Shared Decision-Making Labor and Delivery Team and a Grateful Military Family

Tamika Auguste, MD, Ob/Gyn; Rachael Overcash, MD, Maternal Fetal Medicine and Jane Germano, DO, Neonatal Intensive Care Unit, brought together the care team.
As we outlined in the September/October issue of Connections, our FY 18 “Reach for the Stars” program focuses on four areas that will have the greatest impact on our hospital star rating from the Centers for Medicare and Medicaid Services (CMS). Those areas include the patient experience, mortality rate, safety metrics and readmission rate.

I’m happy to report that with our ongoing quality and safety efforts, we’ve made good progress during the past two years in improving the mortality rate, safety metrics and readmission rate. We have a new chief experience officer, Shawn Smith, who will lead our efforts to improve the patient experience, but physicians and Advanced Practice Clinicians can take immediate steps to affect this metric. As an example of how you can positively impact the patient experience, let’s look at hospital throughput, and how setting the expectation for a hospital stay helps the patient, and helps us.

Setting Expectations
You’ve heard me say that discharge planning begins on admission. Making sure patients and their families understand what discharge means and when it will happen sets the timeline for each inpatient stay.

For example, Endocrine Surgery patients are told during their first pre-op office visit when discharge will occur. That discussion is considered part of the plan of care. Patients and their families are given the approximate number of days the patient will be here, and learn that the patient must leave the room by 11 a.m.

If a family member needs to rearrange a work schedule to pick up the patient, the driver has a better idea of when discharge will take place. The patient and family understand that if the driver can’t come until later in the day, the patient will wait in the Discharge Hospitality Center (DHC), where there are comfortable chairs, snacks, reading materials, a television and a patient care technician on duty. They know that if there are medications to be taken home, those meds can be delivered to the DHC.

For patients admitted through a Medicine service and those brought in emergently, providers will have a different type of discussion about discharge, as the date may fluctuate. The goal is the same, however: no surprises for the patient and family about the time and process for discharge.

An Important Discussion
Here’s why the discharge conversation matters: when you look at our metrics, most discharge orders are written between 12:45 and 1:15 p.m., which means the patient generally leaves the hospital between 3:45 and 4:15 p.m. Because the room must be cleaned, and the next patient transported from the Emergency Department or wherever he or she is boarding, it might be 5:30 or 6 before the next patient is settled into the room.

We need to alter that timeline. All discharge orders should be written by 9 a.m., and if the patient’s ride home isn’t available by 11, our inpatient teams of nurses and residents know that the patient should move to the Discharge Hospitality Center. All attending physicians should support our nursing colleagues, as they prepare your patient to be transported to the DHC. Please don’t allow your patient to stay in the room through lunch, or until the ride comes later in the day.

Having everyone on the same page for our discharge process helps all of our clinical teams plan for the most effective care for our patients. Most importantly, understanding when discharge will take place is one less thing for patients and their families to stress about, as the patient heals.

Gregory J. Argyros, MD, MACP, FCCP is sr. vice president, Medical Affairs and Chief Medical Officer and Designated Institutional Official at MedStar Washington Hospital Center. Contact him at 202-877-6038 or gregory.j.argyros@medstar.net.
Urologists Discuss **Advanced Imaging** versus **Biomarkers**
For Men with an Elevated PSA and a Prior Negative Biopsy

**Prostate cancer** is the most frequent solid organ cancer in men, and it is the third most common cause of cancer-related death. National guidelines continue to recommend PSA screening of men less than 70 years old for prostate cancer, after engaging in shared decision-making. An elevated PSA will often lead to a prostate biopsy. A traditional needle biopsy of the prostate, performed for an elevated PSA, samples less than one percent of the prostate. Unfortunately, the false negative rate for a prostate biopsy can approach 35 percent. Of the 1.3 million men who undergo a prostate biopsy every year, less than 1/3 result in a diagnosis of prostate cancer.

Managing the patient with an elevated PSA and a prior negative biopsy can be challenging. Repeat biopsy can be associated with bleeding or infectious complications, and can result in another false-negative result. Alternatively, a low-grade, indolent prostate cancer can be identified, which often leads to patient anxiety and over-treatment. The ideal test is one that will aid in the detection of clinically significant prostate cancer, which we define as a tumor that will likely progress to locally advanced/metastatic disease without treatment, and is determined by tumor grade and stage.

Multiparametric MRI (mpMRI) has emerged as a more accurate imaging modality for the prostate, and improves the diagnostic accuracy of detecting clinically significant prostate cancer over PSA alone. Suspicious lesions seen on mpMRI can then be specifically targeted during repeat biopsy, using novel biopsy platforms that fuse MRI images to real-time transrectal ultrasound. In men with a prior negative biopsy, 72 to 87 percent of tumors detected by mpMRI are clinically significant. The negative predictive value is around 75 to 89 percent. Studies looking at cancers missed by mpMRI were more often low-risk, indolent cancers, which may not benefit from treatment.

In men with an elevated PSA but a prior negative biopsy, 32 to 39 percent may still harbor an unidentified prostate cancer. In the community, the urologist often offers such patients a repeat biopsy, which can be morbid and result in another negative result. I agree with Dr. Stamatakis that a prostate MRI followed by a MRI-Ultrasound Fusion biopsy is an excellent option. The caveat is that this technology is not available to most urologists, and requires proper MRI machines, radiologists accustomed to reading prostate MRIs and special biopsy platforms. For this reason, I advocate for the use of biomarkers in men with an elevated PSA and prior negative biopsy, as a first step prior to repeat biopsy.

PCA3 is a urine test for RNA that is extensively studied and FDA approved for men with a prior negative biopsy. The sensitivity is 90 percent, and the specificity is 50 percent. A higher PCA3 score is also indicative of higher grade cancer. Advanced blood-based biomarkers, such as the PHI score or 4KScore, combine PSA, free-PSA and pre-cleavage forms of PSA (kallikrein proteases or proPSA) and can increase the diagnostic accuracy of detecting clinically significant prostate cancer over a repeat PSA alone.

Finally, genomic biomarkers are now available to evaluate gene changes in the benign biopsy samples that would predict concomitant occult prostate cancer. ConfirmMDx® uses the prior negative biopsy specimens to assess for an epigenetic field effect due to prostate cancer. In other words, a negative biopsy sampled near a focus of prostate cancer will still show a “cancerization” process at the DNA level. This test has a negative predictive value of 90 percent, and in clinical practice has been shown to decrease repeat-biopsy rate from 43 percent to 4.4 percent, thus avoiding a number of unnecessary biopsies.

In conclusion, biomarker tests can be used successfully to better select patients for repeat prostate biopsy, thereby reducing unnecessary repeat biopsies and aid in the selective detection of clinically-significant prostate cancer.
Jennifer Weber was determined to do everything she could to save her unborn child. When doctors in her home state of North Carolina told her the only hope was to travel to Washington, D.C., for maternal fetal care at MedStar Washington Hospital Center, with subsequent pediatric cardiac care at Children’s National Health System. The active Air Force Technical Sergeant and her husband Nate, also an active duty Air Force Technical Sergeant, immediately packed up and began driving.

Ms. Weber had known for several weeks that her baby had a congenital heart defect and a diagnosis of Trisomy 21. She had also been told that cardiac surgery at Children’s would not be possible until her baby, already named Olivia, reached 34-36 weeks, or 2,000 grams. When her specialist in North Carolina saw hydrops on ultrasound at 30 weeks, 3 days gestation, she was told the situation was grim.

“This was the first time I was truly, legitimately scared,” Ms. Weber recalls. “The doctor offered us comfort care in North Carolina, but I said to him, ‘What if she doesn’t die? I wanted her in D.C.’”

Doctors in North Carolina sent records and made calls to the Special Moms/Special Babies program at the Hospital Center, and Weber and her husband made the six-hour trip through thunderstorms and traffic delays, arriving late in the evening on Friday, Aug. 11.

A Complicated Case
Doctors at Children’s had already met Ms. Weber and were familiar with her case, but physicians at the Hospital Center were only just learning of baby Olivia’s complex heart issue, specifically an endocardial cushion defect.

Tamika Auguste, MD, was the obstetrician working that night. “Our plan was to admit Jennifer to Labor & Delivery, and have maternal fetal medicine see her the next day,” recalls Dr. Auguste. Fetal monitoring, however, showed a Category III tracing, indicating Ms. Weber’s baby was in distress, and the plan changed suddenly.

Recognizing the severity of the situation, Dr. Auguste conferred with Maternal Fetal Medicine Specialist Rachael Overcash, MD, MPH, who agreed the baby’s prognosis was poor. Neonatologist Jane Germano, DO, working her first overnight at the Hospital Center, was also consulted, and spoke with Ms. Weber about issues related to prematurity, as well as what measures could be taken if the baby was born.

“The doctors listened to me,” says Ms. Weber. “They didn’t crush my hope. We drove to Washington, D.C., in a thunderstorm for a chance to meet our baby, and we were given that chance.”
“What was challenging for everyone is we did not know Ms. Weber, and it was a complicated case, dropped on our doorstep at 11 p.m.,” says Dr. Overcash.

By 1 a.m., the three physicians, along with residents Lauren Caldwell, MD, and Margaret Burke, MD, and nurses Sherri Abdalla, RNC-OB INPT, BSN, and Rachel Katter, RN, BSN, knew the options were limited. An ultrasound showed scalp edema and severe hydrops, with fluid in baby Olivia’s lungs, abdomen and heart. Blood flow through the umbilical cord was also abnormal.

**Difficult Discussions**
The team reviewed the findings with the Webers, offering the couple either delivery or expectant management. They stressed the likelihood of survival was low with either decision. The Webers made an important shift in their hopes and expectations: They asked the team to do everything possible so that they could hold Olivia after she was born, even if only for a few brief minutes.

“I told the doctors, ‘this baby cannot die in me,’” Ms. Weber recalls. “I had a miscarriage a year earlier, and that baby died inside of me. I told them that I know all signs point to death, but she isn’t dead yet, and I won’t give up on her.”

Armed with that information, the medical team quickly devised a plan to proceed with a Caesarean section, with the hope of stabilizing the baby, followed by an immediate transfer to Children’s. They also worked with Ore Oluwa, CRNA, to ensure that Ms. Weber would be awake, to see and hear when her daughter was born.

With a myriad of healthcare professionals in the operating room and nearby, including the transfer team from Children’s, Dr. Auguste delivered baby Olivia. Within minutes, Dr. Germano intubated the 3-pound, 9-ounce infant.

“She responded perfectly,” says Dr. Germano. “She pipped up, and she was moving. I put in an umbilical line and we stabilized her.” After approximately 30 minutes of medical care, Olivia was transferred to Children’s.

**A Clear Plan**
While Ms. Weber believes her faith and personal convictions were instrumental in seeing her daughter alive, she knows the medical care she received played a vital role.

“The doctors listened to me,” says Ms. Weber. “They didn’t crush my hope. We drove to Washington, D.C., in a thunderstorm for a chance to meet our baby, and we were given that chance.”

“This is a perfect example of shared decision-making,” adds Dr. Auguste. “I went in with one plan. Jennifer wanted a different plan, and together, we all made the best plan possible.”

Dr. Germano agrees. “This was a very complex case, but once we all conferred and spoke with the family, we had a very clear plan. This was one of those times where a family just wanted time to see their baby, and everything was done to give her the best fighting chance.”

“It’s just amazing to me,” Ms. Weber says. “Olivia was born to touch people, and nearly every person in the operating room had tears in their eyes when she was delivered.”

Dr. Auguste agrees. “Jennifer and her baby touched a lot of lives. It was a very tiring and emotional night. But what stands out to me is how grateful they were, and how clinically strong our team was. Jennifer and Nate got to see and hold their baby.”

“I can’t imagine any other team of people doing this,” says Ms. Weber. “They were the right doctors, the right nurses and the right residents. At exactly the right time. And I will never forget them.”

*Editor’s Note: Olivia Jean Weber died Aug. 17, 2017, five days after she was delivered at the Hospital Center. Her brief life surpassed medical professionals’ expectations, and allowed Jennifer and Nate Weber time with their daughter that they will always treasure.*

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**Special Moms/Special Babies**

Special Moms/Special Babies is a unique obstetrical service at MedStar Washington Hospital Center that provides coordinated, focused pregnancy care for mothers who themselves have a congenital health problem, or who are carrying babies with congenital problems.
Streamlining, Improving Education: MedStar Health Academic Consortium

Take 1,100-plus residents and fellows in 80 training programs across six hospitals, add thousands of hours of continuing medical education across nine providers, and what do you get? A gaggle of complex educational programs, administered by scores of personnel.

Now, there is a better way to conduct this important business: the MedStar Health Academic Consortium. The end result will be a single source for graduate medical education, along with a single source for continuing medical education.

“The consortium offers us a single, organized approach to graduate medical education (GME) across MedStar, with a distribution of resources and increased flexibility in training programs,” says Gregory J. Argyros, MD, FACS, FCCP, senior vice president of Medical Affairs & Chief Medical Officer, and Designated Institutional Official for MedStar Washington Hospital Center.

Continuing medical education (CME) also stands to benefit from the consortium, Dr. Argyros adds. A single accreditation that covers all hospitals will streamline administrative efforts, plus improve education overall. “CME is becoming inter-professional, with a focus on how the healthcare team can work together to deliver optimal care.”

A Centralized Approach

Jamie Padmore, DM, MSc, corporate vice president, Academic Affairs, oversees the mammoth task for both GME and CME. “Our educational programs used to be like a federation of states,” she explains. “As Medlanctic joined with Helix Health and became MedStar Health, this federation had to adapt.” Padmore has worked to streamline and integrate operations into a more centralized approach.

“We don’t want to reinvent the wheel over and over again,” she notes. “Since 2000, when Georgetown University Hospital joined MedStar Health, it has made good sense to have a single contract and salary structure for GME across the system, based at MedStar Georgetown University Hospital. Medical education has been on the forefront of this system-wide approach from the beginning.”

Phase 1 has been to establish a single hiring entity that manages hiring, orientation, payroll and benefits for residents and fellows at all MedStar hospitals. Because the bulk of that infrastructure was already at MedStar Georgetown, it made sense to keep it there.

Jennifer Remington, MHSA, corporate assistant vice president for GME, is leading the effort to streamline GME. With a single human resource function based at MedStar Georgetown, “We’ve streamlined administrative processing for onboarding and contracting with residents and fellows,” Remington says. “As a result, residents have access to important university resources, such as the Dahlgren Memorial Library, plus it allowed MedStar to reinvest in resources such as UpToDate®, a software program that provides access to medical journals and clinical data.”

Clinical Faculty Benefits

The 1,500-plus faculty members across MedStar will benefit. “There is greater opportunity for faculty development and shared resources,” Remington states. “We’ve seen really interesting relationships develop among our program directors and faculty, with people drawing on strengths of other programs.”

Programs are still administered at each hospital, however, with their own faculties and program directors. Also, the match process still resides at individual hospitals. One of the next steps will be to evaluate administrative support for programs at individual hospitals, Remington notes.

Phase 2 has been to bring accreditations under one roof. The Accreditation Council for Graduate Medical Education (ACGME) is the accrediting body for GME. Until now, each hospital and each program within that hospital applied for and maintained its own accreditation.

Under the new system, one institutional accreditation as a consortium will span all hospitals. “It will be easier for program directors and faculty, with less bureaucracy with a single accreditation, more freedom to work together and fewer obstacles to overcome, just to provide good education,” Padmore says.

Individual programs will still be responsible for their own accreditation. Still, programs at different hospitals increasingly are working together to share best practices, both administratively and clinically. For example, general surgery programs at the Hospital Center, MedStar Georgetown and MedStar Union Memorial Hospital meet regularly to plan simulations. Remington also anticipates the development of more regional programs that allow residents to rotate within the system to gain learning experiences in different settings.

Integrating with SiTEL

CME—now known simply as Continuing Education or CE—is also becoming centralized. Bill Sheahan, corporate vice president for MedStar’s Simulation, Training & Education Laboratory (SiTEL), has partnered with MedStar Academic Affairs to integrate CME staff and operations from across the system into SiTEL.

“We’re working to consolidate accreditations and provide improved coordination and access to CE for all of our associates,” Sheahan says. “It’s important that we continue to support the great local CE programs happening today, while building new connections between programs, and tying our CE activities to quality, safety and any emerging system priorities.”

MedStar offers three kinds of CE: regularly scheduled series, such as Grand Rounds and case conferences, tumor boards and
journal clubs; conferences or courses, including didactic and experiential, or simulation-based learning; and enduring material that is offered online.

In 2015, MedStar had nine accredited CME providers through two different accrediting organizations, and each provider managed its own accreditation, every four or six years. In 2016, MedStar Health/SiTEL applied for a single system interprofessional CE accreditation.

Mikki Ashin, director of Continuing Medical Education (CME), announced in early December that MedStar Health has been awarded Joint Accreditation for IPCE for 2 years beginning January 1, 2018 until December 31, 2019. Joint Accreditation™ is a collaboration of the Accreditation Council for Continuing Medical Education (ACCME) the American Nurses Credentialing Center (ANCC) and the Accreditation Council for Pharmacy Education (ACPE).

MedStar Health successfully met all 13 Joint Accreditation criteria and was awarded the maximum term of accreditation as an initial applicant. “I’m pleased that this change allows us the opportunity to simultaneously provide medicine, pharmacy and nursing credits through a single, uniform planning process and accreditation standard. We can improve standards and share best practices among programs,” Ashin says.

Even better, joint accreditation allows CE credit for physicians, nurses and pharmacists through one planning process and credit system. It facilitates the development of continuing education activities in educational formats, which provide members of the healthcare team opportunities to collaborate and effectively learn with, from and about each other.

This improves education overall. “This is a different way of looking at medical education,” Ashin says. “Continuing education is planned by the team, for the team.”

Dr. Argyros clearly sees the advantage in this new approach to continuing education. “Interdisciplinary team work results in the best patient care,” he says.

SiTEL: Electronic Backbone for Education

The MedStar Health Academic Consortium is fortunate to have a strong backbone to support its educational outreach. SiTEL is one of the nation’s most innovative electronic systems for educational programs.

“SiTEL is the enabling infrastructure for on-line learning—didactic and experiential,” explains Sheahan. “It involves teams of educators who build curriculum and manage content for associates across MedStar.”

The genesis of SiTEL was ER One, the disaster preparedness initiative undertaken in 2004 at MedStar Washington Hospital Center. SiTEL was so successful that in 2008 it became a corporate-wide effort.

Interactivity and collaboration are SiTEL hallmarks. “Corporate online learning used to be boring, just checking boxes,” Sheahan says. “We’re taking it to the next level, with self-directed learning that engages people.”

Courses range from complex simulations for such clinical practices as central line insertion to the Language of Caring® course now underway. And it’s not just for clinicians. SiTEL recently offered a course for environmental services associates, with a simulation that taught best practices for cleaning clinical spaces to lower the risk of infection.

Efforts are now underway to consolidate operations across the system from the bottom up and from the top down. “By connecting educational programs across all organizations from the bottom up, this will elevate all the great things happening at the local level and make them more available. From the top down, we can handle administrative tasks such as licensure as one organization. This allows us to leverage the strength of the system,” Sheahan says.

“The scale and scope of SiTEL is a real differentiator for MedStar Health,” Sheahan concludes. “Only a few other healthcare organizations have this focus on innovation.”
Lowell Satler, MD
Gold-Headed Cane Award Winner
Embodies “Ideals of a True Physician”

In his many years in the Cardiac Catheterization Laboratory, Lowell Satler, MD, has literally touched the lives of thousands of people around the world. In recognition of his “devotion to duty and patient care” that is symbolized by the Gold-Headed Cane, Dr. Satler was presented with the highest honor for 2017.

“I was surprised and honored to be accepted into this prestigious group of recipients,” Dr. Satler says. “When I received the award, I was thankful. I enjoy teaching our fellows and giving them opportunities. It’s exciting to help the physicians who are the future of interventional cardiology.”

Dr. Satler currently serves as director of Interventional Cardiology and director, Cardiac Catheterization Laboratory at MedStar Washington Hospital Center. In addition to caring for patients, he is a prolific researcher and author of scholarly publications. He also serves as a mentor to fellows, and is a member of the American College of Cardiology and the American Heart Association.

Dr. Satler’s medical education was through the Accelerated Biomedical Program at Renssalaer Polytechnic Institute, Albany Medical College. His internship and residency were at Albany Medical Center, where he served as chief medical resident before completing his fellowship in Cardiology, at the University of Alabama in Birmingham.

The tradition of the Gold-Headed Cane Award began in England in 1689, with the passing down of the same cane to physicians over a period of 150 years. John Radcliffe, personal physician to King William III, distinguished himself as “the” royal physician by carrying not just an ordinary gentleman’s cane, but a gold-headed cane, adorned by a cross bar for a top, instead of the traditional knob. Dr. Radcliffe passed on his cane to Dr. Richard Mead, beginning the legacy. The Gold-Headed Cane has been a tradition at the Hospital Center, with the tradition beginning at one of the three founding hospitals that became the Hospital Center. The list of physician awardees goes back to 1951.
Past is Prologue

by Richard Goldberg, MD
President, MedStar Medical Group

There is an inscription in the edifice of the National Archives Museum in downtown Washington, D.C.: “Past is prologue.” This quote is from Shakespeare’s The Tempest, and signifies in an eloquent way how the actions and experiences of the past form our future.

What an appropriate way to introduce the progress made in the past two years in the development of MedStar Medical Group (MMG). Across the MMG enterprise, we can identify four overarching categories that reflect a myriad of accomplishments:

- the need for efficient and scalable patient practice
- the development of more than two dozen clinical practice councils
- replacing a burning platform EHR (Centricity) with the MedConnect (Cerner) product
- the integration of the hospital-affiliated practices in the Baltimore region (what we refer to as MMG-A)

Our first priority in MMG-B has been knitting practices together - operations and performance (clinical/quality and operational); policies and procedures; and financial oversight. We are engaged in numerous workflow enhancement efforts to improve both the provider and office experience, along with the patient experience. We’ve also undertaken a number of pilots, including medication management and referral management, with a notion that anything we learn we can scale up to share with MMG-A.

Now we are seeing the expansion of this across the enterprise. On July 1, we began management of the Baltimore-based MMG-A practices. Our focus is on efficient, scalable practices. We are accomplishing this by joining forces with and using existing MMG-A structures and talent, and bringing MMG-B enhancements and best practices to MMG-A…and vice versa.

One of our major quality efforts has been the unprecedented launch and optimization of MedConnect (Cerner) in our Centricity practices. Recognizing that Centricity was an unstable, unsustainable platform, we put a system in place that we acknowledge is far from where it will be down the road. Adapting to MedConnect and its workflows has presented both operational and clinical challenges to navigate. Optimization has been underway for nine months, with more than 750 enhancements going live since January. Optimization is not a finite event. Any true and valid performance transformation effort is an ongoing, iterative and progressive - fueled by a sense of urgency to meet our clinical and operational EHR needs and expectations.

Also in the last 18 months, we’ve guided the development of what is now 26 clinical practice councils. These councils are charged with developing system-wide, evidence-based guidelines for the practice of medicine for specific service lines.

This is a tremendous amount of effort, dedication and accomplishment in our recent past, forming a powerful prologue for FY18 and beyond. Our overarching goal remains to foster cohesiveness, greater efficiencies and consistencies - from a dis-integrated to an integrated entity. I want to underscore that this is a marathon, not a sprint. An integrated, highly functioning medical group takes approximately five-to-seven years to mature. The steps we take, large and small, are building to some very great things in MMG.

MMG is a vibrant organization. Many of us think of vibrant as “colorful.” However, the root meaning of “vibrant” is constantly moving, constantly flowing. And that describes us perfectly…MedStar Medical Group is vibrant – moving and emerging in the present.
Changing of the Guard: First New Cardiac Surgery Chair in 20 Years

The new era for the MedStar Heart & Vascular Institute at MedStar Washington Hospital Center started with the opening of the metropolitan area’s only dedicated cardiovascular hospital, the Nancy and Harold Zirkin Heart & Vascular Hospital. This past August, MHVI welcomed Vinod H. Thourani, MD, as its first new chair of cardiac surgery in more than two decades, following the incredible tenure of Paul Corso, MD.

As such, it’s a new era for Dr. Thourani, as well, who—since entering Emory University School of Medicine in 1990—spent his entire career with Emory’s prestigious heart program. Now the nationally recognized cardiac surgeon and researcher is applying his expertise, experience and passion for patient care “to further secure our position as one of the nation’s premier heart and vascular institutes,” says Stuart F. Seides, MD, MHVI physician executive director.

Dr. Thourani is focusing first on an area where he is an acknowledged authority and where MHVI is already ahead of the curve: structural heart disease.

“Through innovation, research and clinical trials, we’re truly pushing the frontiers of what’s possible in cardiovascular care,” he says.

The Next Frontier
“The Structural Heart Disease Program is one of the things that really attracted me to MHVI,” says Dr. Thourani, who held the dual positions of co-director of the Structural Heart and Valve Center and chief of Cardiothoracic Surgery at Emory. “MHVI is one of a few hospitals in the country with a formal, functioning program dedicated to valve therapies.”

A relatively young sub-specialty, structural heart disease programs are devoted to repairing damages or defects affecting the heart’s architecture: its walls, muscles and, especially, its four major valves. MHVI got in on the ground floor when it became one of the first five sites in the nation to participate in the initial clinical trials for transcatheter aortic valve replacement (TAVR) a decade ago. Today, it is one of the highest volume TAVR centers on the East Coast, performing more than 350 procedures annually at the Hospital Center and at MedStar Union Memorial Hospital. It’s also one of the highest volume centers in the nation for mitral valve surgery.

Dr. Thourani intends to further advance MHVI’s leadership position in this burgeoning field, collaborating with MHVI’s internationally-known cardiology team of Lowell Satler, MD, Ron Waksman, MD and Itsik Ben-Dor, MD.

“During the last 10 years or so, we’ve made tremendous progress in understanding the valves,” says the prolific researcher, currently the national principal investigator or member of the executive committee for seven major new surgical and transcatheter trials on valve repair and replacement devices. “Now we’re applying what we’ve learned from aortic valves, to the more challenging and complex mitral and tricuspid valve disease processes.”

Toward that end, Dr. Thourani recently added the Edwards Cardioband System ACTIVE trial to MHVI’s existing research portfolio.

“Cardioband is a transcatheter-based mitral valve repair system that approaches its target through the femoral vein,” explains Dr. Thourani, ACTIVE’s co-principal investigator. “With this major study now in place, MHVI is one of the first five sites in the nation and the only one in the mid-Atlantic to be able to offer this innovative technique to qualified patients with advanced heart failure.”

By the summer of 2018, Dr. Thourani expects to introduce another pivotal FDA trial to MHVI, this one examining the JenaValve™ TAVR approach for aortic valve leakage, with additional studies anticipated along the way.

“Through innovation, research and clinical trials, we’re truly pushing the frontiers of what’s possible in cardiovascular care,” he says.

New Valve Clinic
Months before Dr. Thourani’s arrival, Drs. Corso and Satler were planning a dedicated Valve Clinic to consolidate under one team traditional surgical, minimally invasive and transcatheter-based care for aortic, mitral and tricuspid valve patients. By having each structural heart patient evaluated by a cardiologist, interventional cardiologist, echocardiographer and cardiac surgeon, patients would benefit from multiple perspectives on treatment and probable outcomes, for more informed patient choices.

The whole concept resonated deeply with the new cardiac surgery chief.

“In the best hospitals, the days of doctors making complex cardiovascular decisions in a silo are over,” says Dr. Thourani, who is experienced and equally comfortable performing open surgical, minimally invasive and transcatheter approaches. “When multiple specialists come together, contribute their unique perspectives and work out the best overall approach, patients benefit. It really amounts to personalized care that is tailored to what’s best for each individual, not to what technique an individual physician knows best.”

“For patients, it’s the best of all possible worlds.”

Academic Medicine, Minus the Hurdles
Dr. Thourani credits MHVI’s many tangible accomplishments in patient care, education and research with luring him away from Atlanta. But there was something else about MHVI that really sealed the deal.
“There’s a history and culture of innovation in patient care here that’s just remarkable,” he says. “MHVI combines the benefits of an academic medical setting with efficiency and flexibility. As a result, its clinicians/researchers can quickly bring promising new therapies and techniques to bear upon their patients’ care, even as they continue to produce excellent outcomes for the sickest of the sick. That’s a very satisfying mix to me.”

Something else that’s satisfying to Dr. Thourani is bringing his wife Marissa and 18-month-old Connor closer to family members in Baltimore and Hagerstown.

“It’s been great being able to spend time with Marissa’s relatives,” he says. “As an added benefit, her grandparents also have a house in Rehoboth, and we both love the beach—any beach, anywhere, in any country—and go as often as we can.”

Not surprising, since he grew up so close to the Atlantic.

A Lifelong Passion

Born in India, Dr. Thourani and his family came to the United States when he was five years old. After a brief stint in Brooklyn, his physician parents moved the family to South Carolina, near Myrtle Beach, for a “safer, slower, gentler environment.” There, Dr. Thourani’s love of both science and the sea took root, and blossomed.

“From the time I was only 8 or 9, I’d spend summers going to my father’s cardiology clinic, where he’d let me use the stethoscope, watch EKGs and just hang around,” he says. “It was great! I even remember thumbing through Hurst’s classic text book, ‘The Heart.’ I was sure I’d be a cardiologist just like dad when I grew up.”

He remained true to those childhood ambitions, but with a slight detour along the way.

“In medical school, I simply fell in love with anatomy, and then surgery,” he relates. “I never looked back, much to my father’s disappointment at the time. I know he had hoped that, one day, I’d take over his practice. But surgery was the right place for me.”

After a research fellowship in cardiothoracic surgery, he delved even deeper, becoming mesmerized by valves.

“They’re like little individual organs that live inside a larger one,” he says. “I was fascinated by the complexities of their repairs or replacements.”

Fortunately for his patients and MHVI, that fascination has only deepened and intensified over the years.

“The field of cardiovascular care, and particularly structural disease, is only going to grow in the future, and with its emphasis on structural heart disease, MHVI is on top of that wave,” Dr. Thourani concludes. “Working as a team, I want to contribute to MHVI’s reputation for excellence in patient care and satisfaction, education and research, and help move us to the next level. These are exciting times in heart care, and I’m thrilled to be at the epicenter here at MHVI.”

Dr. Thourani joins an impressive team of MHVI cardiac surgeons:

Reza Abrishamchian, MD
Ammar Bafi, MD
Steven Boyce, MD
Paul Corso, MD
Jennifer Ellis, MD
Michael Fiocco, MD
Dipin Gupta, MD
Ezequiel Molina, MD
Christian Shults, MD
MedStar Health is closer to a single, unified electronic record.

With the MedConnect Phase III Inpatient Project was successfully implemented at all MedStar hospitals already utilizing MedConnect, almost all physician/APC documentation, including Progress Notes, Op Notes and H&P’s are completed in MedConnect. Amalga is no longer used to create clinical notes at MedStar Washington Hospital Center, and the Amalga Note Writer tool (Amadeus) has been retired. Physicians/APCs can still view historical notes that were created in Amalga.

One of the universally-liked pieces of the MedConnect III project is Dragon Dictation. Using Dragon significantly increases the efficiency of using the MedConnect EHR. Users can see the text within MedConnect while dictating, and corrections can be made in real time. Dragon allows autotext to populate saved templates for the history and physical, review of systems, physical exam and procedures. Ongoing Dragon dictation classes are available to provide basic or advanced skills, according to the needs of the attendees.

MedConnect has ongoing system upgrades and new features in its enhancements:

- **Resident’s Note:** When the resident signs and sends a preliminary note to the attending physician, the attending can save the note, and keep it in the Message Center until he/she is finished modifying the note, and then signs it. The attending is no longer forced to sign modifications as soon as they are made.

- **Dropdown Lists in Auto Texts:** Users can create a personal auto text and add a dropdown list of options.

- **Insert Tagged Data:** Users can tag text and immediately insert it into their documentation while working within the Provider View (HPI, ROS, PE, &/or A&P components).

- **Changes to the Home Medications Component:** The home medications list has a visual indicator of the remaining prescribed medication supply and the ordering provider’s name. The reminder button indicates whether the Meds History is incomplete.

- **Within the Manage Auto text tool:** It is now possible to search the list of auto texts by “key word” to see what is available, rather than scrolling through the list. Personal and global auto texts are displayed on separate tabs, making it easier to locate personal auto texts. Additional auto texts are now available. For example, type “.lab” to see list of lab auto texts, including the new “.labslast24hours, .labslast48hours, .labslast7days.”

- **To Learn More:** Refer to eCoach (Open MedConnect > View > eCoach) and search “Upgrade” for a detailed job aid, such as September 2017 Upgrade: Physician Highlights, 8/7/2017.

MedConnect enhancements arriving in 2018 include:

- **Biomedical Device Integration (BMDI):** Users in procedural areas and the dialysis unit will be able to validate and upload clinical data directly into the patient’s chart from biomedical devices, including dialysis machines and infusion pumps. BMDI is already available in ICUs at the Hospital Center, and Infusion Management will soon become available to Med/Surg units.

- **Heparin Ordering and Monitoring:** Physicians/APCs will order heparin infusions and review nursing documentation within MedConnect, eliminating paper orders and nursing paper flowsheets for heparin drips.

- **PowerChart Touch:** Physicians/APCs will be able to use their personal Apple® mobile devices to access MedConnect for both ambulatory and inpatient charting, using a mobile application. Mobile charting features will include access to
message center and patient lists; review of patient charts; review of diagnostics and clinical results; review of allergies, problems and histories; refill or add new single ingredient medication orders and start clinical notes, using Dragon dictation.

- **Cerner Image Capture**: Physicians/APCs will be able to capture clinical images using their personal Apple mobile devices and upload them directly into the patient’s chart. The application will not store personal health information (PHI) on the mobile device.

- **HealtheLife**: Patients will be able to utilize this portal within the MedConnect application to improve communication with caregivers. It will provide patients with a limited view of their chart, including lab results, diagnostic reports and appointment schedules. Lab results and diagnostic reports will be visible to the patient 72 hours after posting, giving the physician/APC time to contact the patient. This access will improve communication of pertinent results to the patient.

- **Additional Site Implementation**: Implementation of MedConnect at MedStar Southern Maryland Hospital Center, MedStar St. Mary’s Hospital and MedStar Montgomery Medical Center will begin in fiscal year 2019.

- **Future MedConnect Expansions**: PeriBirth® and ARIA® functionalities will migrate to MedConnect.

- **Registration and Billing**: Registration and billing services will begin migration to MedConnect in FY 19, to streamline the registration and billing processes.

Please contact the Medical Informatics team for more information or assistance with using Dragon or MedConnect, at 202-877-CMIO (2646), or page/text page at 202-801-2327, or email WHC-CMIO@Medstar.Net.

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**Additional MedConnect Resources to Request MedConnect Enhancements:**

- Please complete the MedConnect Enhancement request form and submit it to MMG-MedConnectEnhancementRequest@MedStar.net.

- Received enhancement request will be reviewed and prioritized by the specialty's Clinical Practice Councils (CPC) EHR subcommittee.

- Upon CPC review and approval, the enhancement request is submitted to the Clinical Documentation Enhancement Council (CDE) for evaluation, prioritization and placement into production.

- For any specialty not represented by a CPC, the requestor should complete and submit the MedConnect Enhancement request form and the CDE will foster the request through the process.
Erika Page, MD
Emergency Medicine

During her sophomore year of college at Rutgers University-New Brunswick, Erika Page received an email that made her stop and take notice: It asked if she’d like to come learn more about working in emergency medical services and paramedics for Franklin Township, where the university is located.

That email is a big reason why Dr. Page is now a chief resident of Emergency Medicine at MedStar Washington Hospital Center. Dr. Page, who’d spent her freshman year as a college athlete, had decided to take a step back from sports, but missed the camaraderie of a team. She thought long-term, she might be interested in health care, but she wasn’t sure about medical school, so she decided to answer that email.

Dr. Page began riding with the EMS team, and it wasn’t long before she switched over to the fire department. She was one of about three women of a team of 30 firefighters at that time.

“People who tend to gravitate toward EMS often get lured into firefighting,” Dr. Page notes.

For a former athlete in search of a team, she suddenly felt as though she’d found a home. “They call it a brotherhood,” Dr. Page says. “Everybody is family. It’s a pretty powerful feeling of camaraderie and teamwork.”

Dr. Page says that she is working to bring a similar philosophy of family and team to her efforts as a chief resident. “It’s that balance of being a leader and a co-resident,” she says. “You’re trying to do the best job you can, while also being an advocate for those you work for, the residents. In fire, you’re working for the person next to you. Success is only team success.”

When Dr. Page decided to pursue medical school, she was hesitant to be the stereotypical EMT who pursues emergency medicine. When she transitioned to Rutgers Robert Wood Johnson Medical School, she says she went in, thinking, “I’ll find something else.”

But one day, an advisor pulled her aside, and told her what she already knew in her heart: Emergency Medicine was a good fit.

When asked to describe what she loves most about emergency medicine, Dr. Page has a hard time narrowing it down. “The people who work here, the pace, the idea that you never know what’s coming next,” she says. And again, team. “In EM, there’s this understanding that doctors, nurses, clerks, technicians—we’re all in it together.”

Following her chief year, Dr. Page plans to pursue an emergency medicine ultrasound fellowship. “I think it will make me a better physician, and there’s the chance to be involved in resident and medical student teaching,” she says, noting that the ultrasound teams at the Hospital Center and at MedStar Georgetown University Hospital have proven themselves to be incredible models.

Dr. Page received additional experience with ultrasound, when she accompanied Emergency Medicine attending Jennifer Thompson, MD, on a trip to the Navajo reservation at Gallup, New Mexico. There, along with other volunteer physicians, they assisted the Indian Health Service in providing medical care. “I discovered I liked working with ultrasound, and I appreciated that it can save patients tremendous time, including a possible transfer to another facility.”*

Dr. Page also has a keen interest in wilderness medicine, and serves as a mentor to others who want to learn more about it. She teaches a first responder course for the Wilderness Medical Society™, in association with the Virginia Tech Carilion School of Medicine and Research Institute. She hopes to share her knowledge with others in the MedStar Emergency Medicine residency program later in June, with a wilderness first responder day.

As Dr. Page heads into the second half of her chief experience, she has one primary objective, which, not surprisingly, is rooted in team: “I want to finish with as strong a foundation as I can, hopefully leaving the program better for the next person.”

*Editor’s note: the story about the volunteer efforts of Dr. Thompson and Dave Milzman, MD, at the Navajo reservation is in the January/February 2017 issue of Connections. You can read it online: https://www.medstarwashington.org/NavajoVolunteer
One afternoon last year, a patient in active cardiac arrest arrived at MedStar Washington Hospital Center, via the MedSTAR Transport helicopter. At that time, Rahul Bhat, MD, was the associate program director for the Emergency Medicine residency program. He had been at the Hospital Center for 10 years. But he recalls this event as a career-defining moment, because of the pride he felt in watching his residents save the patient’s life.

Dr. Bhat says, “My team of residents was able to successfully resuscitate the patient. Two days later, the patient was up and talking, and able to walk out of the hospital, without long-term neurological effects.”

It’s a memory that Dr. Bhat keeps at the forefront of his mind, mostly because it exemplifies all that he loves about his colleagues and his job.

“I had the resources I needed, and people I could trust. Trauma surgeon Christine Trankiem was at my side, along with the two residents on my team. That life-saving moment for that particular patient made me realize how proud I am to be working here.”

This July, Dr. Bhat took on the role of Program Director for the MedStar Georgetown University Hospital/MedStar Washington Hospital Center Emergency Medicine Residency Program.

To spend even five minutes speaking with Dr. Bhat is to understand the importance of team, and everyone who makes up the residency program’s “family.” His comments are like those of a proud parent.

“I couldn’t ask for a better team to work with, in terms of support and trust,” he shares, and adds as a source of pride that one of his new associate program directors, Joelle Borhart, MD, is a graduate of MedStar’s residency program, while the other, David Carlberg, MD, has been with the team for seven years.

That type of tenure and retention from residency to MedStar faculty is noteworthy for Dr. Bhat. “Forty percent of our alums stay with us, which is a fairly unusual number.” In part, Dr. Bhat, himself an alum of an earlier iteration of the residency program, attributes that strong retention to an exposure to multiple training environments. Physicians in the emergency medicine residency train across seven different MedStar hospitals, as opposed to just the Hospital Center and Georgetown.

“I think they feel well-trained, and there are different environments to choose from, so they can usually see themselves working in one of those when they’re finished with the residency program,” he says.

Yet it’s also clear from Dr. Bhat’s sense of team, and the sacredness with which he treats his residents, that the group’s retention is not simply “location, location, location.”

“I’ve always liked the idea of teaching,” Dr. Bhat says. “You’re helping the next generation of doctors get better, and solidifying your own skills. Teaching has always been the foremost part of what I do.”

As Dr. Bhat sets a vision for his time as program director, he was most focused on matching a great next class. His confidence in the structure of the program and educational content has freed him to consider other priorities, such as building additional fellowships and continuing to recruit graduates to stay within the MedStar faculty.

The MedStar family feeling extends beyond the Emergency Medicine residency program to Dr. Bhat’s own home, and his self-described nuclear MedStar family. His wife works as a pediatrician in MedStar Georgetown University Hospital’s Emergency Department, and both of his children were born at a MedStar hospital.

With two working parents and two active children, Dr. Bhat and his wife have a shared, color-coded Google calendar, to keep everyone’s school and work activities coordinated. The calendar lets them see at a glance what is going on for each family member for the next day, week and month.

“Luckily for us, school for the boys is right across the street, which makes life a lot easier,” Dr. Bhat says. “However, every weekend, we try to have one activity for the entire family, and one activity for each child. My wife and I also try to schedule a date night every couple of weeks.”

Parenthood also means learning some interesting new things that are very different from Emergency Medicine, he adds. “My six-year-old is into dinosaurs, so I can identify any type of dinosaur from any time period—Triassic, Jurassic or Cretaceous. And my eight-year-old is a Cub Scout, so activities with him include camping, outings, field trips and service projects.”
Thoracic surgery has benefitted greatly from new technologies. Robotic surgery is one such addendum to our armamentarium. The robot has enabled us to perform surgeries that were not possible before, using a minimally invasive approach. We can now work in very small spaces with maximum manipulation capability. Both robotic and thoracoscopic surgeries allow us to perform major lung resections, including pneumonectomies (removal of the entire lung) and complex esophageal surgeries with reconstruction.

The robot especially is a great tool for mediastinal tumors and foregut surgeries, including hiatal hernia, paraesophageal hernia, and Heller myotomy to treat achalasia, as it allows the surgeon to operate in small spaces with ergonomic manipulation of the instruments. The results of these minimally invasive surgeries are as good as open surgery, if not better, with equal oncologic outcomes, faster recovery and fewer complications.

Of course, not all surgeries can be performed using minimally invasive techniques. Some of the more complex reconstructive surgeries, such as supercharged jejunal interpositions (where the small bowel is used to replace the esophagus), or pleurectomies and extra-pleural pneumonectomies for mesothelioma cannot be performed with small incisions. At MedStar Washington Hospital Center, we are privileged to have specialists from other surgical disciplines who often come together, to perform these complex surgeries in conjunction.

We are trained in performing minor interventional procedures, such as endobronchial ultrasound and superdimensional navigational bronchoscopy. These procedures are offered at the most specialized centers, and are readily available to any patient who comes to the Hospital Center, to see me or Thomas Watson, MD, our regional chief of the MedStar Washington Integrated Surgery Service. We expect another surgeon to join us in January.

Research remains a priority. With equal emphasis on clinical and basic science research, we are constantly striving to improve clinical outcomes of our patients, and looking for ways to diagnose cancer early. We actively see patients in our lung cancer screening program, and are exploring ways to screen patients for esophageal cancer.

For more information, or to refer your patients, please contact me at 202-877-8115.