

CONNECTIONS



Queries: Why It's Important to Clarify Your Charts





Patient Safety Indicators: Why They're Important

To understand our ongoing focus on Patient Safety Indicators—PSIs—let's start with some definitions.

PSIs were developed by the Agency for Healthcare Research and Quality (AHRQ). On its website, the AHRQ states:

The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth. The PSIs were developed after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in hospital complications using administrative data found in the typical discharge record; include indicators for complications occurring in hospital that may represent patient safety events; and, indicators also have area level analogs designed to detect patient safety events on a regional level.

PSIs are publicly reported, so we want as few of them as possible. Our PSI Review Committee looks at each PSI. Of the 52 that were flagged in November 2019, 29 were overturned, by clarifying the wording in the medical record. Exact documentation is important, so if you receive a query from our Clinical Documentation Specialists or our coders, we'd like you to answer it quickly. (Please read this issue's cover story on Queries)

What Everyone Should Know

- PSIs provide information and are used by The Centers for Medicare and Medicaid Services (CMS) to determine the type of care we are providing to our patients. Our Medicare payments are then adjusted, depending on the quality of care we provide.
- PSIs have inclusion and exclusion criteria. If you receive a MedConnect query about a possible PSI, we are trying to determine whether what you've written in the patient chart meets either criterion. If it does, that determines whether it has to be reported to CMS. It's important for every service at the hospital to take a close look at PSIs.

One way to prevent a reportable PSI is through better communication with all members of the care team, and with the patient and family. Please think about making your patient your partner in care. It may be difficult to have this discussion with some patients. But for many, the understanding of why

care choices are made will help the patient become a willing participant in the care plan, which will make a difference in understanding and cooperation. With a caregiver-patient partnership, the patient can feel that s/he has some control over achieving better health and leaving acute care, which improves and heightens the patient experience.

For example, your patient may not understand why the nurse is making him or her get up and ambulate so soon after surgery, or why it's important to use an incentive spirometer. The patient may not understand why we're trying to decrease our use of urinary catheters, even if the patient is taking a diuretic and has trouble getting up to use the bathroom. By using a strong communication plan to make the patient your partner, s/he can help each day's plan of care go smoothly and improve outcomes.

Our Focus

Ongoing reviews of PSI-12 (Deep Vein Thrombosis, DVT, or Pulmonary Embolism, PE) will continue in department peer reviews. The reason for the focus on PSI-12 is that record reviews have found 39 percent of patients received less than the appropriate prophylaxis, with the most common reason being the patient or family member refusing the dose. Our goal is always to give 100 percent of the correct dosage at the correct time.

Sometime this year, we may create nursing and/or patient education bundles on VTE/VTE Prophylaxis, and "just in time" patient education may be presented. We have also found that there is opportunity to improve the use of the VTE Advisor, a support tool in the electronic medical record. While this is a mandatory field as part of admission orders, the advisory tool is not always optimally applied.

One thing that all departments can do is to ask our physician advisor, Dr. Jessica Fields, to set up a discussion time with your team, to focus on the PSIs that are specific to your service line. Please contact her at atjessica.n.fields@medstar.net.

We want to decrease our number of reportable PSIs, because we want to do the best for our patients. Focusing on PSIs for the rest of this year is the right thing to do, as part of our mission to provide the highest quality, safest care for everyone who trusts us with their healthcare needs.

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.

A Quick Return to Activity After Minimally Invasive Surgery

Gwen Sutherland called her surgery “perfect,” and her surgeon, “amazing.”

Gwen’s medical history included thalassemia, a ruptured ectopic pregnancy, and some internal adhesions, so she wanted to make sure that her uterine prolapse repair and vaginal hysterectomy were done by someone who presented her with the lowest risk of surgical complications.

The 69-year-old Virginia resident’s original concerns took her to MedStar PromptCare, where she was referred to the National Center for Advanced Pelvic Surgery at MedStar Washington Hospital Center. There, she found Andrew Sokol, MD, Urogynecology, an expert in minimally invasive pelvic reconstructive surgery.

An active grandmother who helps care for her grandson, Gwen did not want an external incision, and she hoped for a quick return to her daily routine after surgery.

“I was also concerned about the length of time I would have recovering from anesthesia,” she says, but reports that her anesthesia team of Ma-Paz Giorla, MD, and Ashleigh DeChow, CAA, took care of her needs, and made sure that she had no post-op pain.



Ma-Paz Giorla, MD and Ashleigh DeChow, CAA

Gwen’s day of surgery started first thing in the morning, and she was on her way home around four that afternoon. “I had not one bit of pain, and only needed minor pain control” for the first week she was home. “I didn’t really bleed after I left the hospital, and the post-operative discharge I had was minimal,” she added. “The only ‘can’t’ I heard was, ‘You can’t do any heavy lifting for four to six weeks,’ and that was okay with me.”

“Gwen’s quality of life after her prolapse repair was terrific, with a quick return to activity,” reports Dr. Sokol. “She didn’t have to stay in the hospital, and could recuperate with the help of her adult daughter, at her home.”

Cheryl Iglesias, MD, section director, Urogynecology, says of the half-million hysterectomies performed each year in



Andrew Sokol, MD and Gwen Sutherland



Cheryl Iglesias, MD

America, only 20 percent are done vaginally, even though a vaginal hysterectomy has the fewest reported complications, the least amount of pain, and generally presents the fastest recovery for the patient. Approximately 60 percent of hysterectomies are still done as traditional open surgeries, and 20 percent are laparoscopic and robotic.

At the Hospital Center, explains Dr. Iglesias, “patients can take advantage of seven attendings with expertise in minimally invasive gynecologic surgery and female pelvic medicine and reconstructive surgery. We also have internationally-renowned fellowship programs in urogynecology and minimally invasive gynecologic surgery. Alumni from our program hold significant academic posts and many prestigious programs.”

Gwen was happy that she could tap into that expertise. “I can’t imagine having a hysterectomy, or any other type of pelvic repair, done any other way than the way that Dr. Sokol took care of me. I would recommend this to any woman who needs the expertise he and his colleagues offer.”

Queries: Why It's Important to Clarify Your Charts

You've opened MedConnect, and see that you've received a query.

Question: It's important to answer that query within 48 hours, because:

1. Your response affects your reputation and the reputation of your service line
2. Your response affects our Case Mix Index (CMI), Length of Stay (LoS), readmission rate, and mortality
3. Your response can affect our CMS Star Rating
4. Your response can improve the accuracy of the Diagnosis-Related Group (DRG)
5. Your response affects the quality and safety of the care we provide to our patients
6. Your response can improve our quality metrics

Answer: All of the above.

"If you get a query, it's not a judgment of your treatment for your patient," explains Jessica Fields, MD, MHA, MBA, physician advisor. "We're not judging anyone for a treatment decision. We're making sure that the diagnosis is clear and documented correctly in the patient record."

Chief Quality Officer Karen Jerome, MD, explains it's important for the record to be accurate. "The patient record reflects our excellence in care. As consumers become more aware of the Star Ratings and the Hospital Compare website, our reputation is at stake. We need to fully capture the story for each person's inpatient stay."



Cutline: The Clinical Documentation Specialist team includes (seated) MaCecilia Velasquez, RN; Tashika Newman; Louise Burrell, RHIT, CCS; and (standing) Stephanie Jerome, RN; Ruth De La Concepcion, RN; Soosan Varghese, RN, CCDS, MHCA; Kim Bond, RN, MSN, CCS/CDIP, CCDS; Michelle Tarkington, RN; Sefanit Gizaw, RN. Not in photo: Pauline Palmer-Williams, RN, CCDS, Dana Parker, NP, and Casey Cushman, NP.

Andrea Ryan, RN, senior outcomes manager, assures providers that everyone understands the frustration with receiving a query. "In the past, with paper charts, providers could look at all previous records, each diagnosis and co-morbidity, and have it fresh in their minds. But with the electronic medical record, each episode is 'ground zero,' because coders can only code off the current chart. For example, if you had all the co-morbidities listed in the patient's last admitted stay, you can read that to refresh your memory. However, you have to include it in the chart this time, or we can't determine the acuity and risk adjustment for the current inpatient stay."

One way in which queries are generated is from work done by our Clinical Documentation Specialists, who currently touch 95 percent of discharges, says Andy Markel, CCS, COC, CPC. Markel, senior director of Business Intelligence and Revenue Cycle, says "the work done by the Clinical Documentation Specialists has an impact on the hospital's CMI, which translates into a dollar value estimated between one and two million dollars per month."

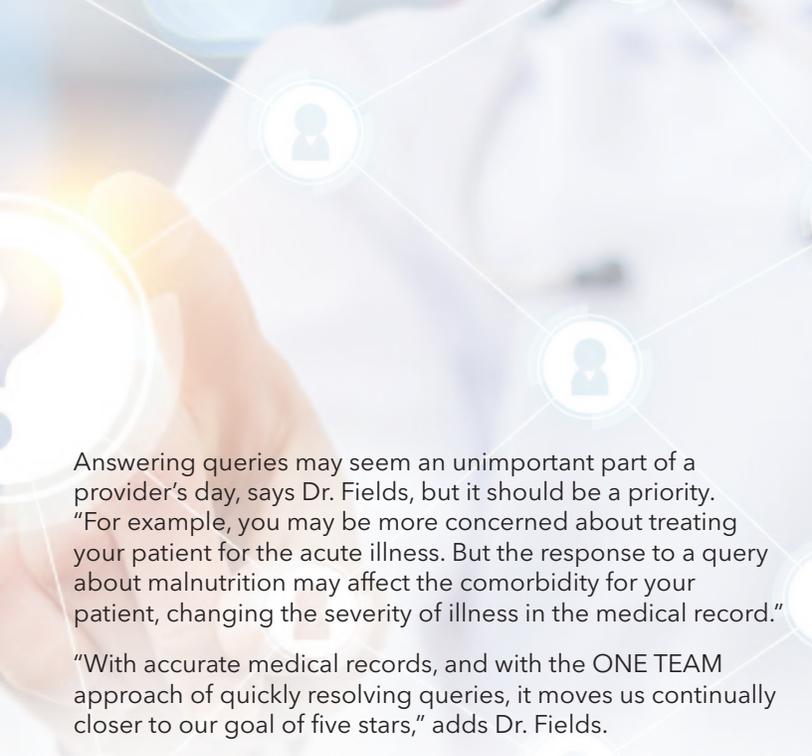
Dr. Fields provides ongoing information to all departments that request clarification about queries and why they're necessary.

"Dr. Fields and her team have been amazing collaborators, as our group works to improve patient care documentation," states Burn Center Director Jeffrey Shupp, MD, FACS. "She is always available to answer questions and provide real-time advice when needed."

"Her lectures have made a huge impact in our documentation practice," says Uzma Vaince, MD, FACP, MBA, Hospitalist director. "With our week-on, week-off schedules, Dr. Fields presents the information to both groups. We identify a topic, and ask her to present. Many times, our sessions run longer than scheduled, due to the interest generated within our team."

To help explain the most common topics that end up in queries, Dr. Fields developed the "Documentation Diamonds" more than a year ago. "Every month, there's a new topic, and the one page of information is sent out with *STAT Update* to all members of the Medical & Dental Staff. You can also get electronic copies by contacting me."

Another example of why it's important to answer a query is cited by Ryan. "We need to make sure that we capture as much acuity as possible for each inpatient, and that any Patient Safety Indicators (PSIs) were not hospital-acquired, if that's the case. In November 2019, there were 52 PSIs, but with clarification provided by queries, 29 of those PSIs were overturned."



Answering queries may seem an unimportant part of a provider's day, says Dr. Fields, but it should be a priority. "For example, you may be more concerned about treating your patient for the acute illness. But the response to a query about malnutrition may affect the comorbidity for your patient, changing the severity of illness in the medical record."

"With accurate medical records, and with the ONE TEAM approach of quickly resolving queries, it moves us continually closer to our goal of five stars," adds Dr. Fields.

Documentation Diamonds

Documentation Diamonds are a monthly tool to help define and explain the most common documentation issues. They are distributed to the Medical & Dental Staff every third Friday of the month, attached as a PDF to that day's STAT Update.

September 2018	Congestive Heart Failure
October 2018	Functional Quadriplegia
November 2018	Accidental Puncture/Laceration, PSI-15
December 2018	Malnutrition
January 2019	Cerebral Edema/Compression/Herniation
February 2019	SIRS vs. Sepsis
March 2019	Body Mass Index (BMI)
April 2019	Acute Blood Loss/Anemia
May 2019	Cerebrovascular Accident (CVA)
June 2019	HIV/AIDS
July 2019	Pneumothorax, PSI-6
August 2019	Chronic Kidney Disease (CKD)
September 2019	Myocardial Injury
October 2019	Pressure Injury, PSI-3
November 2019	Coma
December 2019	Acute Kidney Injury/Acute Tubular Necrosis
January 2020	Pneumonia
February 2020	Coagulation Disorders

Top TEN Questions About Queries

Q: What is a query?

A: A query is a question, asked to clarify and accurately reflect any procedure codes, diagnoses, and/or comorbidities/complications on a patient chart.

Q: Who can receive a query?

A: Attending physicians, Advanced Practice Providers, residents, and fellows—everyone on the team is responsible for the information in the patient chart.

Q: How do I know if I have a query?

A: When you go to MedConnect, you'll see this notification:



Q: Why am I getting a query?

A: There may be a discrepancy in the chart, or a difference in opinions noted in the chart, or a lack of follow-through to rule in or out a specific diagnosis.

Q: Who is sending this query to me?

A: There are three possibilities:

- One of our in-house clinical documentation improvement project nurses, who review charts in real time, as providers see patients
- MedStar system coders, who assess every inpatient chart once the chart is finalized
- A third-party vendor contracted by MedStar Health, Accuity, which reviews a certain number of charts for discrepancies

Q: How is the query formatted?

A: There are four sections:

- Clinical indicators, the reasons why we're asking a question
- The actual query, which is the question you need to answer
- Reviewer notes, from the person sending the query that may be relevant to your answer
- Your response to the query

Q: What do I do, when I get the query?

A: Please read the query, and think about your response. You then have four options:

- Respond
- Disagree with the query
- Defer answering until a later time
- Refer the query to clinical documentation review

If you respond or disagree, your comments will be in the chart.

Q: Where can I find examples of responses to queries?

A: Go to MedConnect > Clinical Documents > Documentation Clarification/Queries

The easiest way to respond is to carefully read the question and answer it as succinctly as possible. Please do not send poems, two-page detailed answers, or comments, such as "YOU read the chart."

Q: Who is involved in the clinical documentation improvement (CDI) project?

A: CDI nurses, the systemwide coding team, and members of the Quality, Finance, and Clinical teams at MedStar Washington Hospital Center.

Q: Why is CDI so important to the hospital?

A: We've focused on CDI improvement for several years:

- We want to accurately capture all complications and comorbidities for each inpatient
- We want to accurately chart the patient's diagnoses for patient safety and quality indicators, mortality, readmissions, and billing

When It Comes to Email Phishing Please Don't Take the Bait

Hardly a day goes by without some type of spam email showing up in MedStar email inboxes. We're all familiar with the "usual suspects"—royalty from distant lands alleging kinship, purveyors of discounted debt relief strategies, and other offers or appeals so ridiculous that surely they can't be true.

The nefarious "art" and science of email fraud has become quite sophisticated in recent years, to the point where you may not immediately realize the message is a hoax, and a potentially dangerous one at that. The practice, known as "phishing," uses data hacked from unprotected email systems to craft a message that appears to be from a trusted sender. But it's actually an attempt to invade a larger computer system, such as the ones supporting MedStar Washington Hospital Center's operations.

Citing what sounds like a legitimate business or personal reason, the email lures the reader into providing personal information (e.g., credit card or Social Security numbers, passwords, etc.) that can be used to defraud the individual or owner of the larger computer network. Similarly, clicking an embedded link or opening an attachment introduces malware into the computer network, giving the scammer unfettered access to important, often confidential information.

Understandably, a busy physician sorting through dozens of emails during the day can be tricked into assuming that such a message is legitimate. Since the Hospital Center's Information Systems have cybersecurity tools designed to catch phishing attacks before they happen, an email should be "clean."

That's true says, John Rasmussen, MedStar Health's vice president and Chief Information Security Officer. But the sources and methods of phishing attacks are constantly moving and evolving targets. With approximately four million emails addressed to MedStar end-users arriving each month, a small number of infected messages can still evade even the most sophisticated and up-to-date technology.

Rasmussen says that while not all of MedStar's more than 30,000 employees will be scammed at the same time, "clicking just one infected email is all it takes to compromise our entire IT network."

The results can be disastrous, particularly since hospitals and healthcare systems hold troves of confidential data that scammers crave. Last year, for example, Albuquerque, New Mexico-based Presbyterian Health Plan was notified by its managed care company vendor that more than 56,000 patients may have had their protected health information exposed in a phishing attack. A healthcare system in Columbia, South Carolina, was targeted in a phishing attack that may have put the information of 23,000 patients at risk.

"Other phishing incidents literally held hospital computer systems for ransom, or diverted thousands of dollars to paying fraudulent invoices that could not be traced," adds Rasmussen.

It's not just hospital databases that are vulnerable. Phishing-induced malware can also infect medical devices and other technology critical for patient care and hospital operations.

"Any network-connected device is at risk, and they're not known for security," explains Andrew Puller, MedStar's director of IT Security. "By the time they go through FDA approvals, the technology is already several years old."

Though organization-level computer networks are typically a phishing scammer's "big game," individual physicians and other employees are not immune. Accessing a personal email account through the MedStar system creates another vector for an infected email, especially when using a mobile device.

"You usually don't see the sender's entire address, so you may miss a tip-off that the email is suspect," advises Inhel Rekik, MedStar Health's director of Health Technology Security. "Along with crippling your own device, hackers can get into your personal address book of trusted contacts, and start phishing them."

Fighting Back

"A race," is how Alice Parrish, MedStar Health's vice president of Hospital Support, Information Services, characterizes the organization's concerted effort to stay ahead of phishing attacks that can occur at any time, and to any user.

"They're continually inventing new ways to get into a system," Parrish says. "We continually update our filters, firewalls, and encryption programs, and have security analysts working 24/7 to monitor messages for security threats."

Yet even with all this technology prowess, physicians and other end-users remain the last and most important line of defense against phishing attacks.

That's why MedStar Information Systems has stepped up efforts to alert physicians, nurses, and support staff to potential phishing enticements. Perhaps the most familiar step is the banner that automatically appears on emails originating from outside the MedStar network. But Stephen Willson, regional director for Information Technology, oversees the Hospital Center's systems, and says that's just the start.

"We want everyone to take the time to look carefully at each email, and decide if it's legitimate or not," he says. "For



MedStar Information Systems leadership includes John Rasmussen, vice president and Chief Information Security Officer; Alice Parrish, vice president of Hospital Support, Information Systems; Stephen Willson, regional director for Information Technology; Drew Puller, director of IT Security; and Inhel Rekik, director of Health Technology Security.

example, do you recognize the sender or return email address? Or is there something unusual about the spelling or grammar?"

The topic of the message may also be a tip-off. Willson recalls receiving an email containing what appeared to be a link to a news article. "It didn't make sense—why was this person sending something to my work address," he recalls asking himself. Sure enough, the message was an attempted phishing attack. Similar suspicious scams include unsolicited resumes, or requests to augment information the sender claims to already have.

"If you know the sender, it's best to verify the email's legitimacy with them by some other means, either by phone or a different email address," Willson adds.

Learning by NOT Doing

Because practice makes perfect for any skill, including phishing awareness, IS also conducts phishing simulation tests, using a variety of common attack strategies. In one recent exercise, six percent of physicians and associates who received emails crafted to resemble suspect messages opened an attachment that could have, in the real world, contained dangerous malware.

"That's progress," Willson says, "but we need to move that needle further, to zero percent."

That means future phishing simulations, with physicians and associates who repeatedly fail the tests subject to mandatory follow-up education and training, as well as other disciplinary actions.

Puller stresses that even with increased emphasis on preventing phishing attacks, mistakes can still happen. A physician or associate who inadvertently falls for a phishing attack should immediately contact the IS Service Desk.

"We applaud anyone who reports a suspicious email, even if they opened something accidentally," he says. "The sooner we can act on it, the better."

While some may consider MedStar's anti-phishing actions to anything from an unwelcome annoyance to a time-consuming hassle, Rekik reminds physicians and associates that combating these threats safeguards not only physicians and associates, but also the patients and families who have placed their trust in MedStar.

"At end of the day," she says, "it's all about protecting patients and providing safe care."

Around the World with Anesthesiology: Four APPs Circle the Globe

Among them, four Anesthesiology Advanced Practice Providers have hit every continent, and their experiences range from sharing lunch with a giraffe in Nairobi to spending 60 grueling hours on a medical mission in Honduras.

What makes them such globetrotters?

Maybe it's because they have flexible schedules, or because their job includes high stress, or because they see this short window of opportunity. They clearly feed off each other's adventures, and often travel together.

Here's an armchair view of their travels:



Bill Doolin, CRNA

Bill Doolin has completed two medical mission trips to Honduras, in addition to many trips just for fun—England, France, Switzerland, Germany, Denmark, France, Aruba, Jamaica, and Turkey, where he got engaged this summer.

Doolin started traveling in high school. "I'm fortunate that my parents encouraged me to travel and to interact with other cultures," he says.

Doolin gets together with his coworkers, sometimes at lunch, but most often at weekend brunches or birthday celebrations. He says, "We quiz each other about where we went, what we would avoid, and what we would do again." In early March 2020, he's taking a short ski trip to Beaver Creek, Colo. with 10 friends.

But the upcoming year may put a crimp in his travels, since there's a "destination" wedding planned. "In Loudoun County, Va.," he laughs. "It's our escape from the city, and we love it!"



Scott Plunkett, CAA

Scott Plunkett says his travel bug didn't start until he was an adult. "I'm from Ohio," he says, "and our only family trips were the same every year—we'd visit our grandparents in Ft. Myers, Fla."

He was bitten by the travel bug later than Bill Doolin, but is catching up fast. He says, "When one of us travels some place and comes back and shares pictures, it opens our eyes, and we want to go, too."

Last fall, he and his girlfriend, Jasleen Kaur, and 20 college friends traveled to South America, where they roamed through Buenos Aires, "a city with a beautiful, cool vibe," he says, "with 19th century architecture, great food, interesting history, and amazing tango and salsa dancers!" They biked through wine country in Mendoza, the foothills of the Andes, where they saw spectacular views; then traveled to Cajon de Maipo in Chile, which was "a beautiful valley surrounded by rugged peaks, with free roaming goats, cows, and horses," he says. "We went to a volcanic hot springs that was phenomenal, followed by a hike to a waterfall, where our guide cooked us steaks."

"When traveling, you should go with an open mind, take it all in, and gain that perspective," Plunkett states. "It changes you, to see how different people interact, and how you fit in as a foreigner. There's nothing more humbling than being dropped off of a bus station in Santiago, not speaking the language or knowing how the ATM works. You learn to sympathize with foreigners traveling in this country."

He's been on a medical mission to Bangladesh, a place he says he'd never have visited on his own. "I'm not naïve, but there's nothing like seeing the level of care there to make you realize how lucky you are, and how fundamentally different someone else's life is, because of where they live."



Tracy Ojeniyi, CRNA

Some might think that Tracy Ojeniyi's methodology for planning a trip is unconventional, but it works for her. She says, "I try to do one big, two-week trip, and a couple of little trips, every year. I start by looking at deals on flights. I'm not so focused on a particular place as much as I am on a deal, my availability, and the weather—I like warm, sunny weather. There's so much to see in this beautiful world, and I want to see it all."

She went to Nairobi last year. "I saw this place—the Giraffe Manor—on TV years ago, and knew I wanted to go. The waiting list is a year long, because they only have 11 rooms. It was incredible; I even shared breakfast with giraffes."

She also went to Zanzibar and the Seychelles, where it was sunny, warm, and included spa time. Ojeniyi's father is Nigerian, so a trip to Africa "is like returning to the Motherland." In Zanzibar, she found a lot of poverty, but the people warm and welcoming. "The average person there speaks three languages: Swahili, German and English," she states. "Americans? We are so sheltered. Meeting those people makes me realize people can be happy with very little."

Caitlin Burley, CAA

Caitlin Burley spent four weeks this fall on the trip of all trips. With two friends, she completed the 50-mile "W Trek" through Patagonia, at the border of Argentina and Chile. They climbed aboard a 190-passenger ship, and rounded the Falkland Islands and South Georgia to reach Antarctica. The 20-day trip included lectures from marine biologists and historians.

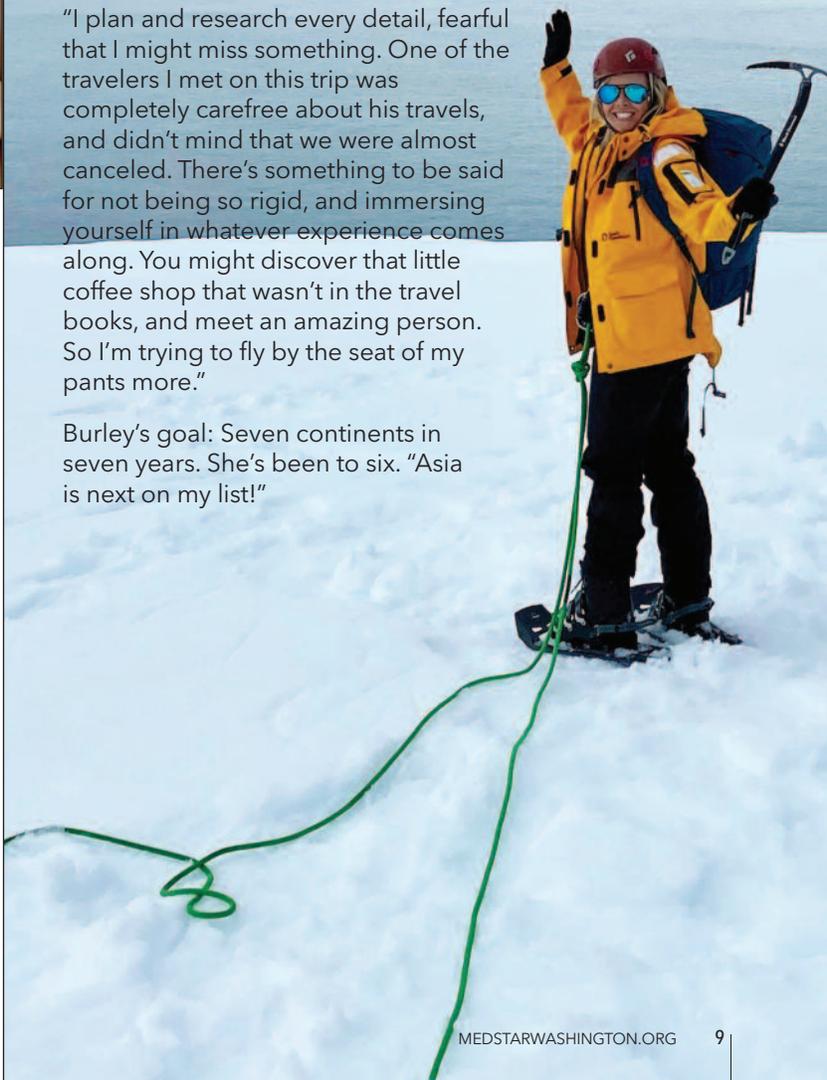
"We took Zodiacs to get up close to penguins, seals, and breaching humpback whales. The views were absolutely unbelievable." They also mountaineered—donning snow shoes, roping themselves to each other, and trekking across glaciers with large crevasses, covered in snow.

Orcas chased a penguin while the passengers were in the Zodiacs, she recalls. The penguin jumped into one of the zodiacs and rode with the passengers, until the whales got tired of following, and the penguin jumped out and went on his merry way.

Another event involved a passenger who broke her leg, and had to be transported to a field hospital, almost causing the Antarctica trip to be canceled or truncated. "I was so stressed," she says. "Luckily it didn't happen, but it taught me a lesson about traveling."

"I plan and research every detail, fearful that I might miss something. One of the travelers I met on this trip was completely carefree about his travels, and didn't mind that we were almost canceled. There's something to be said for not being so rigid, and immersing yourself in whatever experience comes along. You might discover that little coffee shop that wasn't in the travel books, and meet an amazing person. So I'm trying to fly by the seat of my pants more."

Burley's goal: Seven continents in seven years. She's been to six. "Asia is next on my list!"



STEPHEN GUNTHER, MD

Skates into Retirement



On a frigid winter day some years ago, the thermometer dropped to three degrees, followed by precipitation that quickly solidified into a field of ice over the courtyard at MedStar Washington Hospital Center. The day's surgeries were cancelled, and Stephen Gunther, MD, knew a golden opportunity when he saw one. He laced up his ice skates and headed outdoors, to make the best of a bad weather day.

"That first day it was just me," he remembers. "A few residents, including my son, joined me the next day."

That adventure has become an urban legend at the Hospital Center. And Dr. Gunther has retired, after 45 years at the Hospital Center. The first 31 years, he served as chair of Orthopaedic Surgery, where he saw many changes to the practice of surgery and to the hospital itself.

A career in Orthopaedic Surgery came naturally to Dr. Gunther. His father and brother were both orthopaedic surgeons, and one son has followed in the family footsteps.

Born in Troy, New York, on Halloween, 1941, he attended Albany Academy, followed by Yale University. At Albany Medical College, he was elected to Alpha Omega Alpha Honor Medical Society, which was followed by a residency at Yale New Haven Hospital. Each step of the way, he filled leadership positions and played competitive sports. A beneficiary of a military scholarship program, he was assigned to the former Bethesda Naval Hospital after residency.

After three years at Bethesda, a colleague approached Dr. Gunther about an opening at the Hospital Center, to oversee the Orthopaedic Surgery residency program. "I decided to give it a try," he says. "I didn't want to spend the rest of my life wondering about whether I'd like an academic career."

From that point, Dr. Gunther strengthened the residency program and built an equally strong Orthopaedic Surgery department. He pursued research interests whenever he could, particularly working on ways to help damaged nerves recover.

After thousands of surgeries, one case still stands out. "A patient came to me, 20 years after being shot in the knee during the Korean War. He had just started a transmission repair business, and needed the use of both legs. I performed a total knee replacement, and it was still functional, 40 years and two revisions later," he says. "That makes me happy."

During his 45 years at the hospital, arthroscopic surgery was in its early days. "A former resident brought me a photo that showed me putting my eye to a tube, and looking at the joint," he remembers. Today, while advanced technology is ubiquitous, he says many surgeries remain the same. "Techniques are not as different as you might think. We just have better equipment."

What has changed most in his specialty? "All our surgeons specialize in a certain area," he says. Dr. Gunther started as a generalist, but in the past 20 years has concentrated on hand and upper extremity surgery. "I like the detail work," he acknowledges.

Dr. Gunther was the first full-time surgeon on staff, soon followed by others, most also from a Navy background. He has had a hand in shaping the hospital, too, filling many leadership roles, and was given the Gold-Headed Cane Award by his peers in 2006.



Opposite page: Dr. Gunther skates in the frozen-over hospital courtyard 25 years ago

Top left, Dr. Gunther in his Albany Academy uniform

Top right, Dr. Gunther with co-honoree Joseph Lindsay, MD, Cardiology, after the 2006 Gold-Headed Cane Awards

Bottom left, President Gregory Argyros, MD, presents Dr. Gunther with the President's "Above & Beyond" Coin Award

Bottom right, Dr. Gunther leads the pack of senior-level speed skaters in a race

Outside the hospital, Dr. Gunther was active in professional societies, research projects, and publications. He has stayed physically active, playing ice hockey and baseball, even playing semi-professionally. Now, Dr. Gunther sees a chance to wind up his sports participation.

"I'm the oldest hockey player anywhere around," he says proudly. Between sports and his 10 grandchildren, he intends to keep active long into the future.

Upcoming CPE Conferences

Lifelong Learning

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

WEEKLY ACTIVITIES

Numerous continuing professional education opportunities, including Regularly Scheduled Series, take place each week at MedStar Washington Hospital Center.

For a complete list of CPE activities, please visit: CE.MedStarHealth.org

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

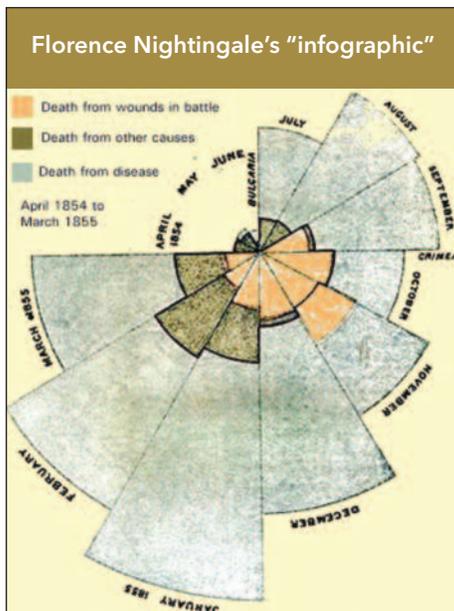
Navigating Changes During the Year of the Nurse

by Tonya Washington, Chief Nursing Officer

Nurses are often celebrated. They are honored during Nurses Week every year, and they always top the “most trusted professional” lists. The World Health Organization just gave us a whole year – designating 2020 The Year of the Nurse, to celebrate the 200th birthday of Florence Nightingale, the Victorian-era crusader considered the founder of modern nursing.

As a nurse for almost three decades, and as the Chief Nursing Officer leading more than 1,800 RNs at MedStar Washington Hospital Center, I believe the accolades are wonderful and well-deserved. (For anyone who wants to celebrate with candy or flowers, my office is in 2A2). Yet one of my missions as Chief Nursing Officer is to use The Year of the Nurse to lead a 2020 re-visioning of nursing.

It’s a big task. Say “nurse,” and most people have a pretty firm idea of a bedside caregiver who helps administer medications and monitor vitals. Like Nightingale, our nurses coordinate the care of patients to achieve optimum health outcomes, facilitating and troubleshooting processes behind the scenes that often go unnoticed. For example, few know Nightingale was a professional statistician and mathematician, the first woman inducted into the Royal Statistical Society in Britain. She is credited with inventing the first infographic, a “coxcomb” that changed British military tactics by showing data visually, proving lack of sanitation, not injuries, killed the most soldiers in the Crimean war.



Like Nightingale, many nurses today are as much scientist/ researcher as caregiver. Half of our patient care nurses are in school earning advanced degrees, many of which will take them back to the bedside as providers. More than 85 percent have a bachelor's degree, and almost all the rest are earning one, as it is now required for employment in most hospitals. This is on top of the

certifications and competencies necessary to be hired for highly specialized care delivery in specialized service lines.

Those entering the career are changing too: 11 percent of nurses today are male, up from nine percent in 2011. Almost



half of all nurse anesthetists are men. In addition, a growing number enter nursing as a second career.

Like providers, nurses spend significant time collecting and analyzing data. In addition, they are creating the software to manage the tasks and information. Nurse informaticists are one of the most sought-after talents in healthcare.

Each bedside nurse is supported by expert nursing teams, including educators, clinical specialists, wound nurses, sepsis nurses, nursing leaders, rapid response nurses, bed management, and case resource management nurses. Nurse scientists support Nursing Grand Rounds and nursing research. A Doctoral Collaborative at the Hospital Center, comprised of dozens of PhD and DNP nurses, leads research on topics, such as managing antibiotic resistant infections, or training to provide care when electronic medical records go down.

All of this is on top of increased emphasis on the key nursing task: engaging patients. Nurses remain the key bedside connection for patients and families, driving the plan of care as well as managing patient and family education, support, and training.

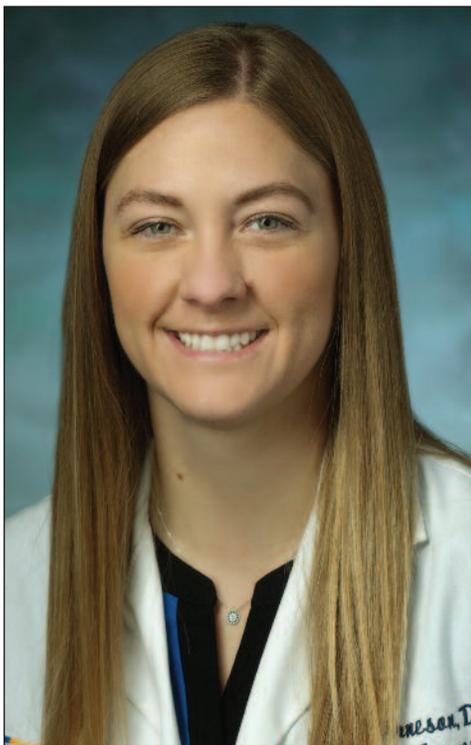
It’s a lot to ask of any clinician, and I’m deeply honored to lead this extraordinary nursing workforce, as we navigate the changes in our profession and health care with our colleagues. The relationship between nurses and providers is among the most important in a dynamic organization like ours. And, we deeply appreciate our collaboration with you, and for all your communication and collegiality, as we work in tandem to provide excellent care. Here’s to continued growth together, with clear 2020 vision of the nursing workforce for The Year of the Nurse and beyond.

Jessica Arneson, DPM

Podiatric Surgery

During this year as chief resident for Podiatric Surgery, it isn't the first time that Jessica Arneson, DPM, has captained a team.

She helped lead the 2013 University of Pennsylvania softball team to victory in the Ivy League Championship, and on to the NCAA National Championship Tournament. As the team's catcher and captain, what Dr. Arneson remembers most from that victory was not her own individual contribution to the season, or even one big game. Rather, it was how she and her six senior teammates grew over the course of four years, and what a stronger team they'd helped create than the one they'd found.



Now, as a chief resident, Dr. Arneson similarly keeps her reflections on the year focused around her colleagues, and the sense of team and comradery that has helped these doctors prepare for their next chapters.

"Everyone tells you the chief year is a lot of work," Dr. Arneson says. "I was blessed with an amazing class of co-residents that have been able to support the work, not just helping me get through, but helping me get

better. They are my best friends, but also the best coworkers I've ever had."

Dr. Arneson is also quick to note that, behind every winning team, is a coach and mentor. And for Podiatric Surgery, that physician is John Steinberg, DPM, who directs the residency program.

"He provided the opportunity for me to come to MedStar, and see what an excellent residency program looks like," Dr. Arneson says. "Dr. Steinberg has provided all of us with one of the best educations our field can offer, and shows us how far you can go in our field, and how much of a difference you can make in patient care."

When it comes to building on an already world-class program, Dr. Arneson hopes that her contribution to the program will be

helping to send physicians out into the world to make a difference. In collaboration with other surgical programs in the country, Dr. Arneson is working to institutionalize two annual mission trips abroad, to under resourced populations. "It felt like a feasible project, and one that our program could really help get off the ground," says Dr. Arneson, noting the trips would likely focus on Central or South America.

Dr. Arneson says she feels incredibly grateful to be learning complex reconstructive surgery from one of the most well-known locations for limb salvage. She'll take that knowledge forward, into a fellowship at The CORE Institute, The Center for Orthopedic Research and Education, in Phoenix, where she'll be concentrating on total ankle replacements and complex reconstructive foot and ankle surgery.

"We can help patients that typically have end-stage deformity and are often left with very few surgical options, essentially having to fuse an ankle in place." Dr. Arneson says she's excited to be a part of recent advancements, to give patients more joint mobility to perform daily activities.

Ultimately, Dr. Arneson hopes to work at a teaching institution, similar to the Hospital Center. "I want to provide what I was able to learn here and in fellowship to residents." She'd also love to follow in the footsteps of several key mentors, and play a role in the American College of Foot and Ankle Surgeons.

Dr. Arneson hasn't donned her catcher's mitt in a few years, but the Podiatric Surgery residents did win a flag football championship last year. She's quick to laugh about their title, and note she's not very good at flag football, but in some ways, it proves her point about a strong team.

"It just shows that we're not just eight random people picked each year. The Hospital Center selected such a well-rounded class that meshed together, and created colleagues and camaraderie that we'll have for the rest of our professional careers."



The future Dr. Arneson tags out a Dartmouth player, leading the University of Pennsylvania softball team to victory for the 2013 Ivy League Championship.

Javairiah Fatima, MD

Vascular Surgery

Javairiah Fatima, MD, is often heard telling her residents and students, "To do this work, you must have your heart and soul invested. It is not a day job that ends with the day, it needs you to be all in."

For Dr. Fatima, the new co-director of the Complex Aortic Center at MedStar Washington Hospital Center, the work of repairing aortic aneurysms and limb salvage has always been much more than a job.

"Being a vascular surgeon is different; you can't just disconnect when you go home, and the next day is the next day," Dr. Fatima says. "Patients have trusted me with their lives. I make sure they can always reach me directly, when they need to. A ruptured aneurysm is not compatible with life, so it's almost like giving them a second chance at life. It's a privilege to have that skill."

Dr. Fatima believes that her profession allows her to develop long-term relationships with patients and families, many of whom reach out at the holidays, year after year, thanking her for saving a life, or regaining a quality of life.

Dr. Fatima was tapped by Vascular Surgery Chairman Edward Woo, MD, to help grow the Complex Aortic Center's capacity. "Dr. Woo is truly putting this Center on the map," Dr. Fatima says. "He said he needed someone who could step in, and hit the ground running around complex aortic work, and I hope that's what I'm doing," she says.

Dr. Fatima is the only female vascular surgeon in the nation to have an Investigational Device Exemption (IDE) to engage in clinical studies around novel techniques in the realm of complex aortic aneurysms.

"This technology gives patients more options, when it comes to complex repairs," Dr. Fatima says. She notes that the Center is currently leading several clinical trials for surgeries for aortic aneurysms, aortic dissections cerebrovascular, and peripheral vascular disease, which puts the Hospital Center on the forefront cutting edge of technologies not available at other major hospitals.

She joined the Hospital Center in the summer of 2019, and Dr. Fatima says she was immediately struck by the team approach, evident across the entire organization.

"The complexity of what we do requires a team approach, and can't be done in silos. It requires excellent collaboration between our team with cardiac surgeons, cardiologists, fellows, residents, nurses, physical therapists, and so many others. The manner in which we work together is unique, and there is a wonderful relationship between departments, which is crucial to success and good patient care."



Dr. Fatima is also excited to bring an additional and diverse perspective to the team. As a doctor of Pakistani origin, Dr. Fatima says she can understand a multitude of shoes that patients walk in, offering what she hopes is a level of insight and compassion through the strength of diversity.

But above all, Dr. Fatima just wants colleagues and patients to know that she is always there for her patients, to provide them the best care possible, and always be approachable.

"Even when I'm on vacation, my phone is always turned on, and I always answer," she says. "I just want them to know that I'm here for them."



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Physician's Perspective



From the Desk of...

Vesna Petronic-Rosic, MD

Chair, Dermatology

Dermatology at MedStar Washington Hospital Center reflects our hospital's mission: to provide sophisticated diagnostic and treatment services for complex conditions from around the region, and to provide more routine care for our surrounding community.

What sets us apart from community-based dermatology practices is the depth of our expertise, and the breadth of our services. Our department includes 10 dermatologists and one pathologist, providing full-service inpatient and outpatient care for more than 3,000 conditions of the skin, hair, and nails.

For inpatients, dermatologists care for patients who have complicated dermatology conditions, and medical conditions with dermatology complications. In addition to general and pediatric dermatology, our specialty clinics accept patients for pigmented lesion and melanoma surveillance, skin cancer, cutaneous lymphoma, connective tissue diseases, immune blistering diseases, transplant-related diseases, and genodermatoses.

Outpatients are seen at six different locations with our main office in Chevy Chase. We treat adult patients at the Hospital Center and in the Physicians Office Building; at MedStar Georgetown University Hospital, and at Lafayette Centre. Our pediatric dermatology

patients are seen at our Tenleytown location.

Skin cancers are a mainstay of our practice. As such, we work closely with the Lombardi Comprehensive Cancer Center's medical, surgical, and radiation oncologists, offering seamless care. We are part of the Georgetown University Melanoma and Skin Cancer Tumor Board, and provide melanoma patients access to the newest treatments with the most promising results. We are first in the MedStar system to offer Mohs surgery.

We treat some very complicated cases, and routinely consult with rheumatologists, plastic and burn surgeons, gynecologists, podiatrists, and otolaryngologists. We offer in-house microscopic interpretation of skin biopsies by highly trained dermatopathologists with expertise in both inflammatory and neoplastic diseases. We offer laser treatment to help burn patients recover function.

Our physicians participate in research projects that push Dermatology clinical and scientific boundaries, with an emphasis on patient safety. We have two academic training programs, one in categorical dermatology; the other combines internal medicine and dermatology. Our 16 residents rotate through the Hospital Center, MedStar Georgetown, and Children's National Hospital. To consult with one of us, please call 301-951-2400.

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