MEP NEWSLETTER

"MEP is the recognized leader in providing exceptional emergency medical care. We improve the health and promote the well being of the individuals and communities we serve."

VOLUME 8, ISSUE 1 AUGUST 2006

MEP LEADERSHIP

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Medical Director SGAH Germantown Emergency Center
Michael Cetta, MD

INSIDE THIS ISSUE:

Meet our Newest Providers 6, 7

Germantown-Our Next Frontier 8

Fixing Up A Car 12

The Growth Gamble

Angelo Falcone, MD

In the beginning of the year we listed four major strategic goals for MEP; smart growth, strengthening our culture, developing our leadership and defining a quality process. In the last issue I discussed the MEP culture. In this issue I will focus on smart growth and what it means for MEP and, more importantly, for you.

Ray Koch, the founder of McDonalds, is quoted as saying "either you're green and growing or brown and dying". There is no in between in that statement. While most would agree that growth is good there are numerous examples where growth didn't exactly provide the kind of value to shareholders that was expected, ala Enron, and other recent and past corporate debacles. So what exactly is the value of MEP's growth for you and how do we plan to do it successfully?

Our plan is to aggressively market MEP in the Washington-Baltimore metro area in order to secure a minimum of one contract a year for the next several years. We have also targeted hospitals outside this area in order to introduce MEP to the Mid-Atlantic region and build the MEP name and "brand". That is where we are going but let's takes a look at where we've been in order to provide some perspective on our chances of achieving this lofty goal.

This year we have witnessed the success of the St Mary's transition and are preparing for the opening of the Germantown Emergency Care Center including the hiring of five new full time physicians to the Shady Grove staff. In the 10 years of the existence of MEP we have grown from 12 full time physicians and 6 MLPs serving 55,000 patients to 35 physicians and 15 MLPs treating 130,000 patients. Impressive statistics no doubt and (same question) what does it mean for me?

The success of a company's growth can be measured in many ways. I would like to focus on two that are critical, *opportunity and market strength*.

Does growth provide opportunity to a greater number of individuals?
There are more individuals involved today, at a leadership level, in making MEP successful than there has ever been in our history. These include an increase in leadership positions at both campuses (ED review, education, ultrasound and EMS to name a few). These leadership opportunities allow younger members of MEP to learn and develop specific skills (including making mistakes) that will be needed to continue to make MEP successful. It also provides a degree of accountability for results that are critical to successful companies.

Does it increase the strength of the group in the marketplace?
The strength of the group is not only a function of "being here", it is also a reflection of the group's ability to bring increased benefits to each provider. We will need to continue to attract premiere talent as well as have an impact on the delivery of care in a positive manner.

So as you can see, we have a plan, a history of success and the belief that each member of MEP will benefit from our growth strategy. Finally, in the next several months we will begin a conversation that clarifies the increasing number of opportunities at MEP. We will also be increasing the frequency of communication about where we are today and where we are going. We look forward to continuing the discussion.

New Training Program

Scott Freedman, MD

Submitted by Scott Freedman, MD: Recently, Shady Grove Adventist Hospital, the Pediatric Emergency Department and MEP have embarked on an exciting, new venture. Though there have been a number of communications describing details of this arrangement directed to the MEP staff, we proudly wanted to share with you the body of a letter Debi Yancer, President of Shady Grove, sent out to SG's employees, the entire medical staff and SGs governing and founding boards, . To appreciate Shady Grove's full commitment to the program, the letter is provided verbatim, with only a small amount of the details removed for this newsletter briefing.

FROM: Deborah A. Yancer, President

DATE: June 27, 2006

SUBJECT: New Training Program at Shady Grove Adventist Hospital

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"….. Shady Grove Adventist Hospital has entered into an affiliation with the Georgetown University/ Washington Hospital Center emergency medicine residency program and Georgetown University pediatric residency program. Beginning on June 29, 2006, our hospital's Pediatric Emergency Department will serve as a designated site to train PL1 and PL3 emergency medicine residents and PL3 pediatric residents.

As you know, Shady Grove Adventist Hospital has one of the busiest emergency departments in Maryland and on the East Coast. Our extensive knowledge and experience with emergency medical care for both adults and children will provide a wonderful training experience for physicians who are in training. In addition, having an affiliation with Georgetown and Washington Hospital Center—two outstanding hospitals in our area—will enhance our hospital's reputation as a center of excellence in the care of children.

Together with Montgomery Emergency Physicians, our goal is to provide excellent care for patients who seek care in our Emergency Department. Our physician staffing will not change, and we anticipate that this affiliation will further enhance our ability to provide the best possible care. Dr. Scott Freedman, the MEP Pediatric Director, and Dr. Julian Orenstein, the MEP Education Coordinator, will supervise the program at Shady Grove Adventist Hospital.

Our reputation as an excellent hospital has helped us to build this important partnership and offer this new program. We look forward to working with the participating residents to provide outstanding health care to our community. We hope that you will join us in celebrating this wonderful new program at Shady Grove Adventist Hospital. "

"Meet MEP's Newest Providers…"

MEP is proud to introduce the newest additions to their organization. Each new provider has been selected for their expertise, experience and their fit with MEP's Mission and Core Values. MEP is pleased these exceptional providers have selected MEP. These Physicians, Physicians Assistants and Nurse Practitioners will continue with MEP's goal of: Excellence in Emergency Medicine (Bio's continued on pages 6 and 7).

Creating a Culture for Success

David Klein, MD

As Chief Operating Officer of MEP, my job description reads: "*To ensure that MEP is a success in all our campuses".*

How do I (we) define success? Most Emergency Department providers would say that a successful group is one that provides quality emergency care. Quality care is usually defined as, "*Emergency care within the standards of care of the hospital, the community physicians, the group's physicians and ACEP".* Every ED group should make this statement about their group! Most groups do provide this type of care. Providing quality care just gets us "a seat at the table". If we didn't provide quality standard of care medicine, we wouldn't be staffing any ED for very long and that seat would be given to someone else.

How does MEP define success? Our mission statement reads: *MEP is the recognized leader in providing exceptional emergency medical care. We improve the health and promote the well being of the individuals and organizations we service".* We want to be the best. Don't be ashamed of saying that. Be proud. No one chose to work for MEP or chooses to stay with MEP because this was their third best option! (Imagine!)

Picture this: You are at a party. Someone you just met asks you what you do for a living. You answer that you are an MLP or a physician at one of the MEP EDs, only to find out that their mother was treated there last week. What is going through your mind? Is it- just the hope that we made the correct diagnosis and instituted the appropriate treatment? I inquire about her overall experience. Was it a positive one? Did she wait long? Did she receive adequate explanations? Was she treated with respect? Were the right consultants called and of course, was the treatment appropriate? The answer to all these questions, not just to one of them, defines success in the ED. We must go beyond clinical success and establish the culture of success.

Culture is defined as behavioral patterns that are characteristic of a community or population. It is the way we act that define us. We have to not just be great clinicians; we need to be great MEP clinicians. We were hired to staff Saint Mary's Hospital ED not just to improve the clinical care patients receive, but also, to change the culture. We were hired to staff the Germantown Emergency Center because the SGAH administration wants to replicate the culture of success we have established at Shady Grove.

Last year, using everyone's input at an MEP retreat, we were able to define *"The MEP way".* Culture is defined by these 12 values. The next step is continue to improve our unique culture is to measure and improve on how we use these values in the workplace in the same way we work on improving our efficiency and quality (as measured by patients per hour, Web QI scores and Peer Review scores).

Every month, a different cultural value will be featured. We will discuss the value at all MEP meetings. You will be asked to provide specific examples of how you or your colleague carried out an act which is in line with the value of the month. The best examples will be printed in the newsletter. Additionally, this will also be discussed at all coaching sessions.

MEP **will be** the premier community based provider of emergency care. By defining, recognizing and actually using these values in the department in our daily interactions with patients and staff, we will ensure the success of our group at every location that we staff.

The Evolution of the Physician/Patient Relationship

Jeremy Tucker, MD

Many things have changed in medicine over the past century. Since the discovery of penicillin there have been many significant advances in all fields of medicine. One thing that had remained fairly constant was the relationship between the physician and the patient. The paternalistic relationship was primarily face-to-face in an office or home with the physician acting as the healer and educator directing care for the patient. The patient usually followed without question. We have all encountered older patients who take numerous medications without knowing why.

Our younger patients certainly do not take this approach. They are more informed and educated than their predecessors. They desire a relationship with their physician that is more collegial. They want a counselor to help them maintain their health. When discussing medical issues they want detailed explanations and they expect options, not directions. This will become even more prevalent as the tech-savvy and affluent baby boomers start experiencing more medical problems within the next 10 years.

Thus, the modern relationship between physician and patient is different. Patients may use computers to help them manage diseases like diabetes. They may bring vital signs, blood sugar levels, recent lab results and medical history on computer printouts when visiting the physician. Some physicians communicate with their patients via e-mail and in some areas of the country tele-medicine is common. The medical information that your patients access is as up to date as the information that you receive, thanks to the internet.

How do we keep up with our side of the relationship? We need to adapt to these changes to keep our patients happy. This has different implications in emergency medicine where the patient may not choose you as their physician. You may not worry about building a practice like a primary care physician but the reputation of your department and hospital is very important for your business in a competitive market. The most important change we can implement is to explain our recommendations to the patient. Offer them options. Let them know why you are starting a particular medication and he goal of therapy. Be sure to ask if they have any questions before you leave the room. Communication with the patient and family is key to building this new, successful relationship

THE CUSTOMERS HAVE SPOKEN!

Congratulations

to the following providers for achieving the top scores in the patient satisfaction surveys.

Saint Mary's Hospital (Press Ganey scores for April –June):

Jill Bujnevic, PA-C

Carol Sullivan, CRNP

Pieter Esterhay, MD

Shady Grove Adventist Hospital (PSR satisfaction survey for February –April):

Julian Orenstein, MD

Annie Soriano, MD

Orlee Panitch, MD

Scott Freedman, MD

Marchele Hills, PA-C

KUDOS to our PCI Program!

David Srour, MD

The state has recently released statistics on hospitals performing PCI for acute MI based on the CPORT data.

SGAH was the busiest center with over 100cases/year and had best door to balloon time. This is no small feat and represents the hard work and dedication of the ED and Cath lab staff as well as all the ancillary services working as a team to provide world class care..

Customer Service

David Klein, MD

Finally!! On the ground. The flight had been delayed due to snow and at long last I had arrived in San Francisco. Now all I needed to do was rent a car. Thirty minutes later I was standing in line at the car rental facility, disappointed to find nine people in front of me. Forty five minutes later I was making progress – I was the fifth in line! Hungry and tired, this was a horrible way to start my vacation. When I finally reached the clerk, I was disappointed again, there was no apology, no explanation and infact the clerk seemed annoyed when I asked him about the delay. He said he was tired and hungry and needed my name to start processing the necessary information. As I replied, I wondered how the current situation was my issue or my fault. I asked him if it always took this long, to which he replied curtly, "…..some customers take longer and this can't be predicted, do you want a car or not?" Sensing his frustration and possible anger (was he mad at me, his company, did he hate his job?), I decided not to ask any more questions….including asking for directions to the city. Was it because I didn't trust him or that the customers behind me were getting restless?

I found my rental car, it was exactly what I had reserved, and it was clean with a full tank of gas. I realized that the goal had been achieved. But did it matter that it took 90 minutes and that the clerk was rude? Shouldn't the end justify the means? I reflected on previous interactions (at car rentals) which had been pleasant, quick and with explanations provided. Those vacations began with a much more relaxed state of mind.

Customer service in the ED is, of course, completely different or is it?. It is only the final clinical outcome that matters. I have heard my colleagues say: "Patients are not customers"; "Where else are they going to go?"; "It is not like we are hurting for patients"; "We don't want the types of patients who don't understand triage and don't expect to wait in an ER".

The definition of a customer is "Someone who pays for goods or services". Patients **<u>are</u>** customers. Do we value their time? Does it matter to you, as their physician or MLP, that it took 6 hours instead of 3 to treat their problem? An explanation or an apology, when appropriate, could certainly help an experience which is anxiety laden for the patient from the beginning. Clinically speaking, there is a better chance the patient will follow your discharge instructions if they do not leave the ED angry and frustrated. Remember, the patients can go elsewhere. Fewer patients require fewer clinicians which ultimately could affect you.

Customer service **<u>does</u>** matter. It is important to the patients, to the hospital administration and to the MEP management team, and therefore it needs to be important to you. At Saint Mary's Hospital, we analyze the Press Ganey scores quarterly. At Shady Grove the hospital uses Jackson Organization Surveys. We analyze those results as well as the results from our own PSR patent satisfaction surveys. We will begin publishing the names of physicians and MLPs who score in the top 25% of the group at each institution.

Try to treat each patient as you would want your family treated. Give them an experience that will diminish their fears and anxiety and maybe you will be one of our next patient satisfaction winners.

ACLS Update

David Srour, MD

Much of what we do in medicine is not based on evidence. Instead we rely on expert consensus, training experience, and "just the way it is done." ACLS is no exception and as more and more real data is obtained, years old practices are being challenged and changed. Some of you may remember routinely giving bicarb and calcium in codes, which was based on no sound data and was subsequently found to be not only ineffective but also possibly harmful The latest iteration of the ACLS guidelines reflects the latest evidence and challenges some our core assumptions about even the ABC's. The following are some of the main points gleaned from the guidelines released this year by the AHA.

Chest compressions:
When you think about it most victims of primary cardiac arrest (VF) are well oxygenated, what they lack is circulation. Therefore the initial emphasis is on chest compressions rather than airway and breathing. Properly done chest compressions can restore about a third of normal cardiac output and has been shown to be a major factor in successful outcomes. Not surprising to anyone who has run a few codes is that chest compression compressions are often performed improperly.

?? The team leader should assure that CPR is being done effectively
?? "Push hard, push fast" is the new mantra. 100 chest compressions a minute is recommended.
?? 100 compressions/minute is difficult for even the most fit to do for very long therefore the team leader should rotate the chest compressor every 1-2 minutes
?? Minimize interruptions in chest compressions e.g. for insertion of airway lines, pulse checks, etc.
?? Allow complete chest recoil
?? Err on side of beginning chest compressions if pulse is not detected in 10 seconds. Pulse detection is time consuming and inaccurate.

Ventilation:
There is a shift in emphasis to chest compressions rather than airway and breathing if the arrest is thought to be primarily due to VF, for the reasons mentioned above.

?? Do not allow securing the airway or ventilation to significantly delay or interrupt chest compressions
?? Perform ventilations at a ratio of 30 compressions to two rescue breaths.
?? Rescue breath should be given over one second and produce a visible chest rise
?? Intubated patients should get 10-12 breaths per minute
?? Avoid hyperventilation, which can result in breathstacking, and autopeep that in turn causes increased intrathoracic pressures, decreased venous return resulting in iatrogenic hypotension or even PEA. I have seen several patients regain a pulse when the code is called which is probably related to this phenomenon. Additionally severe respiratory alkalosis can occur which maybe worse than acidosis

Defibrillation:
With the widespread use of more effective biphasic shocks the value of stacked shocks has been shown to be unnecessary and is no longer recommended.

?? In an unwitnessed cardiac arrest perform 2minutes of CPR before rhythm check or attempting defibrillation.
?? Instead of stacked shocks resume chest compressions 5cycles(2 minutes) if initial shock is unsuccessful and then reattempt defibrillation
?? Successfully defibrillated patients often have a nonperfusing rhythm initially, therefore it is recommended to give several cycles of CPR before reassessing pulse.

There are other changes that can be reviewed online at:http://circ.ahajournals.org

CONGRATULATIONS WENK FAMILY!

Samuel Isaac Wenk
5 pounds 8 ounces
and 19 inches long,
Born on Thursday,
August 3rd, 2006
to
Dr. Jonathan and
Mrs. Jennifer Wenk

Meet MEP's Newest Providers

Kerry Breit, PA-C
MEP SGAH

Kerry Breit received her BS/Physician Assistant degree from the University of Wisconsin, Madison and, she earned her Master of Public Health, Maternal and Child Health, from the University of Washington. Kerry's keen interest in international health led her to South America on a scholarship to work on the design for domestic violence guidelines for providers at the Maternal and Infant Hospital in Lima, Peru. A significant interest for Kerry is access to care and diversity in medicine. Kerry recently relocated to the DC area with her partner Gib and their two Vizslas, Loki and Nacho. Kerry's hobbies include gardening, hiking, camping, mountaineering, soccer and dancing.

Joel Buzy, MD
MEP SGAH

Joel Buzy is a native of Rockville. He completed his professional education at Baylor College of Medicine, after which he completed a year's internship in Internal Medicine at George Washington University, Washington DC where he also completed his Emergency Residency. He worked extensively in Emergency Medical Services as a 911 dispatcher, firefighter and paramedic with a specialty in swift water rescue. He is an active member of the Bethesda-Chevy Chase Rescue Squad. He is also an active member of the FEMA Urban Search and Rescue Team. He and his wife have a beautiful and active two year old son, Tyler.

Jeffrey Fine, PA-C
MEP SMH

Jeffrey Fine received his BS as a Physician Assistant from Hahnemann University, Philadelphia, PA. He completed an Emergency Medicine PA Residency program at the Los Angeles County University of California Medical Center. He served as an EMS Medical Coordinator in Philadelphia and has worked as an Emergency Medicine Physician Assistant in New York, Pennsylvania, California, Maryland and Washington, DC.
Jeff and his wife Julia live on a serene 40 acre wooded property in La Plata. Jeff also celebrated the first anniversary as a new business owner of an Urgent care/Primary Care Medical Clinic in Historic Annapolis.

Deborah Folden, PA-C
MEP SGAH

Deb Folden attended the George Washington University PA program where she received her Master's Degree. She completed a surgical residency at Yale University, Norwalk Hospital in Connecticut. Deb has worked as a Trauma/Surgical PA for 10 years at Prince George's Hospital in Maryland. In 2004, she switched her focus to Emergency Medicine. Deb describes her most pivotal moment in her life as the day she purchased her own home.
If Deb did not lead the life of a rock climbing PA, she would move California and try to get a job working for Access Hollywood.

Manish Gambhir, MD
MEP SGAH

Manish Gambhir attended medical school at Howard University in Washington, DC. He completed his Emergency Medicine Residency at the Weill College of Medicine, Cornell University, New York Methodist Hospital where he also served as Chief Resident. Manish was born and raised in the DC and he loves sports that require a ball: footBALL, baseBALL, basketBALL, and golf.

Emily Gordon, MD
MEP SGAH

Emily Gordon attended the George Washington University School of Medicine and completed her Emergency Medicine Residency at Highland Hospital * Alameda County Medical Center in Oakland, California. She has a special interest in ultrasound, Disaster medicine and EMS/pre-hospital care.
She and her husband met in college at the University of Michigan and are a "Michigan: GO BLUE" household. Her most enjoyable times, aside from her wedding, was in 1991 watching the Michigan-Duke basketball game that went into double overtime.

Meet MEP's Newest Providers

Doron Haughton, PA-C MEP SGAH	Doron Haughton received his Physician's Assistant degree from the Sophie Davis Biomedical/Harlem Hospital PA program. Doron worked in OG/GYN performing deliveries, assisting in the OR and performing Emergency Department consults for the OG/GYN service. In 1999, he began as a solo Fast Track provider then moved to serve as the Chief PA for Surgery and continued to work as a surgical PA.
Amit Kalaria, MD MEP SGAH	Amit Kalaria received his MD from Michigan State University, College of Human medicine. He completed his Emergency Medicine residency at Northwestern University in Chicago, Illinois where he served as Chief Resident. Amit grew up in the area and after a 13 year absence, is glad to be home. His hobbies include aviation, traveling and technology. His wife, Rupa, has taken a Pediatric Hospitalist position at Shady Grove. He loves practical jokes, whether he loves giving them or receiving them is not clear!
Patsy McNeil, MD MEP SGAH	Patsy McNeil graduated from Vanderbilt University School of Medicine in Nashville, Tennessee. She completed her residency in Emergency Medicine at the University of Cincinnati where she also served as Chief Resident. She has served as Medical Director and Educator for the D and J Diabetes education project, as well as Assistant Medical Director for the Holt Haiti Mission Organization, Port Au Prince, Haiti.
Nicole Vetere, MD MEP SGAH	Nicole Vetere attended Duke University obtaining her degree in Biological Anthropology and graduated from Georgetown University School of Medicine. She completed her Emergency Medicine residency at Brown University, Providence Rhode Island, and also served as Chief Resident in the program. Nicole loves to exercise, read, hike and travel. Nicole loves to exercise, read, hike and travel. She has also spent time as an EM Physician in Kenya.
Bridget Vetere-Overfield, NP MEP SMH	Bridget Vetere-Overfield received her Master of Science, Family Nurse Practitioner from the University of Maryland, Baltimore. As an active duty Army reservist, she served as Chief of a primary care clinic providing support services for the acute care facility at Fort Campbell Kentucky. She has held numerous nursing staff and supervisory positions in Hematology-Oncology, adult child Psychiatry, Neurology and Med-Surg nursing.
David Wong, MD MEP SGAH	David Wong attended medical school at Ohio State University. David completed his emergency medicine residency at George Washington University, Washington, DC, where he served as Chief Resident. He was the Officer In Charge, Chemical, Biologic, Radiation and Nuclear Response Team, DeWitt Army Hospital. David is married to Dr. Michelle Wong, who recently completed her Ob/GYN residency at the Bethesda Naval Medical Center. They are the proud parents of Michael Jae-Soon Wong, who is 15 months of age.
John Jones, MD MEP SGAH	John Jones came to DC via a farm in Nebraska, college in New Hampshire at Dartmouth and made the cultural leap to the DC Area to attend medical school and residency at George Washington University. John met his future bride the first day of medical school. While in her fellowship in radiology, Dr. and Dr. Jones discovered they would soon be the parents of twins! After Ryan and Tavian were born, the Jones' moved back to DC. John then embarked on his Pediatric Emergency Medicine Fellowship. When John has the time for enjoying his hobbies, they include squash, reading the financials, and raising orchids.
Jill McGovern, MD MEP SMH	Jill McGovern attended Tufts (located in Boston) for both college and medical school and graduated with a Bachelor of Arts in Child Development. Jill recently completed her emergency medicine residency at Baystate Medical Center in Springfield, Massachusetts and is looking forward to practicing in Maryland and being part of the St. Mary's team. She recently acquired a new Boxer puppy named Hannah. Jill intends to remain a devoted Boston Red Sox fan and is excited to see them play at Camden Yards.

Germantown-Our Next Frontier

Micahel Cetta, MD

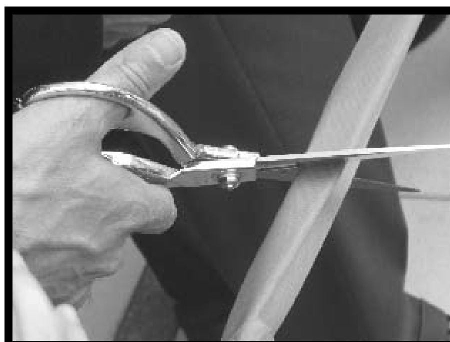
Here we are on the verge of our newest adventure – the opening of the Germantown Emergency Center. Walk through the Germantown campus today and you'll see a spacious, well equipped department (much like a Lexus SUV) ready to handle whatever Montgomery County can throw our way. But did you know that the road to this point was tumultuous and tenuous and has taken over four years? In fact, Maryland health regulators shot down the original plan for the Germantown facility. It was not until a team of hospital and community representatives, including Angelo managed to get the governor to sign a special bill allowing stand-alone Emergency Departments that the Germantown facility became a reality.

The stimulus for the new department grew out of the reality of increasing Emergency volumes at Shady Grove and the expanding population on the I- 270 corridor. The advantages were obvious – additional emergency capacity and a more centralized facility in the county that would reduce EMS transport times. The major opponents were the adjacent hospitals, payors and state representatives. The arguments were the new facility would increase the cost of health care and open a "pandoras box" across the state for other hospitals wishing to add capacity in desirable locations. Stand-alone emergency centers are not common. In fact, only 13 states currently recognize these facilities.

The fight for a free standing ED was taken to Annapolis where originally the regulators felt that it was not the right time for such emergency centers in the state and thereby voted down the proposed regulations. Despite this apparent impasse there was broad support in both chambers of legislators as a bill was easily passed and eventually signed by the governor in the Spring of 2005.

Today the 17,000-foot facility is located on route 118 in the core of Germantown adjacent to the Shady Grove physician office building. Open 24 hours-a-day with 21 beds, fully equipped laboratory and radiology services, the Germantown Emergency Center (referred to as the "GEC") does not seem like an ancillary service of the flagship Shady Grove ED. The GEC has the same capabilities as any ED, including tPA, advanced airway, and pediatric life support. Radiology offers fully digitized equipment with CT, ultrasound and eventually MRI (there is no nuclear medicine capabilities).

Although we have overcome the initial hurdles of state approval and department construction, the biggest hurdle is yet to come – rolling out an Emergency Center offering quality care and improved access. State leaders, who will use our success as a litmus test for further stand-alone centers, will follow the progress of the GEC closely. Logically, one would assume that the facility would reduce waits in ED waiting rooms, reduce EMS transport times and therefore improve overall access to care. The ongoing support of the Germantown community was evident at the recent open house when several hundred community and hospital representatives enjoyed touring the new facility after a dedication and blessing.



Safeguarding Protected Health Information

Sue Boch

To deliver prompt and effective healthcare, you must orally communicate with a patient or others about the patient's protected health information (PHI). Sometimes these conversations can be overheard. As a result, a patient's PHI may be disclosed to someone who isn't authorized to hear it.
These disclosures—known as "incidental disclosures"—won't violate the HIPAA privacy regulations as long as you "reasonable efforts" to limit their likelihood. That is, you must make reasonable efforts to limit permitted disclosures of PHI from being accidentally overheard by people not authorized to have access to them. It also means you are constantly alert to the possibility of unintended disclosures as a daily consequence of proving healthcare in an open area such as our Emergency Department.
Here are 10 rules to help you minimize the risk that this information will be overheard:

Rule #1
If possible, don't discuss a patient's PHI in common areas.

Rule #2
If you must discuss a patient's PHI in a common area, lower your voice or talk apart from others.

Rule #3
You don't need to use private rooms or talk behind soundproof walls to avoid any possibility that conversation will be overheard.

Rule #4
Limit PHI disclosed when calling out patient names in waiting rooms.

Rule #5
Don't use an overhead paging system to call patients by name to a particular unit.

Rule #6
Limit the amount of PHI in a telephone message left with a patient's family member.

Rule #7
Limit the amount of PHI when leaving a message on a patient's answering machine.

Rule #8
Don't use the speakerphone function on telephones located in common areas.

Rule #9
Don't discuss PHI during a telephone call until you've asked whether the other party is using the speakerphone function.

Rule #10
Dictate PHI in private areas.

Privacy standards are now a Federal rule with substantial penalties for non-compliance. In the past, simple respect for a person's privacy was the foundation for appropriate behaviors. I would opine that MEP could still operate under the auspices of respect for every patient and remain compliant, with HIPAA regulation regarding patient PHI. However, SGAH and SMH have adopted policies to embrace HIPAA and MEP is committed to following the policies governing PHI. If you wish to re-familiarize yourself with SGAHs or SMH's HIPAA policies and guidelines, please contact Deb Boden or Patti Tam and one will be provided to you.

Surrounded by Lions

Leonard Chornock, PA-C

"Coaching sessions at Panera's have given me a better understanding of myself and how my work is perceived by others. "

It was Twenty one years ago this month when I began my career as a physician assistant in the emergency department at Shady Grove Adventist Hospital. The entire hospital was surrounded by corn fields and it sometimes seemed like we had more geese in the area than patients in the department. I remember those quiet times fondly and often think how busy we thought we were when we saw twenty to thirty patients after midnight.

The hospital administration has always had it's eye on the future and growth continues to be a fixture in our lives. Along with this growth, we have seen tremendous changes in the way we accomplish our mission.

The computer has become one of the most significant advancement of our times and is an intricate part of the hospital life. It assists us with everything from bed control and patient flow to disease information and discharge instructions. These and other changes, although painful, have assisted us in giving a quality of medical care we can all be proud of.

The Montgomery Emergency Physicians group (MEP) was formed over eight years ago. Like the hospital administration, the leadership of MEP has always had a keen eye on the future. They are always challenging us to grow on personal and professional levels. Our group has more than doubled in size, while keeping the main ideologies of our smaller company at the forefront. The MEP leadership has made several internal changes and showed a willingness to improve itself with difficult management decisions. MEP instituted regular coaching sessions to improve our on the job performance and interpersonal work relations.

Coaching sessions at Panera's have given me a better understanding of myself and how my work is perceived by others. In my most recent coaching session, I was asked, why do you still love your career after twenty one years? First of all, I never thought I would work in the same place for twenty years, let alone have anyone ask me this type of question. Then, I spent weeks trying to think of a good answer that would express my true emotions.

Before MEP came to Shady Grove, the group of physician assistants in the E.D. had very little job satisfaction as we were treated poorly by our previous employer. We had very little autonomy and the message given was that we should be seen but not heard. Since MEP's inception, there is a totally different focus and mindset. We have been turned into a healthcare machine, always looking to help each other to get the job done as effectively and efficiently as possible. I have been encouraged and coached when needed. Personal and professional growth was accomplished through careful retraining and support, all while being made to feel an important part of the MEP team. This was accomplished by the MEP leadership's ability to lead by example with strength and character.

To quote Rabbi Maya ben Charash, one should "Initiate a greeting to every person; and be a tail to lions rather than a head to foxes" . The use of a metaphor of lions and foxes alludes to a lesson in the book Ethics of the Fathers. Following people and being subservient to those who show strength in character and judgment is symbolized by the king of beasts. This is preferable to leading people who consider themselves sophisticated and shrewd which is symbolized by foxes. "It is preferable to be the least distinguished member of an elite group (lions) than the most distinguished member of a lesser group (foxes)." I am happy to consider myself one of the least distinguished members of our group. I am humbled everyday for the ability God has given me to accomplish the work I do while working with such great and talented people. I am truly surrounded by lions in the field of emergency medicine!

We're on the web at www.meped.net

A Year I Never Imagined

Angelo Falcone, MD

As I watched my ten year old daughter, Shannon, listen to a surfboard lesson from Tim Sherer, the owner of "Goofy Foot Surf School" in Maui I was struck by how far our family has come in the last year. Tim spoke of the area that the class was about to surf as sacred ground as the Hawaiian Kings of the past used to surf the waters off Lahaina and now they would continue that tradition.

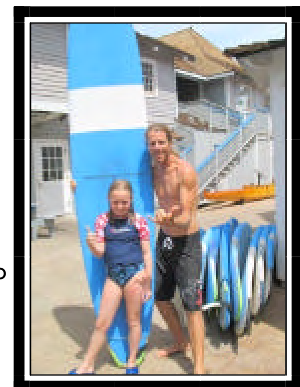
It is hard for me to imagine that Susie, Shannon and Caroline's extraordinary Mom and my lovely wife has been gone for a year. As I spent my vacation in Hawaii I was also reminded that this was a trip Susie longed to take one more time to our favorite place in the world. Time did not allow that to occur though I know she was there with us as we snorkeled in Kapalua Bay, traveled to the top of Haleakala and swam with the green sea turtles. Perhaps it was she who caused the flight attendant to dump a tray of drinks on my seat just prior to takeoff, a reminder to me to not get too comfortable on our flight to paradise.

In the past year I have walked through a valley of utter numbness, overwhelming sadness, total confusion, and personal frustration. I have also found comfort in the memories of the life we lived together and the realization that I am still alive and have two unbelievable young ladies to nurture, parent and love. They have caused me to understand in ways I did not think were possible that Susie's life and spirit do go on. I only have to look at the fierce determination in my daughter Shannon's eyes during one of our "disagreements" or the tender hug from Caroline followed by "I Love You Daddy" to see their Mom and my Susie in all her glory. Granted sometimes the appreciation of these gifts requires some perspective of time!

It is also through this last year that I have come to recognize how little control we have of the life we live. What we do have, of course, is our ability to respond to the hand life deals and choose to face the horrors that others may shudder to imagine in our reality. I have asked several people who have suffered great loss if there was any benefit to what they have gone through. Understanding if there was a "choice" to be made each of us would ask to not carry this burden. The answers I received were ones of a continual struggle to find meaning and a realization that they have a strength to go on, sometimes only for others, nonetheless they do go on.

I have chosen to try and find meaning where there appears to be none. I have chosen to believe that God is ultimately in control of our destiny and I must have faith on where that journey will lead me. I have chosen to see the many blessings I have been given, starting with Susie in my life and continuing with Shannon and Caroline, are not given to many people on this earth. That is not to say this path is easy, for there are times when I still feel the unimaginable pain and loss like the day Susie left this earth.

Those gifts continue with my many friends and members of MEP. I have watched from afar during this year as we struggled to make success occur in a new location, reorganized our group and continued to deliver exceptional care despite capacity issues and nursing shortages. I have been humbled to tell a patient they have metastatic cancer and know what that journey will entail. I have told a husband his wife of 60 years had died and told him how blessed they were to have such a long union. I have also laughed, often, with many patients and families about the trials and tribulations of their or their child's medical predicament.



At the end of our life we all hope we can look back and say we did the most we could with the time and talents we were given. As I have said before Susie did not waste a moment of that time. I also believe I have talents to bring to my patients and to MEP, the same talents I see in many of you. Far be it for me to wonder "if only" as the possibility of "what can be" lies before us. To each of you who have offered support and prayers, seen and unseen, to me and my family thank you sincerely. I hope in time I may repay that debt as we continue to face the future, wherever it leads us, together.

Finally, if you ever find yourself in Maui I would recommend spending some time with Tim and his associates at "Goofy Foot". The next time I am there I'll be up on a board with Shannon and Caroline, living life without regrets or hesitation, and seeing where the next wave leads us. *Mahalo*

Fixing Up A Car

Jonathan Wenk, MD

I was still two-thirds asleep as I lumbered down the hall into the department. I am not a "morning person". I consider waking up at 5 a.m. a form of torture. The charge nurse spotted me.
"You look really tired" she said.
"Thanks" I grumbled sarcastically.
"Do you know the rock group 'the Cars'"? she asked.
My ears pricked up.
"They're here…the guitarist hurt himself".
I loved the Cars growing up. I play guitar and my college band played a few of the Cars hits. Lead guitarist Elliott Easton was a personal favorite of mine when I was about 18.
I ran to the exam room and immediately spotted a boyhood idol: the injured Elliot Easton. He was accompanied by lead singer Todd Rundgren, and bassist Kasim Sulton. Elliott fell and broke his clavicle when his tour bus nearly crashed on I-270. His group had recently reformed after a 17 year hiatus and was about to embark on a nationwide reunion tour with 80's pop icon Blondie as the opening act. Elliott desperately wanted to perform despite his injury.
"I've waited 17 years for this" he said. His words found their way into the next day's newspapers.
I gave him a shoulder sling and swath. I also gave him a clavicle strap to wear. I find this device to be rather useless, but at least he could move his arm enough to play guitar. Elliott and his bandmates were surprisingly polite and friendly. They thanked me and gave me 8th row seats and a backstage pass to their upcoming show.
"Wow!" I exclaimed. "You guys pay better than HMO's!"
I have treated a number of celebrities over the years. Former heavyweight champion Joe Frazier, middleweight champion James Toney, Major League All-Star Curt Schilling, just to name a few. It always adds an additional sprinkle of excitement to an already exciting job. I find it anxiety-provoking, however. Missing a diagnosis in any patient can have serious consequences, but as a physician you never want your name in newspaper headlines. Recently, the medical care for actor John Ritter and Bee Gees musician Barry Gibb has been questioned, leading to high-profile litigation.
I was therefore quite relieved when I saw an alive and well-appearing Elliott Easton take the stage the following night. It was a great performance, (except for Blondie's atrocious neon-green spandex body suit that was unbecoming a 60 year old woman). The Cars sounded terrific. Their hit songs kept the sellout crowd on their feet the entire time. Elliott played well, despite his injury. You could tell he was in pain. Stage hands and roadies helped him change guitars throughout the show.
When the show concluded, Elliott took his jacket off to wave goodbye to the crowd- clavicle strap firmly in place. I ventured backstage after the concert. The band members immediately recognized me as the physician who treated Elliott and ran over to greet me. "Doc!!!" they shouted and offered me a beer. Partying backstage with the Cars was as thrilling to me now as it would have been at 18.

I often wonder why we experience such excitement when we meet celebrities. Is it partly envy at their talents and success? Perhaps, we admire the fact that their contributions to society will endure after they die; they will leave behind a legacy and a part of them. The contributions we make as health care professionals are less acclaimed than hit songs or heavyweight titles. They receive less attention and newspaper headlines unless you miss John Ritter's aortic dissection. But they are no less important. They are how we shape the future. Just ask Dr. Steven Yang- the orthopedist who surgically repaired Elliott's clavicle so he can resume touring.

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