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Dome

JOHNS HOPKINS MEDICINE

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Ronald R. Peterson recounts four decades spent on the front lines of Johns Hopkins Medicine.

A 'Hopkins Person' Beyond Compare

After 44 years, Ronald R. Peterson looks back on accomplishments that have marked his singular career at Johns Hopkins Medicine.

Learn more about the strategic priority for people online at hopkinsmedicine.org/strategic_plan.

Ronald R. Peterson knows how many inpatients were treated on an average day in 1982 at Baltimore City Hospitals, which became Johns Hopkins Bayview Medical Center (about 500). He can tell you the budgeted operating expenses for The Johns Hopkins Hospital in fiscal year 2013 (about $1.8 billion).

Ask him almost anything about Johns Hopkins' administration and operations during the last 40 years, and he'll produce the answer.

Mastery of such detail is one of Peterson's astonishing abilities. So is his skill at working amiably with colleagues in every division within the vast Johns Hopkins Medicine enterprise, and so too is his sensitivity to patient needs and Johns Hopkins' role in the communities it serves.

These qualities help explain why he has steadily risen to ever more important positions of responsibility during his 44 years with Johns Hopkins Medicine–from increasingly critical administrative positions to president of Bayview Medical Center, to president of The Johns Hopkins Hospital, to president of the Johns Hopkins Health System, to executive vice president of Johns Hopkins Medicine. These qualities also explain why he is so widely admired.

Although he will continue to serve as a special adviser to Dean and CEO Paul Rothman for at least a year, Peterson's retirement in January marks the end of an era at Johns Hopkins. It also highlights a career with few equals in the history of American health care systems.

Between meetings, over a lunch of no-salt vegetable soup and broiled salmon prepared in the hospital's cafeteria, the slim, bespectacled 69-year-old recently reflected on his role in many of the significant

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People and Places

RONALD R. PETERSON
PRESIDENT, JOHNS HOPKINS HEALTH SYSTEM
EXECUTIVE VICE PRESIDENT, JOHNS HOPKINS MEDICINE

As I get ready to enter the brave new world of retirement, I've been reflecting on my 44 years with Johns Hopkins Medicine.

That's one-third of this institution's 128-year existence, beginning with the opening of The Johns Hopkins Hospital in 1889. During my four decades here, I've had the privilege of getting to know–and learn from–many of the greats of Johns Hopkins Medicine. Incredibly, a few of them even had direct links to the 19th century founders of the hospital and medical school. It's remarkable to think I've actually been a part of this extraordinary human chain.

Walking around the East Baltimore campus, and Johns Hopkins Bayview, too, I see places that now are named for people I knew. Those people weren't auditoriums, buildings or corridors to me. They were individuals I admired. Their contributions to Johns Hopkins Medicine made it great long before I arrived and while I've been here, and those contributions will endure long after I depart.

I've attended innumerable events in the Thomas B. Turner Auditorium–celebrating our Nobel Prize winners, listening to the inspiring speakers at our annual Martin Luther King Jr. commemoration, and participating in many similar occasions.

Thomas Turner–known to everyone as "Tommy"–was dean of the school of medicine from 1957 until 1968. He first arrived here in 1927 as a fellow. He knew two of the founding four physicians of Johns Hopkins Medicine: William Welch, the first dean of the school of medicine, who died in 1934; and Howard Kelly, the first professor of gynecology, who died in 1943. When you shook Tommy's hand, you were connecting yourself directly with the men in John Singer Sargent's iconic painting, "The Four Doctors."

Tommy Turner lived to be 100, dying in 2002. Dean/CEO Edward Miller and I occasionally visited his Bolton Hill home and sipped sherry with him. We recognized it was a special opportunity to benefit from what Ed called Tommy's "great wisdom and his knowledge and love of Johns Hopkins."

I was lucky to get to know Albert Owens, the soft-spoken, pioneering oncologist who was also a predecessor of mine as president of the hospital—and for whom the auditorium is named in one of our cancer research buildings. I also knew the towering intellectual Vernon Mountcastle, the father of neuroscience, for whom an auditorium is named in the preclinical teaching building.

Additionally, the year I arrived here I met the men for whom the Nelson/Harvey buildings are named: Russell Nelson, a dedicated and impressive president of the hospital from 1952 to 1972; and A. McGehee (Mac) Harvey, a mentor revered by generations of Hopkins medical students, and director of the Department of Medicine and physician-in-chief of the hospital from 1946 to 1973.

Plenty of memories are evoked whenever I'm in the Richard Starr Ross Research Building, which commemorates the school of medicine's exemplary, forward-looking dean from 1975 to 1990; and the Robert Heyssel Johns Hopkins Outpatient Center (more commonly called simply "JHOC"). It is named for my key mentor, the president of the hospital and health system from 1972 to 1992.

My office is in the Edward D. Miller Research Building, named for my extraordinary colleague and good friend, the first dean/CEO of Johns Hopkins Medicine, with whom I collaborated for 16 years to make Johns Hopkins Medicine a reality and bring it into the 21st century.

Walking from the Billings Administrative Building to the Wilmer Eye Institute or to the Weinberg or Sheik Zayed buildings, I pass through the Edward Halle Corridor. It's named for another important mentor of mine. Ed was Bob Heyssel's senior vice president for administration.

Ed Halle taught me a lot about the people dimension of our business—relationship building. He was a consummate relationship builder and impressed upon me the importance of people, because I was not a natural at that. I had to work at it. I was a bit more introspective. But I think, over time, I became quite good at that as well.

Ed Halle also paved the way for one of my greatest opportunities. He was Hopkins' "behind the scenes" negotiator during the lengthy discussions with the city over assuming administrative control of the old Baltimore City Hospitals–now Hopkins Bayview–in 1982. That led to my becoming head administrator of the hospital and then its president two years later, when it was acquired by Johns Hopkins.

I hope that during my time with Johns Hopkins Medicine, I've managed to burnish the legacies left by all of these exceptional individuals.

Johns Hopkins USFHP One of Highest-Rated Plans in State, Nation

For the second year in a row, Johns Hopkins US Family Health Plan is one of the highest-rated private plans in the nation. Johns Hopkins USFHP received an overall rating of 5 out of 5 on the NCQA Private Health Insurance Plan Ratings 2017-2018—one of just five plans in the nation to receive that score. By this measure, it is the top-rated private health insurance plan in Maryland.

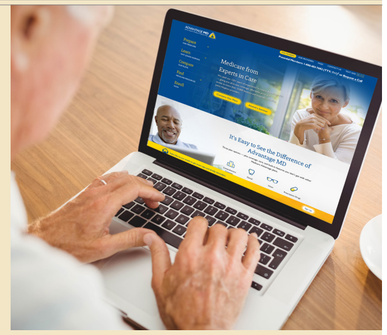
"To be among the highest-rated plans in the country is an honor, as well as a motivator," said Mary Cooke, vice president of Johns Hopkins USFHP. "Everything that we do is in pursuit of serving our military families and retirees with the highest quality of care possible." The plan also received an NCQA Health Plan Accreditation of Excellent, scoring 94.26 out of a possible 100.

Johns Hopkins USFHP offers comprehensive health care benefits to members of the seven uniformed services, including active-duty family members, retirees and their family members, and survivors. With more than 48,000 members in Maryland, Washington, D.C., Delaware, Northern Virginia, south central Pennsylvania, and parts of West Virginia, the plan is administered by Johns Hopkins HealthCare under a contract with the Department of Defense.

"Everything that we do is in pursuit of serving our military families and retirees with the highest quality of care possible."

—MARY COOKE, VICE PRESIDENT OF JOHNS HOPKINS USFHP

Johns Hopkins Advantage MD Adding HMO Plan



Because Medicare is not a one-plan-fits-all solution, Johns Hopkins Advantage MD is adding a new health maintenance organization (HMO) plan with lower cost options for Maryland seniors.

Advantage MD is a Medicare Advantage plan, covering everything that Medicare Part A and Part B cover, plus extra benefits such as dental, vision, hearing and prescription drug coverage. Administered by Johns Hopkins HealthCare, Advantage MD currently offers:

- Advantage MD preferred provider organization (PPO)
- Advantage MD (PPO) Plus
- Advantage MD Group

The PPO and PPO Plus plans have higher premiums but offer more network flexibility and do not require referrals for specialist visits. Advantage MD Group is a retirement plan for eligible retirees of select Johns Hopkins affiliates. With the addition of the HMO plan, Medicare beneficiaries can choose lower cost coverage coordinated by the members' primary care physicians. All care must be received from in-network providers.

Medicare-eligible Maryland residents living in the plan's service area can enroll in Advantage MD (HMO) through Dec. 7.

To learn more, visit hopkinsmedicare.com.

In the aftermath of Hurricane Irma, Johns Hopkins All Children's Hospital staff members gather items for colleagues who work at the hospital's outpatient care center in Fort Myers, Florida. The items, accompanied by many warm messages, filled two trucks. Pictured clockwise are safety and emergency preparedness manager Jesse Rauch; Susan Byrd, senior director of ambulatory services; and marketing liaison Jenna Fuller.

To learn more, visit hopkinsmedicine.org/dome.

Toward a Better Approach to Opioid Use

Experts at Johns Hopkins Pain Symposium see a way forward.

More than half of the people who misuse narcotics get them from family or friends, says Peter Pronovost, director of the Johns Hopkins Armstrong Institute for Patient Safety and Quality.

Prescriptions are often written for more pills than necessary, and patients are encouraged to accept these quantities so that they won't have to pay for refills.

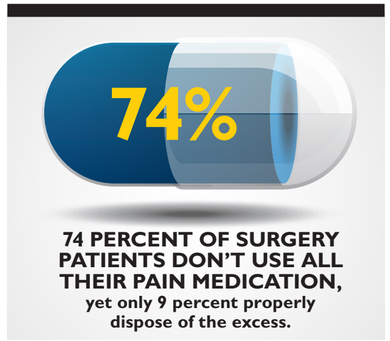
Anesthesiologist and pain medicine physician Mark Bicket has found that 74 percent of surgery patients don't use all their pain medication, yet only 9 percent properly dispose of the excess. They sell or give away their leftover pills, or leave them in medicine cabinets, where they can be taken at a later time by family members, visitors or even children exploring in the house.

Such situations can turn deadly. Last year, prescription opiates were blamed for nearly a quarter of Maryland's 1,856 opioid deaths, with heroin and fentanyl responsible for the rest.

Pronovost and Bicket spoke at the recent Johns Hopkins Pain Symposium, a daylong event aimed at changing a health care culture that gives hospital patients too many narcotics to manage their pain, then discharges them with too little information about what to do with any unused medication.

The symposium, organized by the Armstrong Institute and the Johns Hopkins Hospital Pain Management Committee, was held September 25 in the Chevy Chase Auditorium of The Johns Hopkins Hospital and featured experts from Johns Hopkins Medicine and the Johns Hopkins Bloomberg School of Public Health.

Strategies that were discussed at the symposium include a greater push to non-narcotic therapies, such as acetaminophen or physical therapy; and better instructions to patients about how to dispose of unused pills.



There's much room for improvement. For every 100 opioid prescriptions that a doctor writes, only five go to patients who have exhausted all non-narcotic pain management options, says Pronovost, a practicing critical care physician and Johns Hopkins Medicine's senior vice president for patient safety and quality.

He adds that the medical profession needs to build systems that prevent the misuse of opioid prescriptions. Johns Hopkins has already begun: The health system is creating a "clinical community" to improve opioid management throughout a patient's care experience. It is led by Peter Hill, senior vice president of medical affairs; and Daniel Ashby, vice president for pharmacy services.

The clinical community concept, developed at Johns Hopkins in 2011, brings together representatives from across Johns Hopkins Medicine, including patients and families, to develop a holistic approach to a particular disease or problem.

Other changes are coming from outside The Johns Hopkins Hospital. The federal Centers for Medicare & Medicaid Services, for example, is changing its Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey questions, effective Jan. 1, to ask patients to rate how the hospital communicated about pain, instead of rating how it managed pain.

"We need to do a far better job in our prescribing of opiates."

—PETER PRONOVOST, DIRECTOR OF THE JOHNS HOPKINS ARMSTRONG INSTITUTE FOR PATIENT SAFETY AND QUALITY

Lt. Gov. Boyd Rutherford, the afternoon keynote speaker, is leading a statewide heroin task force that has increased the number of treatment beds in Maryland and ramped up public service announcements and education about the risks of opioid misuse through the "Before It's Too Late" campaign.

"It will take the work of all of us, working with our federal partners, to address this challenge," he says. "It's really about saving lives and bringing more people into productive use in our society."

—Karen Nitkin

Learn more about the Johns Hopkins Pain Symposium: bit.ly/JHPain.
See Bill Clinton and others discuss the opioid epidemic: bit.ly/ClintonatBloomberg.

A New Push to Teach Future Doctors About Late-Life Depression

Online modules developed at Johns Hopkins highlight how to recognize and treat the psychiatric disorder in elderly patients.

Looking defeated, the 80-year-old woman arrived at The Johns Hopkins Hospital from the Midwest. For two years, she'd seen doctors about her chronic shortness of breath and fatigue. But her heart turned out to be fine. Not sure what to do next, her husband found Johns Hopkins geriatric psychiatrist Susan Lehmann in an online search and scheduled an appointment.

Within minutes of meeting her new patient, Lehmann saw classic signs of depression: low self-esteem, poor sleep quality—and anxiety attacks, "the likely cause of her shortness of breath."

"It's not so mystical, but because she wasn't tearful, her doctors never considered depression," the psychiatrist says. This patient, like many Lehmann treats, benefited from antidepressants and psychotherapy

Lehmann directs the Johns Hopkins Geriatric Psychiatry Day Hospital Program and the school of medicine's general psychiatry clerkship. "Most doctors don't recognize the threat geriatric mental health problems bring because they're not trained to do so," she says. Now, with the release of self-paced, online learning modules she's crafted for medical students, Lehmann aims to heighten future physicians' awareness about late-life depression—and its nuances.

Depression affects as many as 15 percent of people age 65 and older. Other mood disorders, such as manic episodes, can also emerge later in life, says Lehmann, who recently published a book on bipolar disorder in older adults. And, she notes, suicide rates among the elderly are rising, especially among men.

Meanwhile, many Americans are living longer. About 15 percent of the U.S. population is 65 or older. By 2030, an estimated 20 percent of the population will be over 65. "We don't have enough geriatric experts for the tens of millions affected by aging," Lehmann says. "And a negative outlook on life can worsen comorbidities, like Parkinson's disease, strokes and cardiac disease."

Expertise in this field remains woefully inadequate. In a recently published paper in *MedEdPORTAL Publications*, Lehmann and colleagues found that some 21 percent of responding medical schools lacked specific instruction or clinical experience focused on geriatric psychiatry. Of those schools, 14 percent reported having no geriatric psychiatrist on the faculty. At some point, says Lehmann, "Every doctor in almost every specialty will interact with geriatric patients. Students need to know what's considered normal aging, from heart problems to memory to mental health."

She says the new modules can bridge this gap with "easily digestible" clinical vignettes and videos showing how to engage with older patients and recognize and manage depression. She hopes more medical schools will adopt the modules, which are free of charge.

Lehmann draws from nearly 30 years of experience practicing and teaching geriatric psychiatry. In 2011, she was awarded the Berkheimer Faculty Education Scholar Grant, offering resources and time outside her regular duties to create the modules. After reviewing them, says Lehmann, students should be familiar with the signs and symptoms of geriatric depression and screening tools to help establish the diagnosis.

"I feel a sense of mission to our older patients," she adds, noting that geriatric depression is highly treatable. "It's so rewarding to help people find a better quality of life."

—Judy F. Minkove

4 Things That Might Surprise You About Depression in Older Adults:

1. It's never a normal part of aging.
2. Clinicians may recognize depression but often undertreat it with low doses of drugs.
3. It's sometimes confused with dementia.
4. Suicide rates among the elderly are growing, especially among 85-plus-year-old white men (47 per 100,000).

A 'Hopkins Person' Beyond Compare

(continued from page 1)

developments at Johns Hopkins Medicine during his more than four decades of service. This is his account:

1970s

Peterson views the 1970s as his "learning period," the time in which he became the protégé of Robert Heyssel, director of The Johns Hopkins Hospital, a title that later became president.

A native of Edison, New Jersey, Peterson entered The Johns Hopkins University as a premed student, hoping to become a physician. When he graduated in 1970, however, family circumstances compelled him to get a job rather than pursue a medical education. After working as a city school science teacher and as a part-time employee of a local kosher caterer, Peterson entered a George Washington University graduate program in health care administration in 1972. When the master's program gave him the opportunity for an administrative residency at The Johns Hopkins Hospital in 1973, he jumped at the chance—and never left.

Peterson recalls that Heyssel "sort of took me under his wing. ... He taught me to think strategically and to not be afraid to think a little bit outside the box." The hospital director also provided opportunities to tackle problems that went "a little bit beyond my own comfort zone."

Before Peterson completed his one-year residency, for instance, Heyssel sent him to work out administrative and financial difficulties at the hospital's Phipps Psychiatric Clinic—what Peterson calls "my first real job." Following his success at that assignment, the director asked him to devise plans for overall hospital cost-cutting measures.

Ron Peterson and fellow administrators discuss the hospital's cost improvement program in 1976.

Incredibly, The Johns Hopkins Hospital had operated in the red throughout its first eight decades. Due to its commitment to the founder's mandate that his hospital care for those who could not pay, the hospital lost money from the day it opened in 1889. When Heyssel became head of the hospital in 1972, it was running a $1.2 million annual deficit. Under the cost improvement program that Peterson implemented, however, the hospital was operating in the black by 1977.

In 1978, Peterson's next challenge became righting the fiscal ship of the Children's Medical and Surgical Center, a 200-bed facility that offered various medical and surgical disciplines as well as subspecialties.

"I began to get the feel for actually running something, administering a hospital," Peterson notes. That experience—and the administrative adeptness it instilled—would prove invaluable when Heyssel gave Peterson his next big job: rescuing Baltimore City Hospitals and transforming it into what now is the Johns Hopkins Bayview Medical Center.

1980s

The Once-in-a-Career Opportunity

Tracing its history back to the founding of the Baltimore City and County Almshouse of 1773, Baltimore City Hospitals was a storied municipal institution with an inspiring reputation for medical firsts—including the invention of landmark cardiopulmonary resuscitation techniques and creation of the country's first intensive care unit. It was called Baltimore City Hospitals because it had both an acute general hospital and a chronic hospital that included a nursing home.

In addition, it had an association with The Johns Hopkins Hospital that even predated the opening of the school of medicine in 1893. Many of its physicians held Johns Hopkins faculty appointments, and Johns Hopkins medical students long had done some training there.

By the early 1980s, however, City Hospitals staggered under annual losses topping $7 million to $8 million. Baltimore's mayor, William Donald Schaefer, wanted to unload it. Not only had running a major hospital become too complex for city officials; it was also causing a major hemorrhage in the city's treasury. Schaefer initiated the equivalent of a "request for proposal" for hospital organizations to take over its management.

Although a number of for-profit health care organizations offered proposals, the mayor was concerned they would "not take care of the poor people or do a certain service that was not making money," Peterson recalls. "Schaefer wanted assurance that whoever was going to run it would continue to care for all who needed access. So that's why I think they gave us the nod."

Heyssel believed that if Johns Hopkins could manage City Hospitals for a trial period and reduce its mammoth deficits, acquiring it would make

"There are few people with the blend of long-term thinking and leadership that is required to put their own enduring stamp on this place. It's hard to imagine what Johns Hopkins would look like without Ron's steady hand guiding the way."

—PAUL B. ROTHMAN, M.D., DEAN OF THE MEDICAL FACULTY AND CEO OF JOHNS HOPKINS MEDICINE

Things You Didn't Know About Mr. Peterson

Ron Peterson describes himself as "very much a Hopkins person"—which also can be said of others in his immediate family. His wife, Elizabeth "Rooney" Peterson, became the Department of Medicine's first professional fee billing coordinator in 1974. She continued doing administrative work on school of medicine grants and other financial management projects, earned a master's degree in administrative sciences from Johns Hopkins University, and in 1987, began a career as a part-time consultant, mostly for The Johns Hopkins University's School of Medicine departments. In 1998, she began volunteering at the Alan Mason Chesney Medical Archives, where she still works.

The Petersons' daughter, Susan, graduated in 2009 from The Johns Hopkins University School of Medicine, completed her residency in the Johns Hopkins Department of Emergency Medicine, and is now an assistant professor of emergency medicine.

Asked how he developed his passion for accuracy and detail, Peterson observes that his father, the co-owner of a small roofing and sheet metal business, did its bookkeeping and paid close attention to the details of that little business. "So maybe that's where I got it," he says.

As a high school student and undergraduate at The Johns Hopkins University, Peterson focused on a medical career—although his mother "always hoped" he would become a minister. "I always thought I was going to become a doctor. So I think I brought all these things together—because, in many ways, I think we do the Lord's work here."

To learn more about Ron Peterson, visit hopkinsmedicine.org/dome.

"He is driven by a true caring for our patients, our employees and our local community."

—REDONDA G. MILLER, M.D., M.B.A., PRESIDENT OF THE JOHNS HOPKINS HOSPITAL

"These two photos of Johns Hopkins Bayview tell one of the great stories of American medicine in the last century: the redevelopment of the Bayview campus into one of the world's leading academic medical centers. It receives almost $300 million annually from the National Institutes of Health and is a beacon of hope for the economic redevelopment of eastern Baltimore City and County. This transformation was made possible by the leadership and unwavering support of Ron Peterson."

—RICHARD G. BENNETT, M.D., PRESIDENT, THE JOHNS HOPKINS BAYVIEW MEDICAL CENTER

sense. In 1982, he chose Peterson to head the group of Johns Hopkins managers who collaborated with City Hospitals' physician leaders to turn around the beleaguered medical center.

Under contract with the city, Peterson and his colleagues cut City Hospitals' losses by more than $7 million in just one year. By 1984, a joint committee of trustees from The Johns Hopkins University and The Johns Hopkins Hospital accepted Peterson's recommendation that Johns Hopkins acquire the facility. Peterson was appointed president of what initially was renamed the Francis Scott Key Medical Center, and later named Johns Hopkins Bayview.

Peterson and his colleagues launched more than two decades of extensive, financially successful expansion of buildings, staff and services. He says his work at Bayview stands as one of his finest achievements.

"To have been part of it was a once-in-a-career opportunity," he says. "It was a win for the city of Baltimore—no more red ink; a win for Johns Hopkins—130 acres of land on which to expand every dimension of our tripartite mission; and a win for the community, with dramatically improved facilities and services provided by Johns Hopkins faculty and highly competent, caring staff."

1990s

The Creation of Johns Hopkins Medicine

When Peterson's mentor, Robert Heyssel, retired from the presidency of The Johns Hopkins Hospital and Health System in 1992, Peterson interviewed for his job.

Instead, the trustees hired James Block, a pediatrician from University Hospitals Clinic at Cleveland's Case Western Reserve University. They were concerned about what they believed was an increasingly competitive threat in the emerging area of managed care, and they considered Block to be especially well-versed in that field.

However, the hiring of Block ushered in an extremely tumultuous time in the history of Johns Hopkins.

Peterson recalls that the new president soon was "constantly knocking heads" with Michael Johns, dean of the school of medicine, and sought Peterson's help with handling the situation.

"Block said he needed somebody to come and work with him who not only knew the organization but was recognized as a stabilizing force," Peterson says.

Peterson became executive vice president and chief operating officer for both The Johns Hopkins Hospital and health system, which then consisted of The Johns Hopkins Hospital, Hopkins Bayview and the Wyman Park Health System, which included the then U.S. Public Health Service Hospital on the edge of the university's Homewood campus and the North Charles General Hospital. He also retained the presidency of Johns Hopkins Bayview.

The recruitment of Peterson as a "stabilizing force" didn't end the problems between Block and Johns. The medical school dean left Johns Hopkins to become executive vice president of Emory University's medical center in 1996. Block also departed that year.

Edward D. Miller, head of the Department of Anesthesiology, became interim dean, and Peterson was named interim president of both the hospital and the health system—while still remaining president of Johns Hopkins Bayview.

In 1997, Johns Hopkins Medicine was established as a unified leadership entity for the hospital and health system. Miller accepted the position of dean/chief executive officer, who would lead both the school of medicine and the overall health system, as well as be the university's vice president for medicine. Peterson became president of the hospital and health system. Miller also named him executive vice president of Johns Hopkins Medicine.

Peterson and Miller formed a remarkable partnership. They not only solidified an effective governance structure for Johns Hopkins Medicine, but also led an equally dedicated team of administrators and faculty members to undertake extensive development projects and expand Johns Hopkins Medicine's scope dramatically over the next 16 years until Miller's retirement.

"We began to establish certain central services, began to do budgeting and planning on a consolidated basis. We began to speak with one voice in Annapolis and in Washington," Peterson recalls. "We began to develop the trappings of a 'system,' if you will. We created the infrastructure to do managed care with Johns Hopkins HealthCare. We began to develop the early stages of a home health services company to serve both adults and children."

In early 1998, Johns Hopkins Medicine acquired Howard County General Hospital, "with an eye toward thinking that we needed to begin moving outside of Baltimore and heading toward Washington," Peterson recalls. And the following year, he and Miller started to develop a physical master plan for the East Baltimore campus.

2000-2017

Building a New Johns Hopkins Hospital and a Regional Health Care System

Peterson considers the 2012 opening of the 1.6-million-square-foot Sheikh Zayed Cardiovascular and Critical Care Tower and The Charlotte R. Bloomberg Children's Center as a landmark achievement in his career.

"I take pride in having been able, on my watch, to do what was necessary to bring the physical facilities of The Johns Hopkins Hospital up to snuff, with excellent programs and people. From a tangible, physical evidence basis, that was especially meaningful. It remains a very visible sign of what we were able to accomplish," he says.

Peterson is also grateful that he could work with Miller and his successor, Paul B. Rothman, to develop "a more highly academically driven, integrated health care delivery system in the Baltimore-Washington region."

In 2006, Johns Hopkins Medicine entered into an agreement with the University of Maryland to jointly own and operate the Mt. Washington Pediatric Hospital

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Ronald R. Peterson
Career Timeline

EDUCATION

1966–1970
Earns undergraduate degree (premed) from The Johns Hopkins University.

1972–1974
Earns a graduate degree in health administration from The George Washington University School of Government.

EMPLOYMENT

1970–1972
Science teacher, Mergenthaler Vocational-Technical High School, Baltimore, earning funds for graduate school

1973–1983
After serving as an administrative resident at The Johns Hopkins Hospital, he becomes administrator of the Henry Phipps Psychiatric Clinic; administrator of The Johns Hopkins Hospital Cost Improvement Program; and administrator of the Johns Hopkins Children's Medical and Surgical Center.

1982–1984
Executive director, Baltimore City Hospitals (now Johns Hopkins Bayview Medical Center) under Johns Hopkins contract with Baltimore City

1984–1999
President of Johns Hopkins' Francis Scott Key Medical Center, which becomes Johns Hopkins Bayview Medical Center in 1994

1995–1996
Executive vice president and chief operating officer of The Johns Hopkins Hospital and Health System

1996–2016
President of The Johns Hopkins Hospital

1997–present
President of the Johns Hopkins Health System

1998–present
Executive vice president, Johns Hopkins Medicine

When a Biology Lecture Turns Personal

A medical student reflects on the day he learned all about the disease that took his young mother's life.

No one prepares you for listening to a lecture about how your mother died. Medical students are trained to recognize grief and distress in patients and invite them to talk about it. We are taught the complex molecular physiology behind diseases common and rare, minor and terminal. But we are not trained to see our own family's tragedy writ large on a lecture screen, broken down into bullet points and illustrated with surgical images.

For me, this moment came on a chilly January morning in the third week of our reproductive systems course. The schedule listed two lectures on ovarian disorders: the first on benign diseases, such as cysts and infections, and the second on cancer.

At the end of the first hour, the professor introduced a case example. The patient was a woman in her early 30s with three months of mild abdominal pain. As we worked through the history, lab values and imaging, it became clear: This was no infection or benign cyst. This young woman had ovarian cancer. The lecturer went on to describe the chosen treatment plan, but I barely heard. My mind had been yanked 22 years away, paralyzed with the sudden reminder of another young woman's cruel diagnosis: my mother's. A board-certified anesthesiologist, marathon runner and mother to two boys, she died from an aggressive ovarian cancer on May 1, 1995. She was 34.

I heard the class applaud. My friend Eva, who knew about my mom, leaned over and asked me how I was doing. Looking at my computer, I thanked her for asking and mumbled something about the last case being a doozy. I had a minute or two before the second lecture began. I'm still doing okay, I thought. I can still do this. I desperately wanted to understand this disease. But the more I thought about it, the sadder I became. I can't do this, not now.

Not wanting to make a scene, I grabbed only my laptop and left the hall, focusing on walking at a normal pace. Then, I found a study room with no windows, slumped against the wall and let down my guard.

It was seven days before I finally willed myself to watch the recording of the lecture. It fit the familiar pattern of a cancer talk—risk factors, clinical features, pathology, etc.—but this time sprinkled with pieces of information that jabbed into my stomach like ice picks.

May not feel mass on pelvic exam until >8 cm.

My dad once said my mom's tumor looked like the Death Star on her CT scan.

An intraoperative photograph showing an abdominal cavity littered with yellowish lobes of metastatic cancer.

Picturing my mother's youthful cream-white skin cut with a scalpel and lifted up by cold steel retractors to reveal disease scattered far from its ovarian origin.

No overall survival advantage for CA-125 screening in average-risk women.

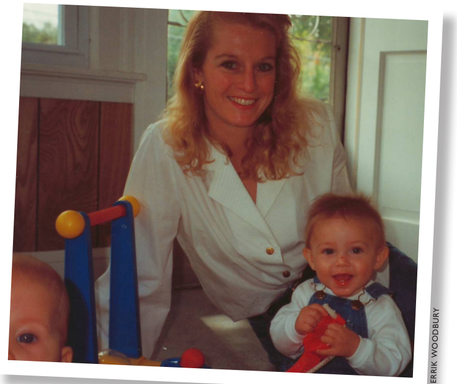
We still don't have a way to catch it early.

All the while, I couldn't shake the stunning awe that every cancer, every disease I learned about in medical school provokes this visceral reaction from someone, somewhere because it has touched their life, like ovarian cancer irrevocably altered mine. How many of my classmates, I wondered, who didn't attend a particular lecture had excused themselves because they were too sad, because the featured disease had once scarred their family? How will we fare caring for our first patients suffering from diseases we could name before we could spell "surgeon"?

Illness touches all of us. New medical students are not blank slates. We arrive carrying the weight of our family's collective experience with health and the medical system. I am far from understanding the full impact of my mother's death on my life in medicine, but I am one step closer to understanding her disease and how I can care for patients whose diagnosis cuts me to my core.

Ovarian cancer has a face and a name and a story for me. Ovarian cancer will forever be represented by my mother. But there are countless more diseases for which I don't have a story. In a few weeks,* my classmates and I will enter the hospital to begin learning the human stories with which to illustrate our textbooks. Faces will replace PowerPoint slides. Conversations will supplant bulleted lists. A slice from a CT scan will lose its abstractness and become a window into understanding Ms. F's bloody cough. Disease will gain a face and a name and a favorite takeout dinner. Disease will become human. And then we'll go to work.

—Carson Woodbury



DERRIK WOODBURY

Carson Woodbury as a toddler with his mom, Kate Kuhn Woodbury, M.D.

**This essay first appeared on Feb. 23 in the Biomedical Odyssey blog.*

To read more about the perspectives of School of Medicine trainees, visit biomedicalodyssey.blogs.hopkinsmedicine.org.

"I have never worked with someone who has the work ethic, the unwavering moral compass to do what is right and the ability to always treat everyone with respect that Ron Peterson has."

—EDWARD D. MILLER, M.D., DEAN/CEO, JOHNS HOPKINS MEDICINE, 1996–2012

A 'Hopkins Person' Beyond Compare

(continued from page 5)

in Northwest Baltimore. In 2007, Johns Hopkins signed affiliation agreements with the Annapolis-based Anne Arundel Health System, parent organization of the 370-bed Anne Arundel Medical Center; and the Greater Baltimore Medical Center, a 232-bed acute care hospital in Baltimore County.

In 2009, Johns Hopkins Medicine assumed control of the Suburban Hospital Healthcare System and its 230-bed Suburban Hospital in Montgomery County. Less than a year later, Sibley Memorial Hospital, a highly regarded, 342-bed facility in Northwest Washington, D.C., joined Johns Hopkins Medicine.

All Children's Hospital in St. Petersburg, Florida, had just opened a $400 million, 259-bed medical center in 2011 when it became the first Johns Hopkins affiliate outside of the Baltimore-Washington area. Since then, All Children's has been renamed Johns Hopkins All Children's Hospital and is in the midst of building a major research and education facility. The hospital's first class of residents graduated this year.

Johns Hopkins Medicine International has also experienced astonishing growth in the 21st century, with academic and clinical collaborations with hospitals, institutes and clinics in Canada, Latin America, Europe, Asia and the Middle East. Peterson participated in the creation of a major joint venture with Saudi Aramco, a global energy and chemicals company in Saudi Arabia. Johns Hopkins Aramco Healthcare collaborates with Saudi Aramco to provide care for approximately 360,000 employees, dependents and retirees.

'Very Much a Hopkins Person'

Peterson says a key reason he has remained at Johns Hopkins for 44 years is because he "enjoys the people dimension"–interacting not only with his colleagues but also with patients and families. He routinely drops in unannounced at patients' bedsides, just to ask how they are faring and to offer a business card with the suggestion to contact him at any time.

"It's a way of keeping in touch with why I went into this business in the first place," he says.

Another reason he has stayed at Johns Hopkins is that the opportunities have outweighed the disappointments. When he was passed over for the jobs of the hospital and health system presidencies in 1992, for instance, he was soon travelling back and forth between East Baltimore and Bayview, juggling his role as Bayview's president with his new position as Johns Hopkins' hospital and health system executive vice president and chief operating officer.

Because of his many successes at Johns Hopkins, Peterson says it has been easy to resist various outside job offers.

"A few were interesting, but I was always still very much a Hopkins person," he says. "I've had enough opportunity along the way to take on new, exciting responsibilities that have always provided me with a sense of renewal."

During his 20 years as president of The Johns Hopkins Hospital, *U.S. News & World Report* named it the No. 1 hospital in the nation 16 times—15 years of that run were in a row. Like Ron Peterson's service to the institution, it's a record unlikely to be matched.

—Neil A. Grauer

To read more about Mr. Peterson's accomplishments, visit hopkinsmedicine.org/dome.

Opening Minds and Hearts to the Power of Palliative Care

Johns Hopkins Aramco Healthcare care team helps ease pain and distress at the end of life.

The patient, just 20 years old, was suffering from osteosarcoma, a type of bone cancer. He had an aggressive tumor, the kind that grows quickly but kills slowly.

When the young man came to the palliative care team at Johns Hopkins Aramco Healthcare (JHAH), he had mere weeks to live. In the time that remained, he wanted two things: to be pain-free and to have his parents care for him at home.

Mohammad Al-Ghamdi, palliative care specialist, and Fatima Al-Rashed, palliative care clinical nurse specialist, met with this patient and his family at their home in Dhahran, Saudi Arabia, assessed his care plan and changed his medication, allowing him to rest pain-free for the first time in many months. He was able to communicate with his family, and his friends could visit and play PlayStation with him. "It was like magic," says Al-Rashed.

The patient died comfortably at home four months later. "That's what he wanted," says Al-Ghamdi. "He didn't suffer, and that's what palliative care is all about."

In the quest to ease the physical symptoms and overwhelming fears that come with chronic pain and incurable disease, palliative care aims to "improve the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering," according to the World Health Organization.

However, in Saudi Arabia, where JHAH operates, palliative care is still fairly limited. Besides JHAH, only one other medical institution, King Faisal Specialist Hospital and Research Center in Riyadh, offers palliative care to the chronically and terminally ill within a patient population of 8 million people.

This slow adoption of palliative care in Saudi Arabia stems from its relative newness as a medical subspecialty and a lack of awareness about the critical role it can play in patient care and satisfaction. There is also a religious taboo in abandoning hope for a cure and, instead, focusing on care. Samer Abushullaih, a JHAH oncologist, says that in the Kingdom of Saudi Arabia, "Palliative care equals, 'We're giving up.'" He quickly asserts, "This isn't true, of course, but that's where we are at this point."

JHAH began tackling these concerns by introducing palliative care soon after Johns Hopkins Medicine and Saudi Aramco formed the JHAH joint venture in February 2014 to create a health care system for the energy giant's 360,000 employees and dependents. Later that year, a team of Johns Hopkins Medicine experts conducted an in-depth review to gauge the need for establishing a palliative care program at JHAH's central hospital, Dhahran Health Center.

The review uncovered a tremendous need for comprehensive inpatient and outpatient palliative care programs—a necessity that will grow as cancer and other chronic diseases become more prevalent due to factors such as longer lifespans and harmful lifestyle choices such as smoking and consuming high-fat diets.

In July 2015, JHAH launched a patient-centered, nurse-led palliative care consult service that already has seen more than 450 patients. The patients typically are suffering from cancer and sickle cell disease, the highest source of Emergency Department admissions at JHAH. However, consults have rapidly expanded to other parts of the hospital, including cardiology, nephrology and neurology.

JHAH also opened an outpatient service last October that has treated more than 100 patients and recently introduced inpatient clinics, where clinicians have seen nearly 20 admissions. Additionally, although hospice care is nearly nonexistent in Saudi Arabia, and home care programs are still in their infancy, JHAH has piloted a program to provide home visits to chronically ill patients who are discharged from the hospital.

The long-term goal is to add 20 beds dedicated to providing both palliative care and hospice in the hospital.

Over the last three years, JHAH and Johns Hopkins Medicine have worked together to develop palliative care programs using a multidisciplinary approach that provides patients with comprehensive programs that meet their needs as they change over time, such as offering an inpatient unit and outpatient clinics paired with hospice and home care.

While Al-Ghamdi and Al-Rashed form the core team, other physicians and nurses, pain managers, care coordinators, hospitalists, social workers, pharmacists and psychologists support their work. They also have worked closely with Rab Razzak, director of outpatient palliative medicine at The Johns Hopkins Hospital. Razzak says, "We are taking a team approach to find out who patients are and what their values are. Using this information, we can help direct their care and make treatment recommendations for them. It's personalized treatment at its best."

JHAH's entrance into palliative care is helping to validate it as an important health subspecialty, and encouraging caregivers in the Kingdom to provide a much-needed form of comfort.

"It's hard, emotionally draining work, but it's worth it," Al-Ghamdi says. "I have never been thanked so much in my 15 years as a physician as I have in the last few months as a palliative care physician."

—Kristen Pinheiro

Physician Mohammad Al-Ghamdi and Fatima Al-Rashed, a clinical nurse specialist, help direct a multidisciplinary approach to palliative care at Johns Hopkins Aramco Healthcare.

"We are taking a team approach to find out who patients are and what their values are. It's personalized treatment at its best."

—RAB RAZZAK
DIRECTOR, JOHNS HOPKINS HOSPITAL OUTPATIENT PALLIATIVE MEDICINE

Reducing Unnecessary Blood Transfusions

Electronic medical records help The Blood Management Program improve practices and lower costs.

Johns Hopkins Medicine saved $2.4 million last year by reducing unnecessary blood transfusions across the health system, thanks to efforts by the system's Blood Management Program using data acquired from the Epic electronic health records. These results were reported in the November issue of the journal *Anesthesiology*, where the article describes a 400 percent return on investment for supporting the program.

"Epic has improved our ability to do evidence-based transfusion practice," says Steven Frank, director of the Johns Hopkins Blood Management Program. "Doing blood management is very data-intensive. We monitor transfusion guideline compliance, and with the right data, you can improve practice by showing providers their compliance rates compared to their peers."

Using interactive dashboards, Frank and colleagues can easily monitor usage of red blood cells, plasma and platelets by individual departments at all five local hospitals in the health system, even drilling down to see the practice of individual providers. Reports are distributed to hospital departments monthly to encourage improved blood utilization and reduce unnecessary transfusions.

"These reports are essentially audits with feedback, and they work because we emphasize positive feedback for those with excellent compliance rates," Frank says. "We've found that's the best way to improve practice." In addition, when physicians go to order blood products in the Epic system, they see a best practice advisory supported by two landmark studies in the *New England Journal of Medicine*, with hyperlinks to the articles.

Building on a successful campaign to reduce unnecessary red blood cell use when Epic went live in July 2016, Frank and colleagues added a push to reduce unnecessary platelet transfusions. "Platelets are the highest risk and the highest cost of all the major blood components, so it makes sense to reduce platelet overuse as well," he says.

—Staff report

To read more about this program, visit hopkinsmedicine.org/dome.

CEO of Johns Hopkins Medicine Reappointed

Paul B. Rothman has been appointed to a second term as CEO of Johns Hopkins Medicine and dean of Johns Hopkins University's School of Medicine. He began a new six-year term this summer. Rothman joined Johns Hopkins University in 2012 as the second CEO of Johns Hopkins Medicine and the 14th dean of the School of Medicine.

National Academy of Medicine Honors

Paul B. Rothman, dean of the medical faculty and CEO of Johns Hopkins Medicine and **Jeffrey P. Kahn**, a professor and director for the Johns Hopkins Berman Institute of Bioethics have been elected members of the National Academy of Medicine. Membership in the academy, considered one of the highest honors in the fields of health and medicine, recognizes individuals who have demonstrated outstanding professional achievements and commitment to service.

First Chief Real Estate Officer

Mitchell Bonanno, M.S.C.E., M.S.R.E., has been chosen by senior leadership from The Johns Hopkins University and the Johns Hopkins Health System to become Johns Hopkins' first chief real estate officer. Bonanno has more than 25 years of real estate development and construction operations experience. He will manage the university's and health system's real estate portfolios and prepare to meet their long-term real estate needs.

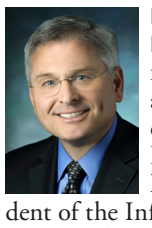
Johns Hopkins University Alumni Heritage Award Honorees

Three Johns Hopkins Medicine employees have received the university's 2017 Alumni Heritage Award. Established in 1973, the award honors those who have contributed outstanding service over an extended period to the progress of The Johns Hopkins University or the activities of the alumni association. The honorees include **Deborah Baker, D.N.P., C.R.N.P.**, senior vice president for nursing for the Johns Hopkins Health System and vice president of nursing and patient care services at The Johns Hopkins Hospital; **Richard Bennett, M.D.**, president of Johns Hopkins Bayview Medical Center; and **Gregg Semenza, M.D., Ph.D.**, director of the Institute for Cell Engineering's vascular program, professor of pediatrics and a 2016 recipient of the Albert Lasker Basic Medical Research Award, for insights into how cells sense oxygen.

40 Under 40

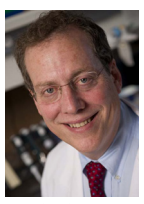
David Narrow, M.S.B.E., a participant in the school of medicine and Krieger School of Arts & Sciences' jointly operated Center for Bioengineering Innovation & Design, has been named by the *Baltimore Business Journal* as one of its 40 Under 40 innovative entrepreneurs for 2017. Narrow, 27, the founder of Sonavex, collaborated with **Devin O'Brien-Coon, M.D., M.S.S.E.**, assistant professor of plastic and reconstructive surgery, to invent a solution for problems associated with postoperative blood clots. Also honored was **Sashank Reddy, M.D., Ph.D.**, 39, a resident in plastic surgery. Reddy co-founded and is CEO of LifeSprout, a company that is developing a nanofiber-hydrogel composite material to restore soft tissue lost to cancer treatments, trauma or aging. In addition, **David West**, 23, a computational pathology innovator and biomedical engineering graduate, was cited for being the founder and CEO of Proscia, a cloud-based, digital pathology platform.

EAST BALTIMORE

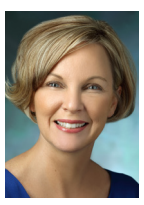


Paul Auwaerter, M.D., M.B.A., professor of medicine and clinical director of the Division of Infectious Diseases, has become president of the Infectious Diseases Society of America for a one-year term.

Eric Bass, M.D., M.P.H., professor of medicine, has been named chief executive officer of the Society of General Internal Medicine. He will serve in this part-time position while continuing his clinical practice and serving as vice chair for faculty development and promotions in the Department of Medicine.



Andrew Feinberg, M.D., M.P.H., professor and director of the Center for Epigenetics, has received the Association for Molecular Pathology's 2017 Award for Excellence in Molecular Diagnostics. The honor recognizes Feinberg's seminal scientific discoveries and contributions to the field of epigenetics.



Karen Horton, M.D., professor of radiology, has been named director of the Department of Radiology and Radiological Science. Since February 2016, she has served as interim director of the department as well as chair of the board of Johns Hopkins Imaging. A 19-year Johns Hopkins veteran, Horton's areas of expertise include body computerized tomography (CT) imaging, 3-D post-processing of CT data and virtual colonoscopy. She recently oversaw the creation of a Johns Hopkins Community Radiology Division to provide services at Sibley and Suburban hospitals.

Mahadevappa Mahesh, M.S., Ph.D., professor of radiology and cardiology, and chief physicist of The Johns Hopkins Hospital, was elected president of the Maryland Radiological Society. Mahesh is the second medical physicist in the nation to become president of a local chapter of the American College of Radiology.

Rachel Salas, M.D., associate professor of neurology, has been named director for interprofessional education and interprofessional collaborative practice for the Johns Hopkins University School of Medicine. She succeeds **Laura Hanyok, M.D.**, now assistant dean for graduate medical education. Salas has served in various medical education roles, including director of the neurology clerkship and medical educator for nurse practitioners. In her new role, she will spearhead efforts to advance interprofessional education and partnerships with professional schools and clinical sites.

Gordon Tomaselli, M.D., professor of medicine and chief of the Division of Cardiology, was recently named the next editor-in-chief of *The Journal of Clinical Investigation*. He will serve a five-year term with an editorial board of peer scientists based at Johns Hopkins.

Robert Wood, M.D., professor and director of pediatric allergy and immunology and an expert on food allergy and childhood asthma, has been named president-elect of the American Academy of Allergy, Asthma, and Immunology.

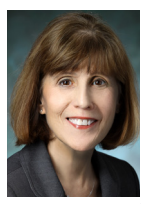
Bin Wu, Ph.D., assistant professor of biophysics and biophysical chemistry, has received a 2017 Pew Charitable Trusts early-career scholar grant in the biomedical sciences. He will receive four years of flexible funding to pursue foundational research. His lab will investigate the role localized protein synthesis plays in the growth and connection of neurons–work that ultimately could lead to new interventions for conditions such as autism and Alzheimer's disease.

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

Kamal Dhanjani, P.A.-C., anesthesiology and critical care medicine, has been elected president of the Baltimore chapter of the Society of Critical Care Medicine. Dhanjani joined the Department of Anesthesiology and Critical Care Medicine in 2006 and currently serves as the physician assistant manager and co-director of the physician assistant residency program in critical care medicine.

SUBURBAN HOSPITAL

Eric Dobkin, M.D., has been appointed vice president of medical affairs. With more than 20 years of experience in hospital quality and safety, he previously served as chief quality officer and vice president of quality/patient safety for the four-hospital Crozer-Keystone Health System in Pennsylvania.



Jacky Schultz, R.N., M.S.N., C.N.A.A., president of the hospital, was recently named one of *Washingtonian* magazine's Most Powerful Women of 2017 in the health and medicine category. Named president of Suburban Hospital in 2016, she has served in many leadership roles since joining the staff in 2005.

SIBLEY MEMORIAL HOSPITAL

Marissa McKeever, J.D., director of government and community affairs, has been named by the Politico website as a 2017 Living Classrooms Rising Star. She will become an ambassador for the Living Classrooms Foundation, which works to strengthen communities and inspire young people to reach their potential through hands-on education and job training.

JOHNS HOPKINS MEDICINE INTERNATIONAL (JHI)

Jennifer Dunkes has been promoted to project analyst. During the past five years, she has worked with JHI human resources to develop and implement the new employee orientation program, help manage the launch of JHI's intranet, and develop the initial design for the first employee engagement and diversity committee.

SHARING BEST PRACTICES–Kristina Hoerl, a registered nurse educator who specializes in radiology at The Johns Hopkins Hospital, leads a simulation to train nurses and radiology technicians at the Nelson Mandela Children's Hospital in Johannesburg, South Africa. Hoerl and other Johns Hopkins Medicine experts visited the new hospital in August as part of an assessment and training collaboration. The project is funded through the United States Agency for International Development's Maternal and Child Survival Program, which is led by Johns Hopkins affiliate Jhpiego. In this exercise, conducted in the CT scan room, Hoerl poses as the parent of a pediatric patient and helps the group identify areas they could improve related to safety and emergency management. Pictured from left are two CT techs and a radiology nurse, while the hospital's head radiology nurse looks on from behind. Learn more about the collaboration at hopkinsmedicine.org/dome.

Dome

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Editor
Linell Smith

Contributing Writers
Ellen Arky, Karen Blum, Neil A. Grauer, Judy F. Minkove, Kristopher Moody, Karen Nitkin, Kristen Pinheiro, Karen Robinson, Carson Woodbury

Copy Editors
Victoria Banks, Ron Hube, Justin Kovalsky, Judy F. Minkove

Graphic Designers
Kristen Caudill, Abby Ferretti, Rachel Sweeney

Photographer
Keith Weller

Dalal Haldeman, Ph.D., M.B.A.
Senior Vice President, Johns Hopkins Medicine Marketing and Communications

Send letters, news and story ideas to:
Editor, *Dome*
Johns Hopkins Medicine
Marketing and Communications
901 S. Bond St., Suite 550
Baltimore, MD 21231
Phone: 410-502-9602
Email: lsmit103@jhmi.edu

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