A health care facility that’s the scope of the Sheikh Zayed Tower and The Charlotte R. Bloomberg Children’s Center doesn’t open with a mere flip of a switch. It takes countless hours of preparation by dedicated staff who will deliver top-notch patient- and family-centered care in the new clinical buildings. This article is the first of three in a series that will capture a momentous chapter in the history of The Johns Hopkins Hospital, from final preparations for opening day to a look back at how the hospital fared as staff and patients moved into the state-of-the-art patient care towers.

PART ONE

S

cated in the lounge of The Charlotte R. Bloomberg Children’s Center’s pediatric procedure area, Marla Dubyak clutches a baby doll and responds to questions from Lauren Grabau: “When did she last eat? Has she had anything to drink? Any fever or cold symptoms?”

Playing a nervous mother and a triage nurse, the PACU co-workers carry on a scripted conversation while 20 colleagues observe and take notes. Grabau’s questions may appear routine in this simulated workflow exercise, but her role is not. When the new pediatric preop and recovery unit opens in April, patient volume will soar, swelling workloads for nurses and support staff. Enter the triage nurse, a new role for the unit designed to foster timely patient throughput.

“The triage person can screen out sick patients ahead of time before they’re handed off to the preop nurse,” says Lisa Shoemaker, a nurse leader on the pediatric PACU. “We’d want to create the position for the preop process to see whether it will streamline things.”

The scenario unfolding in the PACU is one of hundreds taking place across The Johns Hopkins Hospital in preparation for life in the Bloomberg Children’s Center and the Sheikh Zayed Tower. At every level of care, clinicians and support staff are taking the stage in unit-based “day in the life” patient-care simulations, interdepartmental “dress rehearsals” and mock patient moves. All are designed to mimic the actual process of care in a multitude of settings, giving participants hands-on introductions to new workflow patterns, process

(continued on page 4)
It’s all about relationships
Dean/CEO Edward D. Miller, M.D.

The one aspect of my job as dean/CEO that I never thought would be interesting—or, for that matter, that I would be any good at—was fundraising. You think of fundraising as going up to people, sticking out your hand and asking for a $100 million. It’s not that way at all. Fortunately for me, early on in this job, Morris Offit (former chair of the Johns Hopkins University Board of Trustees) gave me one of the best pieces of advice I’ve ever received: fundraising is all about building relationships.

More often than not, setting the stage for these relationships begins with the faculty. They are the ones who’ve either treated patients with the means to give, or they’re involved in promising research that donors are interested in supporting. People ask me how many fundraisers I have, and I always answer, 2,460. They’re called faculty.

An important element to fundraising to keep in mind is that people who give do so because they want to make a difference in other people’s lives. They do it so that fundamental discoveries can be made. You know that investing in Hopkins will make that happen. This is especially true with this generation of donors who want to support people and their projects, who want to be involved in their gift and who want to be kept informed about the progress made from their contribution—they’re willing to give more when they see progress.

There are many examples I can cite to illustrate how all of this ties together. I’ll use the one that resulted in support for the Johns Hopkins Brain Science Institute.

I guess it was about six years ago that I was invited to a picnic in Washington, D.C., one Sunday in October to meet a person who was interested in making a gift. The contact was arranged by a faculty member. I sat down with the person, who came straight to the point: What were my needs? So I said that I had this new hospital that I’m building and I’m looking for money to help build it. Without hesitation, he said he wouldn’t be interested in bricks and mortar.

He asked me to tell him my next priority. I said that if I was looking for an area that needed funding, the brain sciences would be it.

The following Wednesday, this person—who wants anonymity—called me and said he had been thinking about my ideas and asked if $10 million could get me started in supporting brain sciences. I said, yes, I got a group of people together that included Janice Clements, Jack Griffin, Rick Hugain and told them that we had $10 million and to start thinking about how that money might be used to advance brain science. This gave rise to the BSI.

They recruited faculty, found space and started pulling in grants. About 13 months after that meeting, they had spent close to $8 million and they put together a progress report, which I sent to the donor. He said he was blown away by how much we had accomplished in such a relatively short period of time. He then asked me if I would like another $10 million.

So to the BSI kept working, Lauran Jones, Jack, Rick, Jeff Rothstein and I visited the donor and his wife for lunch. He wanted to know about the progress and where we thought we were headed. We presented him with a report and a proposal that showed what we could do if we had another $80 million. He funded it. So what started being a $10 million gift ended up being $100 million to support brain science research. It also gave rise to a very close and warm relationship with the donor, who is still actively involved in what we’re doing.

I’ve never asked anyone for a penny. I simply tell donors what my needs are for the institution, what opportunities exist for them to make a difference. In 15 years, Johns Hopkins Medicine has raised $3.5 billion. That’s a lot of money, but on a personal level, a lot of wonderful relationships with donors.

Filling a prescription for primary care
Johns Hopkins Community Physicians expands its delivery of award-winning care in the suburbs of Washington, D.C.

A community forum several years ago, Suburban Hospital President Brian Gragnolati measured one of health care’s most important “vital signs” when he posed the following question to the audience of mostly retired people: “How many of you have had difficulty, or have a friend or family member who’s had difficulty, finding a primary care physician who accepts your insurance?”

More than three-quarters of the listeners raised their hands. “I was stunned,” recalls Gragnolati, now senior vice president for the Johns Hopkins Health System. “In those days I couldn’t go to a corner store where people didn’t ask, ‘Can’t I find a primary care physician in the Bethesda-Cherry Chase area who accepts my insurance?’

The market wasn’t adapting to their needs, he told them, because practices couldn’t afford to bring new people in and were uncertain about the future of health care delivery. National surveys continue to confirm the trend. According to a 2011 study in Archives of Internal Medicine, only 88 percent of U.S. physicians took on private insurance patients in 2008, a decline of 5.5 percent from 2005. At the same time, only 93 percent of doctors still accepted new Medicare patients.

Now, thanks to their ongoing integration with the JHM family, they not only gained access to specialists, are enhancing, not competing with, health care delivery. In addition to primary care, JHCP has helped Suburban expand its base of specialists, such as vascular surgeons and cardiologists, who accept insurance. Specialists are being recruited similarly for Sibley.

“If you include our hospital-based providers—intensivists and hospitalists—we now have 60 providers in 13 different specialties in the National Capital Region,” Kravetz says. This year, Community Physicians will open primary care practices in Bowie, Germantown and central D.C.—the latter an important market extension for Sibley.

“JHCP is helping to meet the community’s need for access, an employment need for physicians who don’t want to establish a private practice on their own, and the hospital’s need to have young primary care physicians who will practice for a long time and accept insurance,” says Robert Sloan, president and CEO of Sibley Memorial Hospital.

Extending help, filling gaps
In theory, each primary care physician can take care of about 2,500 patients. That means the 14 new JHCP doctors practicing in the National Capital Region can provide care for roughly 45,000 patients, points out Gragnolati, who heads the Health System’s community division. He emphasizes that all new JHCP physicians, including specialists, are enhancing, not competing with, those community physicians in private practice who still work with Suburban and Sibley. However, they also provide a reliable bridge to future health care delivery.
“Many insurance payers have made it very unattractive for small groups or individual practices to participate in insurance plans. A lot of people, particularly the elderly, can’t afford to pay for their own care up front and be reimbursed by their insurance.”

—BRIAN GRAGNOLATI

Care that covers all the bases

Howard County General Hospital embarks on a new way to target treatment for elderly patients.

As the number of geriatric patients steadily rises across the country—accounting for about one-third of all hospital admissions nationwide—hospitals and physicians have grown increasingly aware of the complications and risks that these patients face from long-term stays.

As a result, Howard County General Hospital recently adopted the Acute Care for Elders (ACE) program model, a nationwide effort at improving geriatric hospital care and outcomes for elderly patients.

“Our main goal is to make sure that when elderly patients come through the hospital, they’re able to maintain function,” says hospitalist Anirudh Sridharan, medical director for the hospital’s ACE program. “A win for us is getting these patients back home with the same level of function that they came to us with.”

The program launched as a pilot last November. Located on 4 South, it can accommodate 10 patients. To be eligible for the ACE program, a patient must be at least 70 years old, admitted through the Emergency Department from home, and at risk for functional decline.

For hospitalized patients, the culprit behind functional decline is often immobility. Elderly patients may be admitted to the hospital and find themselves spending the majority of their stay in bed with little exercise or socialization, or perhaps adhering to an abnormal routine that includes middle-of-the-night blood pressure and heart rate checks or catheter changes.

“When any person lies in bed for longer than two days, they start to decondition,” says Francie Black, a nurse practitioner with the program.

“Elderly patients lose muscle mass much more quickly than a 40-year-old and don’t have the capacity to bounce back as easily.”

The ACE model is designed to help patients avoid inactivity and prevent other common risk factors associated with functional losses. Through physical therapy, pharmacy consultations, education, nutrition and high-quality nursing care, the hospital’s ACE team works with admitted patients to make sure that they remain active, well nourished and have plenty of opportunities to exercise their bodies and minds.

Meanwhile, a special medical ordering system takes into account patients’ ages, so that physicians and other providers can remain cognizant of how certain treatments and therapies might negatively affect a person’s cognition or physical function. “As doctors, we need to make sure we’re not tying them down by not giving unnecessary oxygen, by removing catheters as soon as possible, and by making it easier for them to get around,” Sridharan explains.

Medicinal techniques aside, patients are also encouraged to socialize and exercise their minds. That includes eating meals out of bed and in a common area where they can mingle with other patients, play board games, complete crossword puzzles and so on. “With aging brains, if they’re not exercised, they lose the capacity for simple math or keeping track of the day,” Black says. “We want our patients to function here much as they do at home.”

Since the program’s launch, patients have been receptive, Sridharan says, even those who might otherwise be inclined to sit still and recover in bed. “In the past, there was this mentality that if you’re sick, you need bed rest. But now we’re teaching people that’s not in their best interest,” he says. “If you explain to patients that the longer they stay in bed, the weaker they become, they get it immediately.”

—Lauren Manfuso

Kudos for improving care delivery

Five primary care sites of Johns Hopkins Community Physicians have received recognition from the National Committee for Quality Assurance for successfully coordinating and managing patient care through an approach known as the “patient-centered medical home.”

JHCP physician Scott Fessar, director of the medical home initiative, estimates that roughly 60,000 patients are benefitting from the program to improve care delivery. The Hopkins practices were awarded “Level 3,” the NCQA’s highest level of distinction. The patient-centered medical home model focuses on preventing disease, reducing preventable hospitalizations and involving patients in their own care through a team-based approach. It works this way: Each patient sees a primary care doctor who heads a team that may include a nurse, pharmacist, social worker and nutritionist. Providers work together to offer patients easy, 24-hour access to care, either electronically or by phone. They also contact patients regularly between visits to see how they are faring and to reinforce any treatment orders. Success depends upon electronic medical records keeping team members up to date with each patient’s condition and progress.

Fessar helped launch the pilot project in 2009 at the Water’s Edge site in Belcamp, where he is medical director. It has since been implemented successfully at JHCP sites in Hagerstown, Rockville (Montgomery) and Baltimore (Canton Crossing and Wyman Park), all of which earned the NCQA’s Level 3 rating.

The model also encourages patients to participate more actively in their own care—whether it be to stop smoking or lose weight.
Before the curtain rises (continued from page 1)

Most of the simulations under way in the new patient towers are based on the model of "experiential learning," a method that pairs scripted "real-life" scenarios followed by discussions led by trained personnel. A proven bridge between classroom learning and reality, experiential learning also is a way of testing ideas "that we think are going to work on paper," says Julianne Perretta, an educator in the Johns Hopkins Medicine Simulation Center who is helping to develop and set goals for a variety of practice runs in the new buildings.

Unlike the use of simulation for educating nursing and medical students, the scenarios taking place across the historic and new buildings have a different purpose, Perretta says. "The actual process of patient care, whether placing an IV or giving medications, is changing very little." Not so for "all of the things leading up to the interaction with the patient," Perretta says. From mundane concerns such as where to park the car or store lunch, to safety priorities such as lifting patients and medication sign-off, these are the details addressed by the day-in-the-life simulations.

If the scenarios uncover workflow and process flaws and result in more prep work for administrators and managers, then Perretta considers them a success. "We can’t afford to get this wrong once the new buildings open," she says. "We want to solve most if not all of the problems before we move, and they’re often the things that we can’t predict."

As opening day draws near, simulations will become more lifelike and intense, Perretta says. To ready for the two March dress rehearsals, she is working with several departments on "high-fidelity" scenarios in which every second matters with regard to a patient’s welfare. If a team is simulating a code, "They must behave as if the patient is really dying," she says. "That helps us assess the environment and processes more realistically."

Dress rehearsal participants won’t have a script, Hunt says. "We don’t want to give them the details of every single scenario." For example, if rehearsal team members know ahead of time that their scenario revolves around a patient who codes, their response might be too polished to reveal possible design flaws to observers. "We will debrief to understand what went well and what needs to be revised prior to operating in the building," she says.

Hunt is also managing two mock patient

NEW CLINICAL BUILDINGS

On the cover: PACU nurse leader Lisa Shoemaker plays an anesthesiologist who is reassuring an uneasy mother (performed by nurse Maria Dubyak) prior to her baby’s hernia surgery.
moves—one that happened in February and another scheduled for March. Each was planned to run on a schedule identical to the two-day timeframe for the actual patient move, which will take place April 29 and 30.

**Practice, practice, practice**

Because the dress rehearsals center on process design, relatively few caregivers and staff will have a chance to participate, leading several departments to seek more opportunities to work through new protocols and workflows. “I’ve gotten requests to run some additional simulations” to prepare for any number of typical, clinical scenarios, Perretta says. “For instance, if the Lifeline team is transporting a patient from the new ICU, and the patient has sudden medical problems, they might not know where they can find a clinical location where they can stabilize the patient or call and ask for more help.” Practicing transport throughout the sprawling new buildings with mannequins in stretchers will make for better patient safety on opening day, Perretta says.

In January, well before the simulations reach a life-or-death level of intensity, the pediatric PACU nurses took advantage of training time in their new workplace to rehearse for their day-in-the-life scenario. “Practice makes permanent,” says nurse educator Rebecca Putman, echoing the motto of simulation experts such as Perretta. Putman and other nurse leaders wrote the seven-scene skit to depict the process of caring for an infant scheduled for a left inguinal hernia repair. As mother and child made their way from the parking garage to the pediatric procedure area to recovery, each encounter with the triage nurse, preop nurse, child life specialist, surgeon, anesthesiologist, clinical customer care coordinator and others demonstrated the complex choreography of normal clinical operations. Afterward, PACU staff members shared observations and pointed to potential workflow glitches that needed further attention.

No amount of preparation for such a monumental transition is too much—even if it means preparing for a day-in-the-life simulation, Putman says. “As the unit educator, I feel very responsible. I don’t want my nurses to be asked to do something when they aren’t familiar with the location of equipment or supplies and then get frustrated. All of the change and movement have already built up a level of anxiety. We wanted the skit to be a way to introduce things in a peaceful, entertaining and fun way and to carry that attitude to the day-in-the-life simulations.”

—Stephanie Shapiro
A clinic for those most in need

March marks the two-year anniversary of a student-run health resource center that’s helping inner-city residents.

In her first week as a medical student at Johns Hopkins, Claire Sampankapanich boarded a bus with other bright-eyed future physicians to tour some of Baltimore’s grittiest neighborhoods. The blocks of vacant, decaying homes bore little resemblance to the sheltered suburbs of San Diego where Sampankapanich was raised.

Witnessing poverty and homelessness firsthand deepened her desire to work in a disadvantaged community, which Sampankapanich says drew her to Hopkins’ program over others across the country. Inspired, she sought out volunteer opportunities, discovering a passionate group of similarly concerned students who had opened a free health resource center blocks from campus just months earlier. Today, she’s one of many students leading the now two-year-old Charm City Clinic in its mission to reduce health disparities among low-income Baltimore residents.

Whether offering health screenings, helping clients apply for insurance coverage, or connecting them with programs that offer free or reduced-cost prescriptions and doctor’s visits, the student-run operation in Baltimore’s Middle East community helps local facing socioeconomic challenges overcome barriers to health care access.

“It’s really easy to assume that access to health care is the same thing as the availability of resources,” says Mike Rogers, a founding member and community outreach director. While Baltimore has an abundance of health resources, they can be fragmented and difficult to access for some, says Rogers, who spent more time in the Middle East neighborhood than the classroom as an undergraduate at Johns Hopkins.

Lengthy and confusing paperwork needed to apply for state and federal programs that subsidize or fully cover the cost of health insurance, prescriptions and medical care is a huge barrier for clients, many of whom lack adequate literacy skills. The benefits of tapping into such programs are untold. “Ninety percent of the medications that people really need to change the likelihood that they’ll die of a heart attack or stroke are available for about $10 for a three-month supply,” says Ramy El-Dwany, a third-year Hopkins M.D./Ph.D. student who’s been a part of Charm City Clinic since its inception.

Founding members say their model differs from other student-run, free health centers across the country. Instead of providing short-term primary care services performed by medical students seeking an opportunity to hone their clinical skills, Charm City Clinic volunteers act as a conduit to community resources and strive for long-term relationships with clients. Visits, whether by appointment or during walk-in hours, typically take at least 30 to 45 minutes, and nearly half are made by established clients. Lengthy visits help to build trust and allow students to practice interviewing and history-taking skills with guidance from Hopkins physicians who oversee their work.

From its formative stages, Charm City Clinic was created with direct input from neighborhood residents and leaders, among others, who said the community was in need of a health resource center. One of these partners was the nonprofit Men & Families Center. The organization shared invaluable information from its past experience in providing community health services to help get the clinic started, and it has been critical to the students’ understanding of their neighbors’ needs.

Volunteers go to great lengths to ensure their clients’ health needs are being met, calling between visits, scheduling follow-up appointments in the evening or even at the client’s home, if needed. Favorite stories of “extreme follow-up” include standing in line with a client at 5:30 a.m. at Healthcare for the Homeless and, on another occasion, sitting in the waiting room at the Department of Social Services office for half a day. “There has to be a balance between doing it with someone versus doing it for them,” El-Dwany says.

Word of mouth, and grassroots efforts such as going door to door, training community members as outreach workers and using brightly colored hand-painted sidewalk signs to advertise their services have helped the clinic’s volume to double over the past year. In all, volunteers have served more than 500 clients since their doors opened in March 2010.

Now Charm City Clinic leaders are working to build capacity to address health needs for the increasing number of community residents turning to them. To do so, they’re seeking additional help from students and physicians interested in volunteering during the clinic’s weekly walk-in hours on Saturdays. To learn more about volunteer opportunities, call 443-478-3015 or visit charmcityclinic.org.

—Shannon Swiger
In Kuwait, mentoring health care

Hopkins takes a new approach to working with overseas hospitals for improving the standard of medical treatment.

In 2009, after the Kuwait Ministry of Health decided to overhaul the nation’s public health care system, it sought input from a number of renowned academic medical centers. Johns Hopkins Medicine International (JHI) quickly responded with a proposal to the ministry. And then Hopkins waited—and endured.

Extensive discussions with the ministry led JHI to develop a new concept, one that focused on how outside academic medical centers could work with Kuwaiti hospitals. JHI managing director Zubin Kapadia and Mohan Chellappa, president of global ventures, stayed in touch with the ministry, even as the country’s parliament replaced their cabinet twice in 2011—a set of circumstances that required building new relationships after each change. Months passed, and Kapadia and Chellappa consistently answered questions and offered reassurance that Hopkins’ commitment remained firm.

Finally, on Christmas Day of 2011, the patience—and mutual trust—paid off. Realizing that Hopkins’ expertise and resources aligned with their needs, the Ministry of Health signed a five-year collaboration agreement to improve the quality and delivery of health care at four of Kuwait’s five public general hospitals.

The agreement also called for expanding the nation’s pool of administrative and clinical talent, and to assess and address national public health issues.

If the objectives of both parties are met, Kuwaiti citizens will have more consistent and even safer health care experiences, as well as reduced need to leave the country for medical care. Hospitals will operate more efficiently and more effectively, with less risk and reduced costs. The Ministry of Health will have a firmer grasp on public health issues and an expanded toolbox for addressing them. In short, mentorship from Johns Hopkins Medicine will have forever changed the entire national health care system.

This contract ensures a lasting impact on a region in which International already has an extensive portfolio. For example, JHI affiliates in Lebanon and the United Arab Emirates continue to learn from the physicians, nurses, and staff of the schools of medicine, nursing, and public health.

“Our work at the community hospital level will set the foundation for much more advanced care in Kuwait for years to come,” Kapadia points out. He expects that this foundation will make Kuwait more attractive to specialists, which means more in-country health care options down the line.

The relationship between Kuwait and Hopkins will be like a mentorship, which Kapadia calls a more sustainable collaboration. “Instead of simply instructing and guiding them, we’ll raise their level of capacity by instructing and guiding them over five years,” he says.

In Kuwaiti culture, successful mentorship requires carefully nurtured peer relationships, so that recommendations and advice are trusted and valued. Kapadia believes that this model will distinguish Hopkins in the marketplace, where most Western academic medical centers serve as leaders or managers, rather than as mentors or guides.

Mentors will sit in teams at the four hospitals and be divided between administrators, who will guide leadership in establishing hospital-wide policies and systems, and medical experts. These clinicians will certainly share best practices for procedures and treatments, and also for running a department.

A region’s office will handle project-management details, recommending to the Ministry of Health strategic approaches to health administration and public health issues. The contract requires Hopkins to fill two public health official positions. From this office, they will be accessible to anyone within the public health system.

International currently is recruiting people, both from within Hopkins and outside the institution, for both the regional office and the team for one of the hospitals. Teams for the other two hospitals will be recruited and deployed later this year.

From Baltimore, Rebecca Altman, director of the project, will make sure that the people on the ground in Kuwait have the resources to carry out their roles. She’ll also make frequent visits to the regional office. “We’ll empower a body of passionate, well-educated health care providers,” she says, “and enable them to make changes that will have broad impact on care delivery. What’s even better is that we’ll help them establish the pathways to continue improvements even after we’re gone.”

—Cyma Bennett Governs

A team approach to preventing falls

Suburban Hospital nurses take the lead in protecting patients from avoidable injury.

Patient falls are a common occurrence in hospitals, according to numerous national studies.

Falls rate can range from more than 2 to more than 9 falls per 1000 patient days, with 30 percent of them resulting in serious injury to patients. They’re also costly—prolonging hospital stays, depleting resources and leading to malpractice suits.

As soon as the patient is stabilized and returned to a safe place, the group investigates the cause of the incident. They evaluate the physical environment, the medical history that the patient has taken and the patient’s ability to understand instructions. The team generates a report, which is reviewed by the hospital’s nursing quality safety service council.

“This is a nurse-driven initiative that provides us with real-time understanding and education,” says nurse Carol Beckford, the council’s chair. “We reviewed the falls data and identified the need for a change. Nursing council members researched best practices, created and approved the practice change, and we widely communicated it.”

Since the Morse Team was created in November 2011, the incidence of falls at Suburban Hospital has remained under the Joint Commission’s benchmark of 3.73 falls per 1000 patient days. Patients, family members and visitors have taken notice of the process and have voiced their satisfaction. They like knowing that Suburban is working on falling falls. “It’s a hospital-wide initiative owned by everyone,” Beckford notes.

—Debra Scheinsberg

"Our work at the community hospital level will set the foundation for much more advanced care in Kuwait for years to come." —ZUBIN KAPADIA

International’s Zubin Kapadia, Rebecca Altman, Mohan Chellappa and Nicole Bosson are ready to assist Kuwait public health officials in improving health care standards.
transplantation program, has re-

The Johns Hopkins University

School of Medicine has joined

the Association of American

Medical Colleges and the Ameri-

can Association of Osteopathic

Medicine to establish the Military

and Veterans Health Institute.

As part of First Lady Michelle

Obama’s “Joining Forces” initia-

tive, the institute has the mission of

advancing care for veterans and

their families in the areas of

clinical care, basic research, and

training.

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SIBLEY MEMORIAL 

HOSPITAL FOR

SPECIAL SURGERY

Edward “Ted” Mill-

er Jr., chairman of the board of trustees and president of RCS

Construction Services, LLC, has been chosen from among

hundreds of nominees to receive the 2012 Outstanding

Director Award in the nonprofit category

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Board of Trustees. The award rec-

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beyond expected standards of ser-

vice, skillfully handling the opera-

tional oversight of the Johns Hop-

kyns Bayview Care Center.

Notable Nurses

Jeanne Keruly, M.S., C.R.N.P.,

assistant professor of medicine and

director of the Ryan White

HIV/AIDS Clinical Services Program,

has been named vice

cchair of the Greater Baltimore

HIV Health Services Planning

Council.

HIMSO

June Marlbor

has been appointed

vice president of de-

velopment. As vice

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