mobile team consists of geriatricians, nurse practitioners, social workers and support staff, all of whom embody a holistic and compassionate approach to the care of our patients.

We also care for our patients here in the hospital, should they need more care than can be provided in the home. We have a seamless relationship with the Hospital Center Emergency Department and MedSTAR Transport, so patients can be admitted to our Geriatric inpatient service within hours, should they become unstable at home. It is a closed-loop system that works well. We are also able to coordinate hospice care for our patients with end-of-life illness.

Recently, we examined the impact of home-based primary care on Medicare costs. We found that Medicare costs were reduced by 17 percent during a two-year period, when our care for elders with severe and advanced illness shifts to the home. We also know it is often safer for such patients to receive care in the home.

There is great value and meaning in caring for patients at this profound stage in life. But when things become really hard, or if patients are doing poorly, it is important to step back, review care goals with family and loved ones, and focus on what is best for the elder. Dignity and comfort should always be the paramount goal.

For more information about the Medical House Call Program, please email karl.e.dejonge@medstar.net or call 202-877-0576.