From Dyads to Triads: New Structure Means New Support For Unit-Based Clinical Leadership

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Preparing for IMOC 2.0
A Benefit to You and Your Patients

Early in calendar year 2020, we’ll be hearing more about the next phase of IMOC, our Interdisciplinary Model of Care.

IMOC began at the Hospital Center in June 2016, as a pilot project on several units. The concept was simple: the attending physician and nursing director joined with others involved in a patient’s care, which could include the patient’s nurse, social worker, case manager, respiratory therapist, nutritionist, and anyone else. They all rounded on that patient together, to make sure everyone, including the patient and family, understood the plan of care and when to anticipate discharge. IMOC was a great success on the pilot units, and the program went house-wide in 2017.

Fast forward to the last month of 2019: all providers should be on board with IMOC team rounding, to show your patients that you all agree on the treatment plan, and to provide information and answer questions that patients and families may have. For example, inpatients may not understand why they are getting a prophylactic injection of an anticoagulant, and how it’s appropriate to have it as part of their hospital stay.

With the expanded IMOC, there will be more “local ownership,” down to the unit level. This means we’re looking for quality over quantity, meaningful encounters over transactional ones, and there will be less of an emphasis on rigid documentation. If 4C comes up with a routine that works for caregivers on that unit, the same plan might not work for 2C, and that’s okay. Each team needs to find the way to use IMOC that most benefits patients on the unit.

Particularly at nights, on weekends, and holidays, your team may be smaller, and not able to round on each patient. Utilizing the new IMOC, you would strategize which patients would benefit most from hearing from the entire care team, and then making sure you all went to see those patients.

Our Advanced Practice Providers, especially on the surgical units, will be more involved with IMOC rounding. We’re seeing greater success with adding APPs to the dyad leadership team—make sure you read our cover story for this issue, “Dyads Into Triads,” and you see how a third care leader greatly helps our patients understand what we do and why we do it, and how having an APP in IMOC rounding eases the work load for all clinical leaders.

Other changes for IMOC will focus more on the patient and family—how they can be involved, and how they can contribute to the plan of care with the provider team. We want to make sure that communication loops with the patient and family are closed, that they understand the “why” for everything in the treatment plan, and that they understand what the patient’s next steps will be, after discharge.

IMOC has demonstrated that team rounding is a better way for us to focus on quality, safety and the patient experience for all inpatients. If you have ideas for additional improvements for IMOC, or have questions on how it will work for your patients, please contact me, or Ira Rabin, MD, vice president, Operations & Clinical Resource Management, ira.y.rabin@medstar.net.

Jeffrey S. Dubin, MD, MBA, is sr. vice president, Medical Affairs & Chief Medical Officer at MedStar Washington Hospital Center. Contact him at jeffrey.s.dubin@medstar.net.
“Respect” is not just an iconic song from the 1960s, it’s the “R” in the MedStar Health SPIRIT values. And it’s an important factor for us to use, so we can continue growing the healing environment that our One Team works to provide.

I hope that physicians and Advanced Practice Providers always demonstrate respect for each other, for all other members of the care team, and for our patients and their families. I’d like to see the definition of “care team” expanded, to include people we used to think as ancillary—nutrition services, environmental services, and people who don’t directly touch the patient, but whose jobs still impact care.

When we talk about respect throughout “the hospital,” we aren’t referring to the building. “The hospital” is anyone who contributes to our ongoing quality, safety, and patient experience efforts. Everyone here plays an important part in creating the healing we want our patients to have, and the nurturing that our patients and their families expect.

So how do we do this? As the new President of the Medical & Dental Staff, I’d like to ask for your help. Everyone can contribute to that One Team goal. We have eyes and ears in different parts of the hospital, and we can all help invigorate and initiate change where it’s needed.

Depending on your interest—quality, safety, or the patient experience—you can volunteer to become involved in a hospital-wide committee, or if your time is limited, you can always send your thoughts to the providers who lead these groups. Please email me, at david.g.moore@medstar.net, or set up a meeting for the times that I’m in the hospital. For a face-to-face meeting, contact Danielle Coates in Medical Affairs, 202-877-7509, or through email, at danielle.g.coates@medstar.net.

One aspect of respect that most caregivers rarely consider is being mindful of your own good health. MedStar Health is emphasizing respect for its providers by focusing this year on wellness, with Urologist Dan Marchalik, MD, working as medical director for the system’s well-being program. As a response to suggestions made by providers, Dan has been leading several initiatives, to build up a culture of provider wellness and to prevent burnout.

At a recent presentation to our Medical Board, Dan detailed MedStar’s new concierge service, available to physicians, residents, fellows, and Advanced Practice Providers. Here are some of the things a physician concierge can do, at no cost to you:

- Assist with daily tasks, such as finding a local roofer or changing your flight reservation
- Help you navigate your MedStar benefits
- Connect you with a financial planner
- Coordinate free career coaching
- Offer support and advice for preventing burnout, maintaining work/life balance, and any other issues that affect your quality of life

All Guide Care Concierge conversations are confidential; you can schedule one at 800-554-1399, or through the website, www.medstarhealth.org/well-being, or with the new MedStar ConciergeConnect mobile app. For the app, search for “MedStar ConciergeConnect” in the app store on your smartphone or tablet. The concierge service is available Monday through Friday, from 8 a.m. to 8 p.m. Eastern time.

You can also take advantage of MedStar’s linkage to Care.com, which can help you with arranging emergency child care or elder care. Care can be provided in your home or at one of 80 sites in the region.

In the past several months, more than 200 clinicians have utilized this service, with an average of 1.8 hours of time saved per provider, per call. You can find these and other well-being resources on the MedStar webpage, https://medstarhealth.org/wellbeing.

Our hospital leadership needs to hear your other suggestions and opinions, which are crucial to working as One Team and continuing our tradition of excellence. I hope to hear from you, and would encourage you to reach out to other physician and APP leaders.

David Moore, MD, is president of the Medical & Dental Staff at MedStar Washington Hospital Center. He can be contacted at david.g.moore@medstar.net or 202-877-7509.
For the past several decades during every Nurses Week, the 1,900 RNs at MedStar Washington Hospital Center give a Nurses Choice Award to an outstanding physician collaborator in each service line. This May, the physician winner for Medical/Surgical services consisted of two hospitalists and a nurse practitioner, who together work with the nursing director, as part of 2D’s clinical leadership.

Iseri Obadaseraye, MD, Corica Rogers, MD, and Nurse Practitioner Emily Burman “consistently demonstrate their unwavering investment in the 2D vision of elevating clinical proficiency through providing educational sessions, reinforcing Interdisciplinary Model of Care (IMOC) absolutes, thoughtful inquiry, and shared communication,” said 2D Nursing Director Quincy Nicole Smith’s nomination.

The unit-based “triad” had arrived.

The hospital pioneered clinical dyad leadership in 2016, with the goal of increasing collaboration and coordination among clinicians on each inpatient unit. This dyad partnered the medical director and nursing director, giving joint accountability for unit-based outcomes, and adding financial incentive for improvements and consistency. Results were immediate and dramatic enough that MedStar Health adopted the dyad concept systemwide just one year later.

On some critical care units, Advanced Practice Providers were already embedded in the structure of the unit. Nurse practitioners, for example, support cardiac critical care on 2NW, and physician assistants are a staple in the Emergency Department.

Last year, the team that manages the dyads—led by Chief Medical Officer Jeffrey Dubin, MD, and then-Chief Nursing Executive Susan Eckert, MSN, RN—added Advanced Practice Providers to the clinical leadership partnership on Medical/Surgical and non-ICU units in the MedStar Heart & Vascular Institute (MHVI), creating the “triad” concept. Today, nine units, ranging from geriatric care on 1C, to neurologic units 2E/2EIMC and 2F, to non-ICU units 3NE, 3NW and 4NW in MHVI, use a triad for clinical leadership.

The Hospital Center is part of a growing trend nationwide to utilize APPs to augment patient care. Due to changing rules for residency work hours, increased complexity of patients, demands of electronic medical records, and growing hospital patient loads, the number of APPs in acute care settings is rising. There’s an increase in the number of APP programs nationwide: according to the American Association of Colleges of Nursing, NP degree programs grew from 282 in 2000 to 424 by 2016, and according to the Accreditation Review Commission on PA programs, the number of PA education programs will grow from 238 today to 300 in 2021.

Moving to the triad leadership model acknowledged and formalized the increasing role of APPs on inpatient units, notes Dr. Dubin. “With medical directors scheduled to be on duty for seven days, then off for seven days, plus the support needed in intensive care units, it made sense to have APPs helping bridge the gaps. They are important to the continuity of care, so making them part of the clinical leadership made sense.”

The leaders involved in the new triads say the benefits of the triad were immediate and meaningful. On 4F, which treats complex medical patients, Caroline Argyros, PA, “is the glue that holds us together,” notes co-medical director Rosemarie Rollins-Folks, MD. “When we come in, she already knows the

The leadership team on 4F includes Caroline Argyros, PA; Rosemarie Rollins-Folks, MD, medical director; Christopher Gibson, MD, medical director, and Komlan Ayim, MS, RN, CMSRN-BC, nursing director.
patient’s status. We spend less time trying to catch up, and more time focused on the actual needs of the patients.”

“Having Caroline as a co-leader also ensures safe transitions and continuity,” adds co-medical director Christopher Gibson, MD. “It’s clinical oversight that overlaps the physician and nursing leadership, so tests are ordered and followed up, and the patient knows what is happening.”

In fact, communication between the triad leadership is key, notes 4C co-medical director Giovana Olivera-Caceres, MD. She and Kosuke Yasukawa, MD, Claire Kent, PA and Nursing Director Rachel Watkins, BSN, RN, meet monthly, and Watkins meets with anyone assigned to the unit on a weekly basis. “There’s also a lot of online communication,” says Dr. Olivera-Caceres. “We have a very active group text.”

On 4C, where the number of physicians coming in to check on their patients varies, having APP leadership “plays a key role when the medical directors are not working on the floor,” notes Dr. Yasukawa. “Claire can teach residents, and when other physicians are seeing other patients, she plays a key role in keeping the rhythm on the floor, since visiting

The hospital pioneered clinical dyad leadership in 2016, with the goal of increasing collaboration and coordination among clinicians on each inpatient unit.

One of the key benefits is having another provider to connect with physicians, if there are difficulties reaching or getting a response, when doctors are not on the unit.

The triad collectively reviews benchmarks, such as throughput and patient satisfaction metrics, and together decides how to approach improvements. All triad leaders are present for staff meetings, and attend huddles during their shifts. They share unit-based education about issues and initiatives.

For the nursing directors, this brings extra reinforcement and balance. “Nurses have been more comfortable with the additional communication and familiarity that comes with a designated APP leader. The fact that the triad comes to the huddles and talks about everything helps with bonding, builds a rapport and keeps the team focused on issues we need to address,” says Watkins.

For the Advanced Practice Providers, the leadership position “has been beneficial in expanding the role of an APP on the medical unit, with enhanced visibility and confidence in our role for consultants and nursing, as well as with rotating members of my own team that come to our floor,” says PA Argyros. “I appreciate that leadership roles like this one provide the opportunity to positively contribute to our hospital culture, and provide our patients with the best care possible.”

Ultimately, the goal is to move the needle on unit metrics and outcomes, and the triads seem to be having a positive effect. On 4C, for example, the FY19 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores for communication with nurses and communication with physicians were above target of 85 percent much of the year. Unit 4F was also at or above target much of the time.

The triad team likes the three-pronged leadership approach. “Our patients are so thankful,” notes Dr. Olivera-Caceres. “Claire visits in the morning, helps them with their questions, then we come in to make certain the plan of care is moving forward. Without her help, it just isn’t the same.”
It’s a dramatic scene found in countless movies and TV shows: an emergency call goes out for a doctor. A physician steps out of the crowd, and calmly takes control of the situation. Usually, the matter is resolved within minutes, unless…well, let’s not give away any spoilers.

Though such emergencies are rare, life does occasionally imitate art to a certain extent, and several MedStar Washington Hospital Center physicians on the Connections Editorial Board have been in the right place at the right time to help.

Several years ago, psychiatrist Stephen Peterson, MD, was strolling with his wife on the boardwalk at Rehoboth Beach, Del., when someone burst from a restaurant pleading for help. Dr. Peterson went inside, and learned that the restaurant’s 80-year-old owner had collapsed, apparently from a stroke.

“They had gotten him in a chair. He looked somewhat confused, with one side of his face drooping,” Dr. Peterson recalls. “The restaurant workers also said he couldn’t move his hand on the same side.”

Someone had already called 9-1-1. Dr. Peterson had those who were present write down the time the owner’s symptoms started, so they could tell the paramedics, who could give that information to the receiving physician. Then he put his knowledge to work.

“A common instinct is that the patient should lie down, but that’s not always good for some types of strokes,” Dr. Peterson says. “He looked comfortable, so I decided it was best to just watch and keep him steady until the ambulance arrived.”

The fact that Dr. Peterson is a psychiatrist didn’t seem to matter in the situation. Even if anyone had asked, he would have had no qualms about identifying his specialty.

“I knew what we needed to do,” Dr. Peterson says, adding that he did have to run through a mental checklist of CPR steps, in case it became necessary.

As minutes ticked by with no sign of an ambulance, however, some observers grew understandably agitated. The victim was a well-known, beloved figure in Rehoboth, and bystanders started to fear the worst. That’s when Dr. Peterson put his training to work.

“I encouraged everyone to remain calm, and noted that they’d done all the right things to help their friend,” he says. “That diffused the tension, and seemed to help everyone feel better.”

When the ambulance finally arrived, Dr. Peterson stepped aside to allow EMTs to do their work. After the victim was rushed away, Dr. Peterson quietly left the scene, as well. Stopping in the next day, he learned that the owner had indeed suffered a major stroke, and had been transferred to a larger hospital in Philadelphia for treatment.

“They thanked me again, and that was the last I heard of it,” he says.

Emergency at 40,000 feet
Dramatized medical emergencies set aboard aircraft are particularly tension-inducing, given the passengers’ isolation and vulnerability. Such “what if’s” were on the mind of Cheryl Iglesia, MD, the Hospital Center’s Section Director for Female Pelvic Medicine and Reconstructive Surgery. She was on a flight home from Chile, when she responded to help a woman experiencing dizziness.

“English wasn’t her first language, which made it difficult to learn precisely what she was feeling,” Dr. Iglesia recalls. While most passenger aircraft carry a cache of medical supplies, “this one was very limited—just a BP cuff, a flimsy pulse ox probe and a few meds,” she says. “Meanwhile, I’m wondering if we should be thinking about making an emergency landing.”

After some further observation and serial neuro checks, Dr. Iglesia decided the patient was stable enough to make it back to Washington, where an ambulance would be waiting. She adds that another in-flight incident, involving a patient with sudden fever and diarrhea after swimming, was more easily resolved.

“The on-board supplies were better, though I wish they’d included some gloves so I’d have felt safer about touching him,” Dr. Iglesia says. “He was able to take some fluids and had a friend to help. I did suggest that the flight attendants shut down that toilet.”

Radiation Oncologist Adedamola Omogbehin, MD, is also no stranger to providing high-altitude medical treatment. On a
transatlantic flight several years ago, he came to the aid of a young woman who had begun shivering uncontrollably.

Flight attendants had moved the passenger to a secluded part of the plane, where Dr. Omogbehin found her conscious and huddled under a blanket. He calmly asked the patient a few questions about her medical history, as he took her pulse and blood pressure, which were normal. When the patient mentioned that she’d started to feel bad after lunch, he concluded that she was suffering some kind of allergic reaction.

“The on-board medical kit had some Benadryl, which she could take,” Dr. Omogbehin says. “I checked on her every hour afterward, and she was feeling better by the time we got to the airport.”

Dr. Omogbehin characterizes the incident as rather straightforward.

“Somebody in the flight was full of pharmaceutical company representatives, but I was the only doctor.”

Being on the alert

Though physicians are understandably focused on patient’s needs in an emergency, they should also be fully aware of their surroundings. Near the end of a run, Radiology Chair James Jelinek, MD, saw a woman suffer a seizure and collapse, as she was crossing a busy neighborhood street.

“Seizures are not my specialty, but I knew I had to stop her from hitting her head against the concrete,” Dr. Jelinek recalls. “And, I had to think about protecting myself.”

Dr. Jelinek’s concerns were well-founded. Each year, thousands of first responders are struck and injured by motorists at crash scenes. Forty of them died in 2018, a 60 percent increase from the previous year. With distracted driving increasingly common, simply yelling and waving may not be enough to get a driver’s attention.

Fortunately, Dr. Jelinek was able to get a motorist to stop and shield the patient, and call 9-1-1. As for the seizure victim, her symptoms gradually abated, and she regained consciousness.

“It took only about three minutes for the ambulance to arrive, but it sure seemed longer,” Dr. Jelinek says.

As with his colleagues’ incidents, Dr. Jelinek doesn’t know what became of the person he helped. And while none of the physicians expected any compensation for their efforts, Drs. Iglesia and Omogbehin did receive complementary bottles of champagne from the respective airlines.

“It was a nice thought, but I don’t drink,” Dr. Omogbehin says with a laugh. “I’m just glad it was a happy ending.”

“And Is There a Lawyer in the House, Too?”

From Day One of their careers, physicians pledge to “do no harm” to the best of their ability. But in an emergency, are there potential consequences that might make a physician think twice about responding to a call for help?

Larry Smith, MedStar Health’s vice president of Risk Management says that while a medical professional is under no legal obligation to assist in an emergency, “various medical bodies consider one ethically bound to do what he or she can to help under the circumstances they’re presented with,” such as location or limited equipment.

Smith adds that the legal aspects governing what a physician elects to do are relatively straightforward.

On land, liability protections are typically codified in state-specific Good Samaritan laws. Smith notes that provisions in Maryland, Virginia, and the District of Columbia are particularly strong.

“Unless there’s gross negligence or willful misconduct, the physician is protected,” he says.

Federal law takes over in the skies with the 1998 Aviation Medical Assistance Act, which provides liability protection for emergencies occurring on domestic flights, and overseas flights originating in the U.S. Upon landing in a different country, however, the physician becomes subject to its laws and regulations.

“The laws vary from one country to the next, but most are pretty reasonable,” Smith says. “They want to encourage people with certain valuable skills to help, whenever there’s a need.”

For the most part, Smith says the risks of responding to a medical emergency are relatively small. “In my career, I’ve seen more people congratulated and thanked than punished,” he says.

Still, Smith cautions that some plaintiff lawyers can “get creative” if there’s a bad outcome or somebody’s unhappy with what happened. There are also an infinite number of “what if?” scenarios, from responding to an event outside one’s specialty to being accused of impeding another responding physician.

“Our policy is do what you think best,” Smith says, “and MedStar will stand behind you.”
Exercise enthusiasts agree—there’s nothing like a good run, or walk, or ride, especially when it’s for a good cause. And this past September 14, more than 950 runners, walkers and wheelchair users enjoyed a delightful dash through the streets of Georgetown for the 39th annual Race to Beat Cancer.

Sponsored by the Four Seasons Hotel Washington, DC, the Race to Beat Cancer has become a local institution of sorts, not just for the exercise or tasty post-race breakfast of smoked salmon and champagne, but also to help raise much-needed funds for cancer research. Washington Cancer Institute at MedStar Washington Hospital Center has been the race’s prime beneficiary for the past two decades, receiving a total of more than $2.7 million. That includes 2019’s goal-breaking collection of more than $485,000!

What makes Race to Beat Cancer truly special is that all those contributions go directly to research programs at the Cancer Institute, which treats more cases of cancer than any other institute in the region. Although we are fortunate to have a variety of funding sources for many established “big picture” efforts, including valuable partnerships with other cancer institutes and universities, there’s only so much available to address other needs, from providing a foundation for physician investigators to explore promising new approaches to enrolling patients in clinical trials.

In other words, by supporting locally based cancer research, the Race to Beat Cancer also supports local patients.

In the past year, for example, contributions from the 2018 event helped a Washington Cancer Institute cardio-oncologist develop an algorithm for physicians to better follow cancer survivors, with the goal of both predicting and preventing cardiac complications after cancer treatment. Another exciting new project aims to evaluate markers in the blood, which could predict the development of secondary cancers, coronary artery disease, and dementia in cancer survivors. And, there’s a new study looking into ways to improve supportive care in preventing hair loss in African American women undergoing chemotherapy.

Race to Beat Cancer funds are also being used to support ongoing clinical trials in early stage breast cancer, advanced colorectal cancer, advanced prostate cancer, and early stage bladder cancer.

A particularly gratifying aspect of the Race to Beat Cancer is that dozens of MedStar Washington Hospital Center physicians, nurses, staff members and their family members regularly join in the event as participants and volunteers. Such support is testimony not only to their personal recognition of the Cancer Institute’s important work, but also the commitment and collaborative spirit they bring to patient care every day. Several Hospital Center departments and employee groups formed race-related fundraising teams, with contributions eligible for a donor match up to $225,000. And by the way, online contributions to these teams are still being accepted, so there’s time to make an already successful event even better.

Let me close by thanking the Hospital Center community for its continued support of the Race to Beat Cancer. Even though the participants crossed the finish line several weeks ago, the work of the Cancer Institute goes on. And your generous contributions as participants, contributors, and even sidewalk cheerleaders keeps us going. See you for Race to Beat Cancer 2020!
“How can I help?”

People in health care professions often hear this question from patients and family members. After all, showing gratitude has been found to benefit both the healing process and finding closure after an unpleasant outcome. That makes finding the right outlet for expressing gratitude particularly important.

But answering this question isn’t always easy. No one wants to convey the wrong impression or motives, of course, but neither should a sincere offer of help be overlooked.

Helping physicians, nurses, and staff members find the right response is just one of the many roles of MedStar Washington Hospital Center’s Office of Philanthropy. We offer thoughtful and nuanced guidance for responding to questions about philanthropy without compromising the intricacies of the caregiver-patient relationship. Each step forward is taken with full collaboration with and consent from physicians, and with due sensitivity to the feelings of patients, family members, and others who may be involved.

And it’s important to remember that philanthropy does not automatically imply a financial gesture. Patients show gratitude by word-of-mouth referrals, advocating on behalf of healthcare issues, or donating time as a volunteer. It’s all about identifying the best match for what a patient or family member can and wants to do, and how do they get started on a path to make that all-important difference.

Speaking of making a difference, Hospital Center associates also have many ways to express gratitude and help their colleagues as well. Along with formal internal giving programs such as the annual MedStar-wide annual “Power to Heal” campaign, there are a host of charity events such as the recent Race to Beat Cancer 5K, which benefits the Washington Cancer Institute. The Office of Philanthropy can also connect associates with other programs and initiatives that enable them to support their colleagues’ work.

So when someone asks, “how can I help?”—even if that person is you—remember that there are any number of potentially right answers. Please contact me at 202-877-6558, or harvey.green@medstar.net. Thank you for letting us help find the best answer.

Harvey Green is vice president and Chief Philanthropy Officer at MedStar Washington Hospital Center, with oversight for the Office of Philanthropy to lead fundraising efforts for the Hospital Center, and also for MedStar Heart and Vascular Institute, including the Nancy and Harold Zirkin Heart & Vascular Hospital. Most recently, Green was the Senior Director of Fundraising and Development at the Krieger School of Arts and Sciences at Johns Hopkins University. While there, he managed a team of professional fundraisers during a seven-year, $6 billion university-wide effort. Prior to Johns Hopkins, Green served in a leadership role as Executive Director at the University of Florida Health Science Center and College of Medicine, where he raised philanthropic dollars for the new medical education building. Green also worked at the University of California, San Diego Medical Center, on several fundraising and capital campaigns that yielded multi-million dollar gifts to institutional priorities.
MedStar Washington Hospital Center is taking steps to become a national leader in the effort to prevent and reduce the number of unintended incidents with patients, to reduce the number of workplace violence occurrences. One of the more effective tools developed by an interdisciplinary team and used throughout the hospital is the patient safety contract.

“Beginning three or four years ago, we began to work on our safety contract program,” says Mark Marino, RN, co-chair of the Workplace Violence Prevention Committee at the hospital and with MedStar Health. “There is literature showing the use of tools that set limits and define appropriate behaviors are effective in managing the violence and aggression that some patients can develop during an inpatient stay.”

Safety contracts most often are initiated by nurses, who have the most contact with patients.

Marino advises physicians to take complaints seriously, even if they do not see the behavior themselves. “In many cases, patients take on a different demeanor with physicians,” he explains.

Unacceptable behaviors can range from violent assaults to sexually suggestive behavior to verbal abuse. “Patients need to be reminded of their responsibilities while they are with us, and that we have an obligation to keep all members of our care team safe. We need to explicitly spell out inappropriate behavior, and advise patients about the repercussions of continued unacceptable behavior,” Marino says.

The hospital uses an interdisciplinary approach to establishing and enforcing safety contracts. “When a patient presents a risk to our staff, other patients, or visitors, our care team works to create a safety contract that offers protection to all staff members,” explains Ira Rabin, MD, co-chair of the committee and vice president, Medical Operations and Clinical Resource Management.

“Nurses bear the brunt of bad behavior, because they are with patients 24/7,” Dr. Rabin notes. “When physicians accompany the nurses to present a safety contract, it shows that the inappropriate behavior is not going to be tolerated by any member of the care team.”

Here’s how it works. The associate who has experienced the unacceptable behavior initiates the process, filling out a one-page contract that describes in detail the inappropriate behavior. A nurse leader and the attending physician then present the contract to the patient, asking the patient to agree to adhere to his or her responsibility for appropriate behavior. If the patient refuses to sign the contract, the physician and nurse note that the contract was presented and explained to the patient, and it still is put into effect.
There is one important caveat: the patient must be competent, which can be assessed by any physician. The patient must know right from wrong, and understand the ramifications of his or her behavior, Dr. Rabin and Marino stress.

A safety sign is placed on the door to the patient’s room, to alert anyone entering, including technicians, environmental services team members, and nutrition services associates. The sign is a purple triangle with an “S” and a brief description of the safety risk.

“This sign alerts all associates to speak to the patient’s nurse, and to determine if the associate is okay to enter the room alone, or whether the associate needs to be accompanied by someone else,” says Dr. Rabin. The patient’s risk for harm to others is also noted in the banner bar of the electronic medical record.

The program has been very successful, Marino reports, as measured by lost or restricted work days resulting from injuries from patients. Plans are in place to institute safety contract programs at all MedStar hospitals in the coming months. Marino reports that the system is training 12,000 associates this year in de-escalation and violence prevention tactics.

On any given day, one to five safety contracts may be in place. “All safety contracts are reported at the daily leadership huddle,” says Marino. “The most common inappropriate behaviors are verbal threats,” adds Dr. Rabin. “If patients do not adhere to the safety contract, there are consequences, although it is difficult to discharge a patient who has a need for hospitalization.”

For those patients who are not medically stable to be safely discharged, but who continue with inappropriate behavior, there are steps that can be taken, such as taking away television privileges or the patient’s cellphone.

Family members and visitors who become disruptive or a barrier to care are not given safety contracts, even if they are the patient’s medical representative.

“We take threats seriously. Verbal abuse can lead to physical abuse. This is not a punishment; we must protect our staff,” Dr. Rabin concludes. “Therefore, any disruptive visitor should be immediately removed from the hospital, even a power of attorney. They can be given an update every day on the phone. We have to be able to provide excellent care, but in an environment that is safe for the patient, the family, and all members of the care team.”

Anatomy of a Safety Risk

A patient is admitted to the hospital with a systemic infection and a history of IV drug abuse. This patient is belligerent to the nursing staff, but very accommodating to a parade of visitors. After one such visit, the nurse enters the room to find a syringe dangling from the patient’s arm.

The nurse promptly initiates a safety contract, detailing the patient’s continued IV use in the hospital and an ongoing verbal abuse of staff. When an attending physician and nursing manager present the safety contract, the patient denies the behaviors.

The patient is moved to a locked unit, where no visitors are allowed. If a visitor manages to sneak in, staff is told to contact public safety personnel, and to search the patient’s belongings. The patient’s cell phone is also confiscated, to prevent any contact with IV drug providers.

The patient threatens to check out of the hospital and is advised that is the patient’s right, but reminded that irresponsible behavior will not be tolerated. The patient’s safety contract remains in place through the remainder of the hospitalization.
Upcoming CPE Conferences

MEDSTAR CONFERENCE HIGHLIGHT

BC3: Breast Cancer Coordinated Care – An Interdisciplinary Conference
February 27-29 | Grand Hyatt Washington | Washington, D.C.
Course Director: David H. Song, MD, MBA

BC3 will offer presentations and panel discussions on a number of currently important topics in the local treatment of breast cancer including oncoplastic surgery, the role of prophylactic mastectomy and quality of life as it pertains to survivorship. Experts in the field will cover the state of partial breast irradiation, intraoperative radiation therapy, timing and indications for post-mastectomy radiation, and neoadjuvant chemotherapy and its role in restaging breast cancer. Additionally, the program will examine nipple-sparing mastectomy both therapeutic and prophylactic, treatment of breast cancer in a previously augmented breast, the status of MRI screening for breast cancer, the effects of reconstruction on the delivery of post-mastectomy radiation, and the evolving role of alloplastic materials in breast reconstruction. It will also cover in depth the state-of-the-art emerging field of lymphatic surgery to treat lymphedema as well as sensory concerns to the most complex reconstructions available covering topics such as sensation sparing mastectomies to restoring sensation with nerve transfers. The latest updates on national trends and data on financial toxicity related to cancer care will also be discussed.

For more information and to register, visit bc3conference.com

UPCOMING CPE EVENTS

Update on Pancreaticobiliary Disease
February 22 | The Ritz-Carlton | Washington, D.C.
Course Directors: John E. Carroll, MD | Nadim G. Haddad, MD | Reena Jha, MD | Emily R. Winslow, MD, MS

Advances in Prostate Cancer 2020
March 28 | The Wink Hotel | Washington, D.C.
Course Directors: George K. Philips, MBBS, MD, MPH | Ross E. Krasnow, MD, MPH | Young Kwok, MD

2nd Annual Play with Aces and Always Win: Pelvic Surgery at its Best
April 3-4 | Washington Hilton | Washington, D.C.
Course Director: Vadim V. Morozov, MD
Course Co-Director: James K. Robinson, MD, MS

Pharmacogenomics (PGx) 2020
April 4 | Bethesda Marriott | Bethesda, Md.
Course Directors: Sandra Swain, MD | James Welsh, MD | Max Smith, PharmD

Diabetic Limb Salvage Conference
April 16-18 | JW Marriott | Washington, D.C.
Conference Chairmen: Christopher E. Attinger, MD | John S. Steinberg, DPM
Course Directors: Cameron M. Akbari, MD, MBA | Karen F. Kim Evans, MD | J.P. Hong, MD, PhD, MBA

Frontline Cardiology
May 2 | College Park Marriott Hotel & Conference Center | Hyattsville, Md.
Course Directors: Sriram Padmanabhan, MD | Carolina Valdiviezo, MD

12th Annual Abdominal Wall Reconstruction 2020
June 4-6 | Mandarin Oriental | Washington, D.C.
Conference Chairman: Parag Bhanot, MD
Course Co-Directors: William W. Hope, MD | Jeffrey E. Janis, MD

For more information regarding MedStar Health conferences, please visit CE.MedStarHealth.org
African American men in the District of Columbia live 15 years less than white men, and African American women live nine years less than white women. Infant mortality in the African American community is also six times likelier to occur, when compared to other groups. Why is this the case, and more importantly, how do we prevent it? These questions are the focus of research on the disparities of care and health equity for all in D.C.

At MedStar Health, we are in an ideal situation to be a national leader in health equity research. We sit at the crossroads of academics and real-world medicine. Washington, D.C. is the nation’s capital, and an example of many major cities, where there are markedly different levels of health and wellness across the city. In this sense, the area served by MedStar Health serves as a microcosm of the nation, in terms of patient outcomes and treatments, and is an ideal location to conduct health equity research.

With more than 300 points of access across our region, health equity research is one method that we leverage, to be aware of and concerned about regarding these issues. Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

- It includes the opportunity to participate in clinical trials and other research studies, so we can ensure the treatments and interventions we develop and offer our patients are optimized for all our populations.

- It requires identifying and mitigating obstacles to achieving optimal health, such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education, and housing, safe environments, and health care.¹

To address health inequities, we must leverage our strength as an academic medical system, to ensure that minorities are represented in our research studies.

Participation in clinical trials remains low among the general population; one to three percent take part in clinical trials, with African Americans the lowest of all groups (only 0.5 to 1.5 percent participate). For Cancer Services, 68 percent of patients are African American, which is an opportunity to increase participation in research. More than ten years ago, researchers at the Hospital Center were awarded National Institutes of Health (NIH) funding under the ARRA Act mechanism, to help increase participation of African Americans in cancer trials at the hospital. “Today’s Truth: Research Brings Hope” may sound familiar to some providers, as Research Brings Hope² has grown, as a mechanism to shine a positive light on clinical research for participants.

Furthering the inclusion of minority populations at the Hospital Center in research, a team investigated whether there was potential to change the minds and attitudes of African American patients with breast cancer, to encourage their participation in breast cancer research, the INSPIRE-BrC study.² The work on INSPIRE-BrC sought to leverage educational intervention by community health workers, to positively increase the perceptions of mammogram safety and efficacy in breast health and cancer awareness. This work connected with the community, specifically in Ward 5, to understand how we can encourage patients to seek treatment and result in more positive patient outcomes.³

One of the distinguishing attributes of MedStar Health is our passionate commitment to advancing health, and the countless ways in which we deliver on this promise to our patients, associates, and community. We are training the next generation of clinicians to ensure that we are treating all members of our communities, and doing so in the most equitable way. As an academic health system, novel discoveries and breakthrough innovations benefit our patients immediately, and allow us to deliver the highest quality of care, with the best possible outcomes.

²https://www.medstarhealth.org/mhri/increasing-participation-in-research-breast-cancer/
Irina Tunnage, DO, MHS
Obstetrics & Gynecology

Irina Tunnage, DO, says that in her heart, she always knew she wanted to be a cancer doctor. Having grown up in a close knit family of Ukrainian immigrants, several of whom had personal brushes with some form of cancer, it felt like a way she could have a positive impact.

Now as chief administrative resident for Obstetrics & Gynecology at MedStar Washington Hospital Center, Dr. Tunnage plans to continue her training, in gynecologic oncology.

Her time researching reproduction and cancer while completing an Master’s of Public Health degree at The Johns Hopkins University Bloomberg School of Public Health helped solidify her concentration.

“I learned what the field of gynecologic oncology was all about,” Dr. Tunnage recalls. “It felt like such a unique specialty, with its own chemotherapy and surveillance. There’s no other oncology specialty that allows for total oversight of patients from start to finish.”

Following her master’s degree, Dr. Tunnage had always planned to go to medical school, but ironically, cancer diverted her plans. Her grandmother had been recently diagnosed with pancreatic cancer, so Dr. Tunnage chose to spend one year as a research program coordinator for the National Familial Pancreas Tumor Registry at JHU’s School of Medicine, before starting medical school at Touro College of Osteopathic Medicine.

For Dr. Tunnage, this was her way of “walking the walk” with her beloved grandmother. “I was far away, and pursuing these big dreams that validated my parents’ decision to leave the Ukraine. I couldn’t make her food or take her to medical appointments, but in a world of oncology research, I became our family’s researcher,” she says. Ultimately, her grandmother enrolled in the national tumor registry, which helps identify a tumor marker specific to pancreatic cancer.

Now in her year as chief resident, Dr. Tunnage’s biggest priority is successfully implementing a leadership curriculum for residents. The multi-day leadership track focuses on different skills, common goals, and team culture.

“One significant takeaway is that having a forum that fosters culture conversations and space to discuss shared goals can be a game-changer,” she notes.

Dr. Tunnage credits the Hospital Center with encouraging her leadership from day one, and investing in her ideas, with an orientation toward innovation. When she arrived as a first-year resident, she had an idea for a mobile application that offered physicians access to the most up-to-date research and data available, before speaking with patients. After sharing the concept with her attending physician, Dr. Tunnage was encouraged to pitch the idea to the MedStar Institute for Innovation.

“Two months into my intern year, the app was up and running,” Dr. Tunnage says. “MedStar is invested in its trainees, and in what innovation looks like.”

This July, Dr. Tunnage will begin a fellowship in gynecologic oncology at NYU, building on the foundational balance of surgery, medicine and research she’s amassed. Whatever next steps follow, she knows that future roles must include that trifecta: “For my entire career, I’ve been able to carve out time for research—that makes me feel like I’m contributing to the world of oncology—and teaching. So those are going to be part of my life forever.”
Gaby Weissman, MD
Cardiac MRI, Fellowship Director, Cardiovascular Disease

When Gaby Weissman, MD, arrived at MedStar Washington Hospital Center in 2005, he was arriving for a one-year fellowship in cardiac MRI and CT. At the time, formalized training in that specialty was the exception and not the rule, with the Hospital Center offering one of the few programs in the country.

“I interviewed here with no connection to Washington, D.C. But I really liked the people, as well as the patients who came through the doors,” says Dr. Weissman, who had just finished a Cardiovascular fellowship at Yale University. “Still, I had no intention of staying. I planned to be here for one year, and then move on.”

Nearly 15 years later, Dr. Weissman has no intention of leaving. He joined the faculty in 2007, and since 2014, has served director for Cardiac MRI, and as program director for the Cardiovascular Disease fellowship.

“I voted with my feet,” Dr. Weissman says. “My wife likes to remind me that staying was never in the cards for us, but I really like the environment here. I’ve had the opportunity to work with trainees, to be involved in academics, research, and groundbreaking technology—all in a very collegial environment.”

One rejuvenating component of Dr. Weissman’s tenure has been the opportunity to engage in MedStar Health’s two-year professional development series, MedStar Teaching Scholars. The program aims to help clinician educators rise to the level of scholars in their field, teaching those educators how to apply research principles to medical education, consume research literature critically, and to collaborate around new research in their fields.

And Dr. Weissman’s academic work focuses largely on how the next generation of cardiologists is trained. “In medical education, you usually observe the ‘expert,’ and then just do it yourself,” he notes. “Instead, we’re now giving people the tools to do this in a thoughtful and evidence based manner, while building a community of people in MedStar with formal training in medical education.”

The Teaching Scholars program involved a research component which all participants must complete. With a laugh, Dr. Weissman is quick to categorize his own final project as an “utter failure.” But the context is important: The aim of his project was to develop new tools, for measuring the quality of care provided by the Cardiology fellows.

“Learning from your failures is as important as learning from your successes,” he says. The benefits of participating in the two-year series far surpassed his own individual project, which, he believes, was the entire point. “Learning essential skills and learning what doesn’t work is as important as learning what does work. At the end of the day, making these mistakes helps.

This program allowed me to be thoughtful about how to approach a problem. This experience made me a better educator, helped me begin a career as a medical education investigator, and helped me attain leadership positions in the nationally. I would highly recommend it to anyone in MedStar who is interested in this topic.”

“I’ve gotten to grow as a physician taking care of patients, as an educator, and as an academic researcher,” Dr. Weissman adds. “Cardiology has grown dramatically over the past few years, with new techniques, an increased focus on measuring and striving for quality, and integrating multiple cardiovascular teams in offering patient-centered care. I believe I’m part of that, and the fellowship is part of that.”
What sets apart the department of Neurosurgery is our expertise, technology, volume, and results. At MedStar Washington Hospital Center, the MedStar Neurosciences Center enables us to offer a multi-specialty approach to care, which provides optimal, long-lasting results for patients with brain and spinal conditions.

Our team includes five full-time and one part-time neurosurgeons, supported by 18 Advanced Practice Providers. The hospital has two Neuro-Critical Care units, with a total of 25 beds, and a Neuro-Intermediate Care unit, both with highly trained staff to help patients recover maximum function.

We treat the largest number of pituitary tumors in the region. Our approach combines the expertise of neurosurgeons, neuroendocrinologists, and neuroophthalmologists, to identify tumor size and location, devise the best treatment approach, and then follow patients’ progress long-term. We work closely with our colleagues in Cancer Services, to treat patients with any kind of brain or spinal tumor.

The Hospital Center was home to the first Stroke Center in the region: the NIH Stroke Program at MedStar Washington Hospital Center. For patients with aneurysms, our neurosurgeons provide surgical and interventional treatments, using the most sophisticated technology.

The best neurosurgery outcomes require advanced technologies. We have the city’s first Airo® Brain Lab Intraoperative CT scanner, which precisely guides us during surgery. We used this technology on 350 cases in the first year, which made us the nation’s most rapidly growing program.

Whenever possible, we use a minimally invasive approach to surgery. We have a Leica scope with an intraoperative computer system and a three-dimensional intraoperative microscope. The Hospital Center has been approved to install the area’s first intraoperative robot specifically for neurosurgery cases.

Research efforts include data-gathering about length of stay in the neuro ICU, improving outcomes through early mobilization after surgery, and early introduction of palliative care. We are also doing ongoing research into pituitary tumors.

The hospital has 14 neurosurgery residents, and serves as a training site for medical students throughout the area. We are active in training other surgeons on how to perform advanced procedures. For more information, questions, or to refer your patient, please contact our office, at 202-877-5026.