MARYLAND HEALTH CARE *Quarterly*

State's new health legislation leaves 700,000 uninsured

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Maryland's Medicaid eligibility gets governmental boost

More than 700,000 Marylanders still left without insurance

MAXIMILIAN FRANZ

Gov. Martin O'Malley's new health care legislation widens the circle of Medicaid eligibility by another 100,000 Marylanders.

ERIC STOCKLIN

Vincent DeMarco, of the Maryland Citizens' Health Initiative, has been fighting for health care for years and is 'thrilled' with the recent legislation.

By Karen Nitkin
Special to The Daily Record

Barbra Lancelot of Silver Spring still has a few years to go before she qualifies for Medicaid. But for her, these are not the golden years. "I'm one of those baby boomers who isn't having a wonderful time at this point in my life," she said.

Suffering from fibromyalgia, arthritis and depression, she stopped working a few years ago and soon found she couldn't afford to pay $375 for health insurance. She also can't afford the estimated $700 or so a month her prescriptions cost, so she just lives with the symptoms of her ailments. "I have pain every hour of every day," she said.

Lancelot worked as an early childhood special educator for more than 40 years, but stopped recently when her job was reclassified to two part-time positions without benefits, she said. Since May, she has had no insurance.

Recently, Lancelot testified before the state legislature in favor of expanded health insurance coverage in the state of Maryland. Her efforts helped usher in a historic bill, approved Nov. 19, which will expand coverage to an estimated 100,000 more people in the state.

The main feature of the law, which goes into effect Jan. 1, is that it will raise the income eligibility bar for Medicaid, boosting it to 116 percent of the current poverty level, up from the current 40 percent.

Ron Pollack, the executive director for **Families USA** — a national nonprofit organization for health care consumers — said Maryland's action is "very encouraging," particularly because it proves that such measures are politically viable.

"I think it will serve as an example and a catalyst for similar action in other states across the country," he said. "If Maryland can adopt this legislation, I think it makes it more likely that other states will consider doing something comparable."

Though affordable health insurance consistently ranks in polls as one of the top domestic concerns of Americans, until now, Maryland, for all its wealth, has ranked as one of the lowest states — No. 41 out of 50 — in coverage.

The reason, according to Del. Peter A. Hammen, chair of the House Health and Government Operations Committee, is simple: "There were always other priorities," he said, particularly education and the environment.

The state has historically done better at insuring children, who now receive benefits if they are at 300 percent of the federal poverty level, he noted.

The poverty level ranges from $10,210 per year for a single-person household to $20,650 for a family of four, and up from there. A single person like Lancelot would need to earn less than $11,844 to qualify for insurance under the new plan.

But Lancelot, who made about $15,000 last year through a combination of unemployment insurance and some contract work, said she filled out an application but fears she still won't qualify. And even if she does, the fact remains that some 700,000 people in the state won't be covered under the new plan.

The bill also provides subsidies to small businesses, with between two and eight employees, of $1,000 per year for each employee enrolled in an employer-sponsored plan, and will also give money to businesses that provide wellness programs. These measures also would not help Lancelot, who currently does not have steady employment.

The new legislation will take about $280 million out of state coffers by the 2013 fiscal year, said Hammen. "It's very costly, and I think it's one of the reasons it hasn't been tackled up to this point. This was a necessary, albeit expensive, first step that we had to take."

To offset that cost, the state is implementing a new $1 cigarette tax, taking effect June 1. Hammen also said he worked to make sure the state received matching federal grants for as much of the money as possible.

Vincent DeMarco, president of the nonprofit **Maryland Citizens' Health Initiative**, noted that Gov. Martin O'Malley has been much more supportive of insurance reform than the previous governor, Robert L. Ehrlich Jr.

"We are thrilled," said DeMarco, whose group was formed in 1999 to fight for expanded health insurance coverage in Maryland. "What it means is that 50,000 fewer kids are going to smoke in Maryland and 100,000 more people are going to get health care."

He added: "It's good policy, good economics; it really makes sense."

While it still falls short of the organization's goal of affordable health insurance for all Marylanders, "This lays the foundation," DeMarco admitted.

Pollack agreed that the Maryland policy is a good start, and expecting more is probably not realistic. "It's hard to imagine that you go from — nationwide — 47 million people uninsured to zero overnight," he said. "I think success on a step-by-step basis is very important because you can build on that success, whereas failure breeds a sense that this is an issue that is politically impossible to deal with."

Both Hammen and DeMarco noted that improving coverage for Marylanders actually reduces costs for everyone. People without insurance tend to seek treatment in emergency rooms, which is not the most cost-effective way to manage health, said Hammen.

A typical family now pays about $1,000 more in insurance premiums to cover the costs of people without insurance, Hammen said. And as insurance gets more expensive, more people drop it, which in turn makes premiums rise. Four years ago, he said, 600,000 Marylanders had no insurance. Today, that number has increased to 800,000, he said.

Though the new legislation is a step in the right direction, said Hammen, Maryland still has more work to do. Increasing subsidies for small businesses is one idea, he said, as is raising the Medicaid eligibility to 300 percent or even 600 percent of the federal poverty level.

"I think we're going to take a step back for about a year and determine what our options actually are," he said.

Lancelot, who is divorced and whose children are not able to help her, said the new law is "better than nothing," but not by much. "It's still leaving out 78 percent of the people who need help," she said.

She is just one of many Marylanders who know how difficult every day can be without insurance.

"As my health gets worse, my capacity to make money also gets worse," said Lancelot. "It's a continuing slide."

Relief in sun's rays for SAD sufferers

By Mary Medland
Special to The Daily Record

As winter progresses and the days shorten, more Americans find themselves feeling lethargic, anxious and even severely depressed. Many brush these emotions off as just a case of the "winter blues," but studies show they may be a sign of much more.

"Seasonal Affective Disorder (SAD) is very real," says Scott Aaronson, M.D., director of clinical research programs at the **Sheppard Pratt Health System**. "Animals sleep more, eat more and are sluggish."

However, continues Aaronson, while SAD is often classified as depression, there are those who have SAD symptoms but are not depressed. Other possible symptoms include increased need for sleep, increased appetite — especially for carbohydrates — and decreased interest in socializing.

"Most of my adult life, I've been aware that I get low on energy in the wintertime," says Bob McPeak, webmaster at **Goucher College**. "I've never been diagnosed as having SAD, but when I was talking about this with my mother she said that she had been using a light box and found it really helpful. Of course, as I'm married to a psychiatrist, I tend to do a lot of self-diagnosing."

What is known is that latitude plays an important role in the rate of SAD. "In one study, it was estimated that 9 percent of people living in New Hampshire suffered from SAD, while those living in Florida had 1.5 percent occurrences. My SAD is much better in Baltimore than it was when I was living in Boston, and while I don't have statistics, I'm sure it is even worse for those living in more northern climes," Aaronson says.

"SAD has more to deal with where you live than whether you are young or old or of a certain racial or ethnic background, and usually begins affecting people when they are adolescents. And although there does seem to be some family propensity to SAD, its expression is dependent on where you live and the length of daylight."

When one is exposed to natural sunlight, there appears to be some effect on brain chemistry. "However, we are not sure what the lack of exposure to natural sun causes," says Aaronson.

"I start seeing people coming into my office after the autumnal equinox, when the day is equal in hours to the night. The vast majority of people are coming before the shortest day of the year, which is about Dec. 22," Aaronson says. "People start getting better by the spring equinox in March. But if you are coming to me in February thinking you have SAD, it's more likely that you simply have cabin fever."

For the most part, there are two types of treatment: light and medications.

The sun provides full-spectrum light, but our homes and offices have low green spectrum light. Full-spectrum light has all the colors of the rainbow, while normal incandescent and fluorescent light tends to be low in certain wavelengths of light.

"We don't know why that is, but certain non-full-spectrum light does not seem to improve people's Seasonal Affective Disorder," says Aaronson. "I advise people to sit in front of these [full-spectrum] light boxes for 30 minutes to an hour when they begin their day," Aaronson says. "But getting people to do that is very hard."

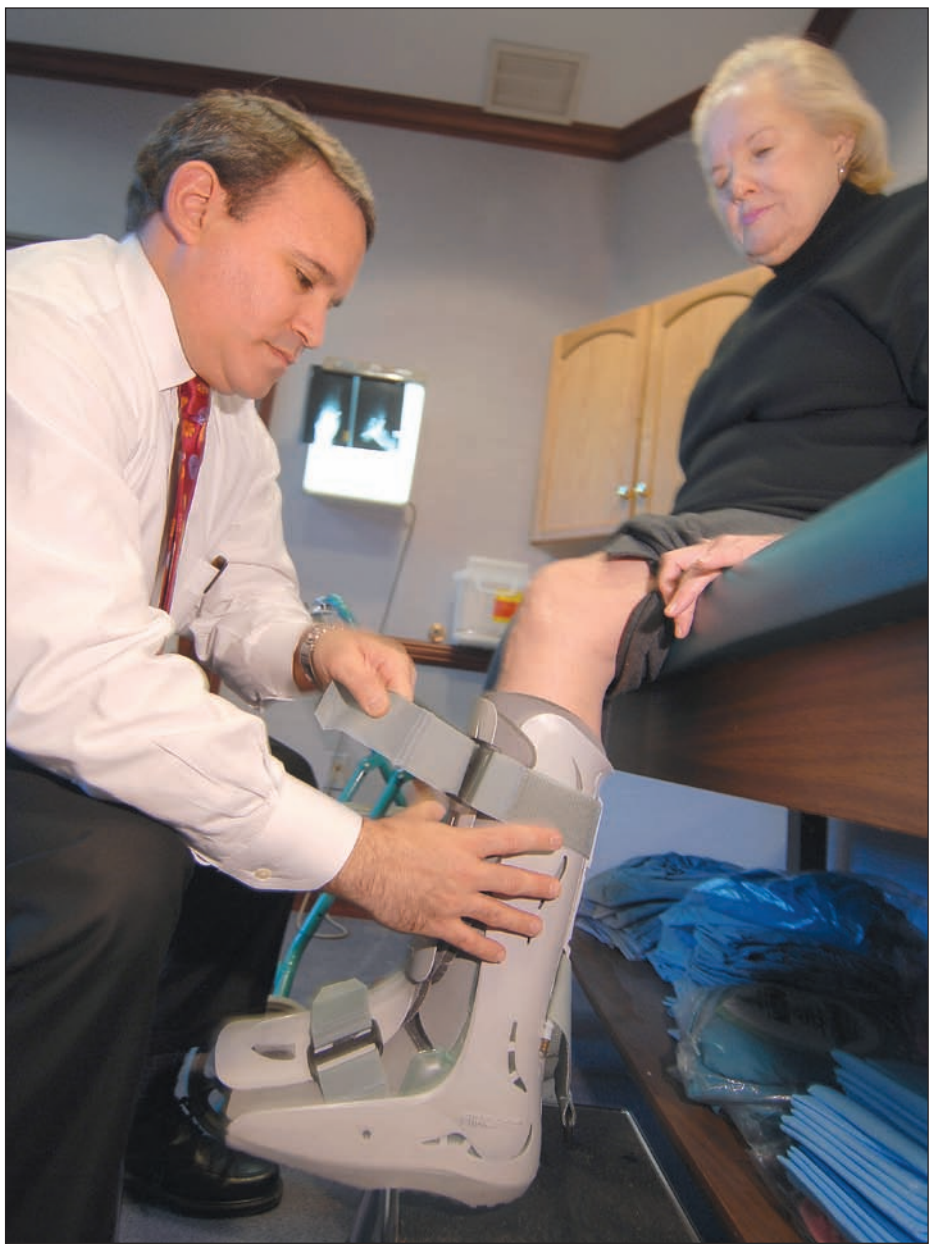
Wellbutrin, an anti-depressant medication, has been approved by the FDA for the prevention of Winter Depressive Episodes. "While many anti-depressants have shown efficacy with SAD, we're currently studying Armodafinil … it's not really an anti-depressant, but a medication for excessive daytime sleepiness that sort of wakes people up," says Aaronson.

"I'm working on a study with Norman Rosenthal, and we are looking for people currently suffering with SAD who are willing to participate in a study about the effects of Armodafinil for this condition."

McPeak, who believes he has a mild case of SAD, keeps his Verilux HappyLite Deluxe Sunshine Simulator at his office — and he really doesn't care much if the light box has a real effect or is simply a placebo.

"If it's all 'in my head,' and I think the light box helps me, I'm happy," he says. "Of course, I think the people who see me at work probably think I'm getting a tan."

Patient patterns visible in visits to doctor's office



MAXIMILIAN FRANZ

Orthopedist Jeffrey T. Brodie, M.D., says that most patients come to him at the end of the year, mainly for insurance reasons. 'Sometimes their deductible has been met and they want to have their surgery at the end of the year.'

By Carrie Oleynik
Special to The Daily Record

The colds, flus, viruses and bugs that come with winter typically mean more trips to the doctor or pediatrician and, like it or not, additional time spent in their waiting rooms. According to the **Centers for Disease Control and Prevention**, last year's flu activity peaked nationwide in mid-February. Despite last year's peak, viral illnesses may hit their highest point as early as December and as late as March.

During a similar time frame, Jeffrey T. Brodie, M.D., chief of the division of foot and ankle surgery at the Orthopedic Institute, St. Joseph Medical Center, sees a rise in the number of patients coming in, but not because they've come down with the flu. The busiest times of year for Brodie are the fall and winter, with spring slowing down before a typically quiet summer.

"A lot of times I see many of the patients that I treat at the end of the calendar year because it has to do with their insurance," Brodie said. "Sometimes their deductible has been met and they want to have their surgery at the end of the year."

Patients — mostly seeking treatment for chronic pain or deformity in the ankle or foot — don't see Brodie during the winter months to hide scarring with winter clothing. Instead, patients opt for surgeries in the sedentary months of winter because life — and physical activity — slows down.

Naturally, these patterns vary from office to office. "If I were to speak to a hand surgeon, another orthopaedic surgeon or any of the other 18 of us in the office, we would all have different downtimes to report. We all tend to be busy and quieter at different times," said Brodie.

While the waiting rooms of orthopaedic, pediatrician and family doctor's offices may see long waits in the winter, area eye doctors may notice a small increase in patient visits before the holiday season, followed by a small drop during the holidays.

"Overall, I think we're a little bit busier in the spring. The newer physicians at the Krieger Institute see more patients during the spring months," said Donald A. Abrams, M.D., chief of ophthalmology and director of the **Krieger Eye Institute** at **Sinai Hospital**.

Working with approximately 12 other physicians at the Krieger Eye Institute, Abrams specializes in glaucoma and cataracts at two locations: Sinai Hospital and Quarry Lake. For those coming in to see the two physicians that specialize in LASIK treatment at Sinai, Abrams added that the performance of the economy helps determine the potential volume of patients coming in for LASIK surgery.

"When the economy is hovering like it is now, there is a bit of a drop in those coming in for LASIK," he said.

"Sick" buildings find relief in renovations

By Alan Dessoff
Special to The Daily Record

It's not unusual for people to become ill because of something in the building where they work or live. But the condition known as "sick building syndrome" (SBS) apparently isn't as common as it was just a few years ago.

Although there is no data, anecdotal evidence suggests that reports of SBS have declined in Maryland and nationally as building owners, managers, engineers, maintenance staff and outside service contractors have become smarter about what causes SBS and how to prevent and treat it.

As defined by the U.S. Environmental Protection Agency, SBS describes situations in which building occupants experience acute health and comfort effects with symptoms including headache; eye, nose or throat irritation; dry cough; dry or itchy skin; dizziness and nausea; difficulty in concentrating; fatigue; and sensitivity to odors.

The symptoms appear to be linked to time spent in a building, but no specific illness or cause can be identified. The complaints may be localized in a particular room or zone or may be widespread throughout the building. Most people who experience symptoms of SBS report relief soon after leaving the building, according to the EPA.

Another term, "building-related illness" (BRI), is used when symptoms of diagnosable illness are identified and can be attributed directly to airborne building contaminants. In these cases, building occupants complain of symptoms such as cough, chest tightness, fever, chills and muscle aches. The symptoms can be clinically defined and have clearly identifiable causes; people who experience them may require prolonged recovery times after leaving the building, the EPA says.

The most high-profile reports of SBS in Maryland came from several dozen of the nearly 1,000 people who worked in the Investment Building in Towson in the late 1990s. Many of them, employees of state and Baltimore County government agencies, experienced illnesses connected to the building's air quality and were eventually moved to another building.

"Today it's a lot different. People have become more attentive to indoor air quality and you don't hear [SBS] talked about as much as it was before," says Marc Fischer, senior vice president and director of management services at **Transwestern** in Columbia and a past president of the Baltimore chapter of **Building Owners and Managers Association International**.

"You don't hear about it as much, so I guess it's on the decline in this area," adds Jennifer Leach, president of **Leach Engineering** in Baltimore and also president of the Baltimore chapter of the **American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE)**.

EPA cites inadequate ventilation as one of the causes of or contributing factors to SBS. It notes that ASHRAE recently revised its ventilation standards to provide a minimum of 15 cubic feet per minute (cfm) of outdoor air per person, with 20 cfm/person in office spaces and up to 60 cfm in other spaces, depending on the activities that normally occur there.

Fischer suggests that SBS developed as a recognizable problem when commercial buildings began to be constructed with windows that could not be opened from the inside, "so the only way to get air was through the ventilation system." That touched off "a real battle between energy efficiency and having comfort," says Leach. "We sealed buildings so tightly that the outdoor elements could not get in and then we found that we sealed them so tightly that none of the bad stuff could get out."

Problems also might develop when a building is not used or maintained the way it was designed to be. "Building uses change. They move walls … and things like HVAC systems are not taken into account," says Leach.

Most indoor air pollution comes from sources inside a building, according to EPA. Indoor air pollution also can be caused by outdoor air sources and biological contaminants including bacteria, molds, pollen and viruses, the agency states.

Although the causes of SBS are not always easily identified, specialists involved in building operations say they have become more attentive and proactively responsive to possible causes. "Today we're seeing a focus on mold. Property managers know a lot more about water infiltration and they're managing mold situations better," Fischer says.

Pushed by their tenants, property managers also are paying more attention to volatile organic compounds in carpeting and paints. "Ten years ago, you would have painted a building and not even thought about it. If tenants complained about the smell, you would have told them, 'Well, that's the smell of the paint.' Today, I think people are taking indoor air complaints a lot more seriously," says Fischer.

On the Move

St. Agnes Hospital recently hired *Margaret "Maggie" Valcourt* as senior nursing supervisor. Valcourt will be responsible for providing leadership and oversight of all the nursing supervisors in the hospital. She will also provide managerial and clinical links between the nurse managers, department directors and nursing supervisors.

Delmarva Foundation is pleased to announce the winners of the Maryland and District of Columbia Hospital Trustee "Driving Quality" Awards for 2007. The winner for Maryland is *Edward L. Cahill*, who has served on The Johns Hopkins Hospital board since January 1999. The winner for the District of Columbia is *Dr. Katherine Goodrich*, director of Hospitalist Medicine at George Washington University Hospital since 1999.

Diane Campbell, a student in the Master of Science Nursing program at **College of Notre Dame of Maryland**, received the Good Neighbor Award from the Sexual Assault Resource Center in Bel Air. Campbell is an education specialist with Upper Chesapeake Health. She represents Upper Chesapeake on Harford County's Domestic Violence Prevention Committee, a volunteer group involving law enforcement, the judicial system, health department and others.

Harbor Hospital announced the appointment of *Kevin Kearney* as director of principal gifts. Kearney was previously in development at Mount Saint Joseph High School in Irvington, Md. He began his career at Mount Saint Joseph as director of alumni relations and annual giving. He was responsible for growing the school's annual fund by more than 120 percent in the first three years.

The American Lung Associations of Maryland, Virginia and North Carolina have merged to become the **American Lung Association of the Atlantic Coast** Inc. A new board of directors, consisting of current board members from each of the three affiliates, will govern the merged organization. Locally, governance will be provided by a state leadership board to be chaired by *Mark Altemus*.

Columbia MedCom Group, the only 100 percent employee-owned medical communications firm in the nation, announced that *Eleanor O'Rangers* has joined its subsidiary, Medicalliance Inc., as vice president of scientific strategy and business development. O'Rangers joins the company from Phase Five Communications, where she served as vice president, cardiovascular and metabolic brand strategist. She brings nearly 10 years of experience in the pharmaceutical industry.

Carroll Lutheran Village has hired *Dr. Tommy A. Ibrahim* as its staff physician. He is a member of Carroll Hospital Center's Family Medical Associates practice. At Carroll Lutheran Village, Ibrahim has assumed full-time duties of seeing clients from all levels of care in the continuing care retirement community.

TOMMY A. IBRAHIM

Six new physicians have joined local ob-gyn practices providing care to patients at **Anne Arundel Medical Center**, the only hospital in Anne Arundel County that provides full maternity services. They are: *Dr. Joy'El B. Ballard; Nicolle Bougas; Dr. Jackie Nichols; Dr. Tymesia Hudson; Dr. Mesie Rogers;* and *Dr. Margaret Jessica Keith.*

Karen Armacost, director of Hopkins ElderPlus at **Johns Hopkins Bayview Medical Center**, has been granted fellowship status by the National Gerontological Nursing Association (NGNA). This honor recognizes those who have made significant contributions to the field of gerontological nursing. Armacost will serve as an advocate for aging and health issues in cooperation with NGNA and act as a liaison between the association and other nursing and gerontological organizations.

Six **Johns Hopkins University** researchers have been elected to membership in the National Academy of Sciences Institute of Medicine. *Ron Brookmeyer*, *Dr. Frederick M. Burkle Jr.*, *Aravinda Chakravarti*, *Kay Dickersin*, *Dr. Andrew Feinberg* and *Dr. Lynn R. Goldman* are among 65 new members nationwide. Election to this prestigious body affirms their remarkable contributions to medical science, health care and public health, as well as to the education of generations of physicians. It is one of the highest honors for those in the biomedical profession.

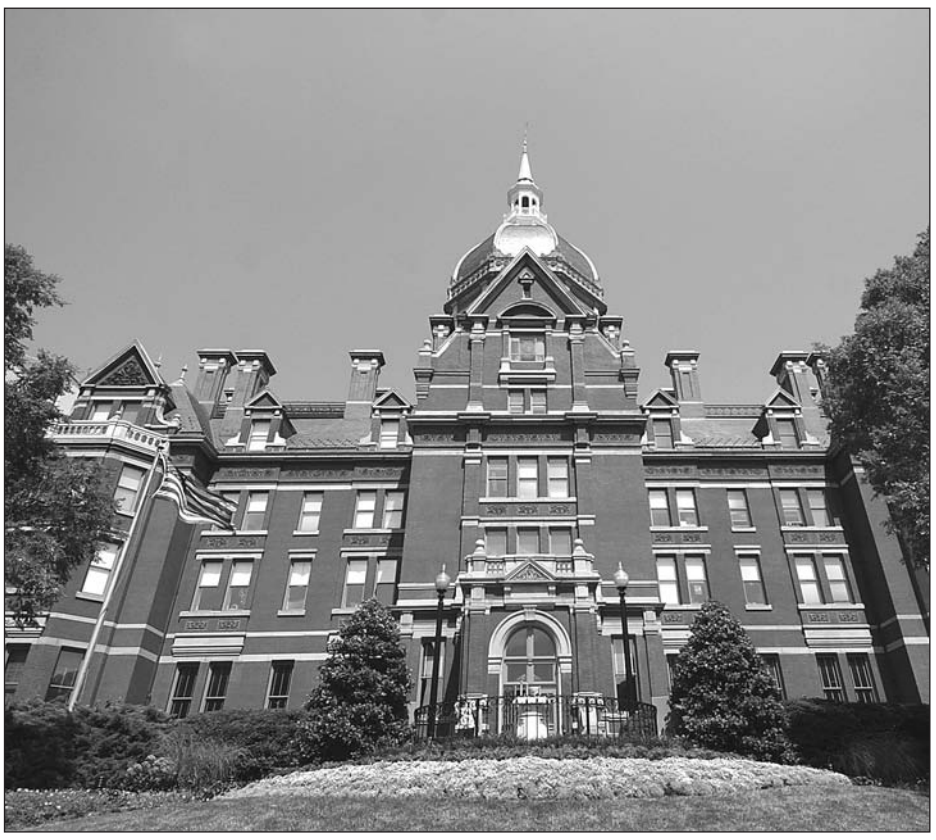
A veteran health care professional with more than three decades of diverse experience has been named executive director of oncology services at **Greater Baltimore Medical Center**. *Brian McCagh* had been serving as interim director since May 2007. McCagh and Gary Cohen, M.D., medical director of GBMC's Cancer Center, are responsible for the

BRIAN MCCAGH

SEE ON THE MOVE PAGE 7

Enhancing the hospitals of Maryland

Compiled by Emily Arnold
Special to The Daily Record


ERIC STOCKLIN
Johns Hopkins recently upgraded its X-ray imaging capabilities by installing one of the most powerful CT scanners in North America.

Anne Arundel Medical Center

The Anne Arundel Medical Center recently signed the Healthy Food in Health Care Pledge, committing the hospital to creating a healthy food system by both serving healthy food and utilizing it as preventive medicine that can maintain and even improve the health of patients. The program, called Health Care Without Harm, is a wide-ranging campaign toward environmentally responsible health care.

Atlantic General Hospital

Atlantic General Hospital has opened a new Wound Care Center. Located in the James G. Barrett Medical Office Building, the center will specialize in the treatment of problem wounds mainly suffered by the elderly and diabetic. Close to 19 million Americans have diabetes, 1.8 million of which suffer from a problem wound. In Worcester County, the prevalence of diabetes is nearly double the national average. The Wound Care Center will serve the community as an outpatient program in conjunction with the patient's primary-care physician.

Calvert Memorial Hospital

Calvert Memorial Hospital just completed the largest expansion in the hospital's 88-year history. One-fourth of the hospital — or just under 72,000 square feet — is either brand new or rebuilt. Among the improvements are a greatly expanded Emergency Department, a new 10-bed Critical Care Unit, 16 additional acute-care beds, 300 more parking spaces, a concourse for outpatient services and a modernized laboratory.

Franklin Square Hospital Center

Franklin Square Hospital Center has broken ground on a $175 million, seven-story patient tower scheduled to be complete in 2010. The tower will feature an expanded adult Emergency Department, a separate pediatric Emergency Department and inpatient unit, a 42-bed intensive care unit, four new medical/surgical suites, expanded private patient rooms, and additional services and amenities focused on high-quality patient care.

The Johns Hopkins Hospital

Johns Hopkins has installed the first 320-slice computed tomography — or CT — scanner in North America. The device is the most powerful X-ray imaging machine in its class, and can measure even subtle changes in blood flow or minute blockages forming in blood vessels smaller than a toothpick in the heart and brain. The scanner has more than five times the detector coverage of its commonly used predecessor. It costs more than $1 million and is already available for general clinical use.

The Memorial Hospital at Easton

The Memorial Hospital at Easton and Shore Health System has a new Emergency Department. The previous department was opened in 1983 with the capability to serve 12,000 patients. However, the hospital's Emergency Department currently treats 40,000 patients annually. To better meet that demand, the hospital constructed a 50,000-square-foot addition and renovated 10,000 square feet of existing space.

Peninsula Regional Medical Center

The Peninsula Regional Health System recently broke ground on a 25,000-square-foot building at the Woodbrooke Medical Center complex. Peninsula/NRH Regional Rehab, a physical rehabilitation partnership between Peninsula and National Rehabilitation Hospital Ambulatory Services, will be located at the Woodbrooke complex.

Shady Grove Adventist Hospital

Shady Grove Adventist Hospital has opened a new mother/baby unit, which will feature 48 private postpartum suites where families can rest, get acquainted and continue to receive high-level care from the hospital's care providers. Each suite features private bathrooms, gliders, televisions, desks and even sleeper sofas for relatives to stay overnight. Said Shady Grove President Dennis Hansen, "Welcoming a baby into the world is one of life's most important moments and it deserves a very special space for the entire family." The new unit — located in the 207,000-square-foot tower recently constructed by the hospital — is the first tower section to open. The tower aims to make patients and visitors feel more at home, with such amenities as free wireless Internet, family lounges with kitchens, hidden hospital equipment, and lighting and colors carefully selected to create a more calming atmosphere.

Sinai Hospital/LifeBridge Health

Sinai Hospital of Baltimore, InTouch Health and the Hospital Privado del Sur in Argentina have all collaborated to achieve the world's first successful surgery using the Remote Presence Robot, RP-7. Sinai Hospital bariatric surgeon Alex Gandsas, M.D. — telementoring from more than 5,400 miles away — worked with Sergio Cantarelli, M.D., and Gabriel Edidi, M.D., to perform a laparoscopic gastric sleeve procedure on a 39-year-old patient in Bahia Blanca, Argentina.

Manufactured by InTouch Health, the RP-7 allows a physician at one location to mentor surgeons at a remote site via a high-speed Internet connection. The mobile robot — controlled by a physician with a joystick — displays the doctor's face on a 15-inch screen. It is equipped with two-way cameras, microphones and wireless technology to provide high-quality, real-time audio and video communication between doctors — even when they are on different continents.

University of Maryland Medical Center

Surgeons at the University of Maryland Medical Center in Baltimore have successfully performed a combined heart and liver transplant — the first in the state. The organs were transplanted in a 33-year-old patient during a procedure that took almost 11 hours. Fifteen people in two transplant teams participated in the operation. Prior to the transplants, the recipient of the new organs, Trevanoyn Shelton, would lose his breath after walking only short distances. He waited two months for the matching organs to become available. Shelton was able to return home after only two weeks recovery, and reports that he is feeling healthier than he has in years.

On the Move

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leadership and direction of the oncology service line.

The **Alzheimer's Association, Greater Maryland Chapter**, has elected three new members to the board of directors: *Dr. Samuel Ross*, CEO of Bon Secours Health System; *John F. Schulze Jr*, Associate, Colliers Pinkard; and *Sylvia Mackey*, wife of former Baltimore Colt and NFL Hall-of-Famer John Mackey.

Dr. Mehran Habibi has joined the surgical oncology team at the **Johns Hopkins Bayview Medical Center**. Habibi also is an assistant professor of surgery and oncology at The Johns Hopkins University School of Medicine. He has been published in several medical journals, including American Journal of Oncology Review and The American Surgeon.

Meriann Ritacco has been named executive director of **Vantage House Life Care Retirement Community** in Columbia. Ritacco is former executive director of North Oaks in Baltimore. She has spent 25 years in personal care, nursing home and continuing care communities. Vantage House contains 222 apartments for active seniors, ranging from cozy studios to luxury penthouse residences.

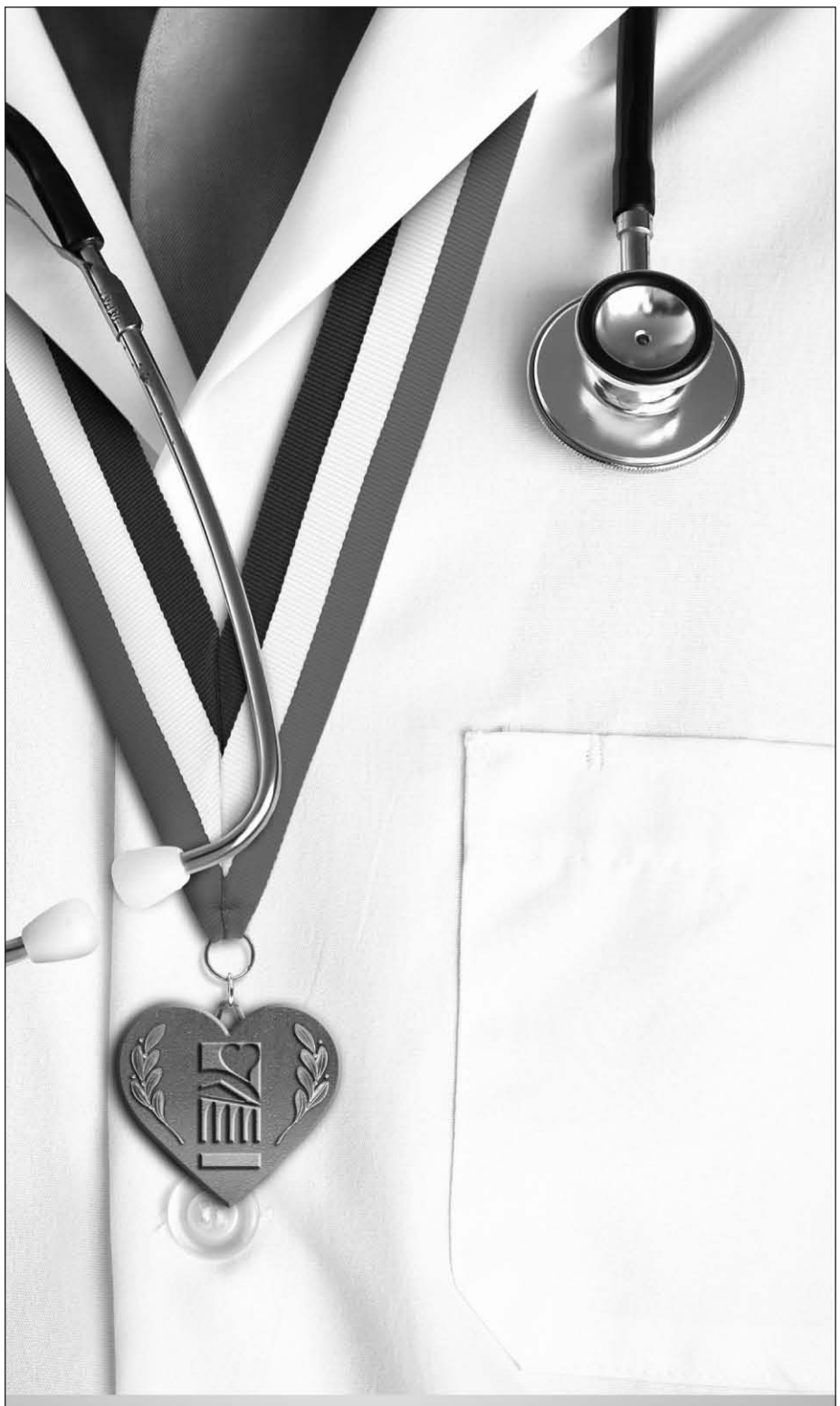
Craig Clive, a veteran human resources professional with more than three decades experience, has been named director of compensation and benefits at **Greater Baltimore Medical Center**, where he will have responsibility for managing the hospital's overall compensation and benefits budget. Clive previously served as a consultant for GBMC in the role of senior compensation analyst. He has extensive experience with compensation evaluation, individual and team incentives, salary structure development, salary surveys and performance reward systems.

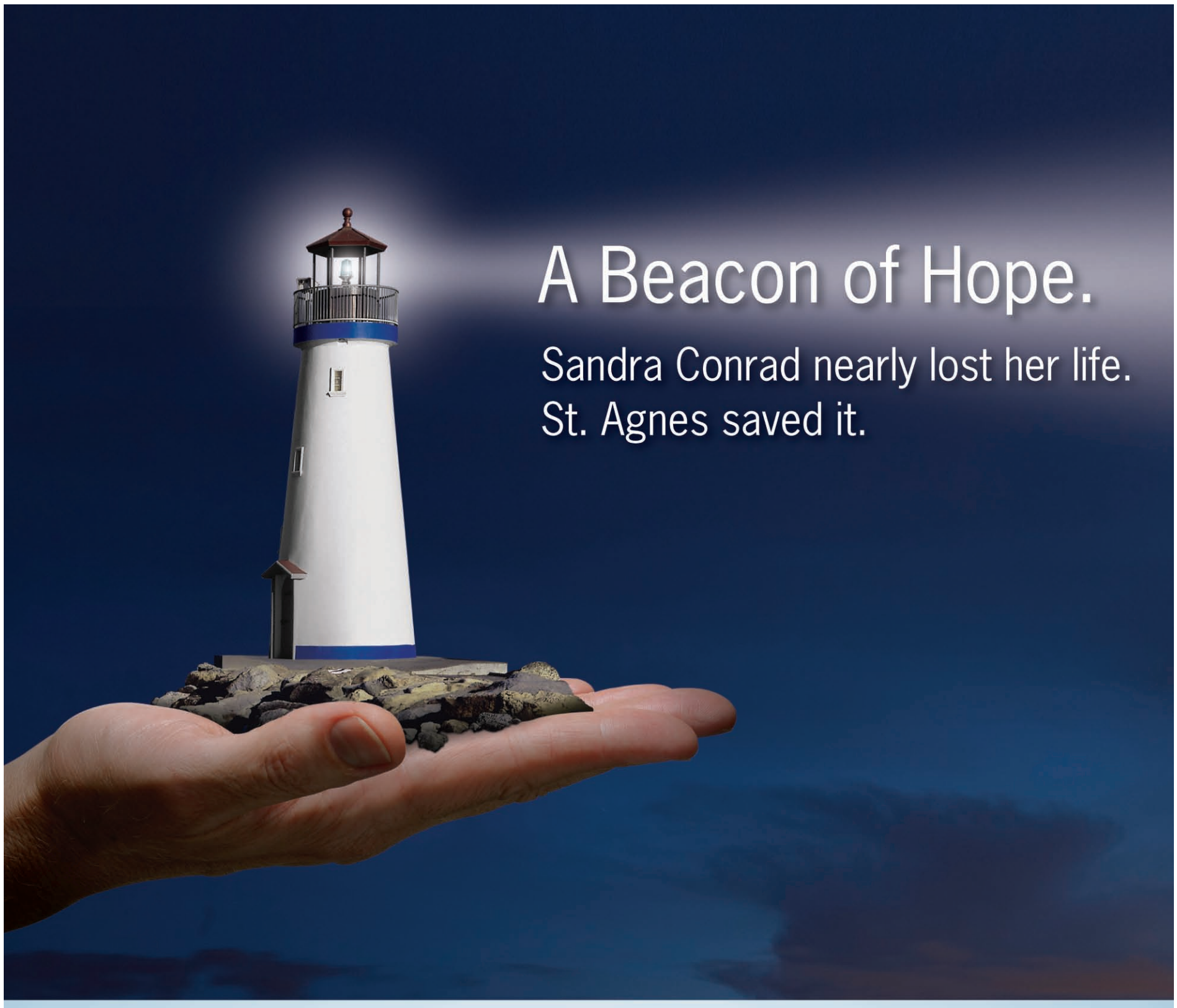
Howard County General Hospital has appointed *Sharon P. Hadsell* to senior vice president of patient care services. As such, she is responsible for all inpatient nursing units as well as emergency services, women's and children's services, ancillary services, clinical education, and patient care staffing and operations. Hadsell brings extensive nursing experience to her new position.

SHARON P. HADSELL

Elliot McVeigh has been named the new director of the Department of Biomedical Engineering at The **Johns Hopkins University**. McVeigh joined Hopkins' Department of Radiology in 1988. In 1991, he also joined the Department of Biomedical Engineering. McVeigh has helped develop the research program in cardiac MRI and directed Hopkins' Medical Imaging Laboratory, which seeks to develop new imaging techniques and advance existing ones to solve problems in medicine and biology.

With a generous donation of $3 million from a grateful Frederick County patient, **Greater Baltimore Medical Center** has established an endowed chair of urological research, a groundbreaking development for a community hospital. *Dr. Ronald F. Tutrone*, GBMC's Division Head of Urology, will serve as the first chairperson of the William E. Kahlert GBMC Chair in Urological Research, the hospital's first-ever endowed research chair. This marks one of the largest gifts made to GBMC from a living donor.





Since its founding by the Daughters of Charity 145 years ago, St. Agnes Hospital has been a Beacon of Hope for the community. For Sandra Conrad, that hope came at the renowned St. Agnes Chest Pain Emergency Center. When her heart stopped suddenly, the rapid response of a team of emergency and cardiac care specialists saved her life. "They performed emergency angioplasty," says Sandra. "Had they not been able to do that right there, I would not have lived." The first of its kind when it opened in 1981, the Chest Pain Emergency Center has served as a model for hospitals nationwide and has helped establish St. Agnes' reputation for excellence in cardiac care.

To continue providing the best in care to patients like Sandra, St. Agnes Hospital has embarked upon a $212-million Campus Revitalization project. Funded in part by donations to the St. Agnes Capital Campaign, the project's first phase, to be completed early in 2008, will provide a newly renovated and expanded Emergency Department. Other phases will bring a new patient tower with all private rooms, two state-of-the-art operating suites, an expansion and renovation of the Cancer Center, two new parking decks and a redesigned Maternity Center and Neonatal Intensive Care Unit. This Campus Revitalization will ensure that the best diagnostic and treatment options for heart disease—or any illness—will always be available to our community.

Invest in hope.
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