# SBH-PHYSICIAN

THE MAGAZINE OF SBH HEALTH SYSTEM MEDICAL STAFF **SPRING/SUMMER 2018**


# SBH OPENS ITS NEW BARIATRIC CENTER

SBH Health System
1866 2017
BRONX

**SBH-PHYSICIAN**
Spring/Summer 2018

SBH Physician is a publication developed and created by the Marketing and Communications Department at SBH Health System.

Executive Editorial Board
**DAVID PERLSTEIN, MD, MBA**
**ERIC APPELBAUM, DO**

Editorial Board
**RIDWAN SHABSIGH, MD**
**EDWARD TELZAK, MD**

Editor, Medical Staff
**GERARD BALTAZAR, DO**

Editor
**STEVEN CLARK**

Creative Director
**MICHELLE O'GARA**

Marketing Coordinator
**CHELSEA GRANT**

Web Programmer
**KENNETH HO**

Marketing and Communications Interns
**RODERICK PEREZ**
**MICHAEL RINALDI**

**MEDICAL BOARD**

President
**MARY GRATCH, MD**

1st Vice President
**CHRISTOPHER GRANTHAM, MD**

2nd Vice President
**JEFFREY LAZAR, MD**

Secretary/Treasurer
**LISETTE ROBLEDO, MD**

SBH Health System
BRONX

4422 Third Avenue
Bronx, NY. 10457
718-960-9000

*Facebook.com/SBHBronx*
*Twitter.com/SBHBronx*
*Youtube.com/user/StBarnabasHospital*
*Linkedin.com/company/SBHBronx*

www.sbhny.org



# Table of Contents



## MESSAGE FROM SBH CHIEF MEDICAL OFFICER


Dear Colleagues,

Dreams of summer are not the only notable happenings around campus these days; we have several exciting updates to share with the SBH family. Let's begin with our cover story. Please join me in welcoming a very talented surgeon, Dr. Nissin Nahmias, as medical director of our new Bariatric Surgery program. Obesity and the associated physical and psychological complications pose significant challenges to many in our community and this program can offer solutions to help those affected by putting them on the road to better health.

This issue also highlights many of the great programs and initiatives, big and small, which are occurring throughout the institution. Read about the "G-Nite" program created by the Department of Internal Medicine that focuses on enhanced evening rounds that is intended to improve communication with patients and their families. Have a look at the "Open Notes" article about SBH's efforts to make treatment notes available via the patient portal. Be sure not to miss the "Relay Program" which introduces the efforts of our Emergency Department to stem the tide of the opioid crisis in our community. I am especially proud of these programs as they truly demonstrate SBH's commitment to patient-centered care.

We celebrated National Doctor's day a few weeks ago with a wonderful event honoring our entire medical staff's commitment and dedication to SBH and the patients we serve. Make sure to read about our four award recipients and the unique ways they make SBH a special place which means so much to all of us.

Wishing everyone a terrific summer!

Eric C. Appelbaum D.O.

Eric Appelbaum, DO, FACOI
Executive Vice President/ Chief Medical Officer

# CPRO Office Works with Community Physicians

The phone rings incessantly, more than 100 calls a day, streaming into this non-descript office on the fourth floor of the Braker Building on the SBH campus like water on a sun roof during a torrential rainstorm. Primary care physicians call to refer patients to hospital specialists, while their patients telephone to schedule appointments.

It's just another day in the life of SBH's Community Physician Referral Office (CPRO). The CPRO office is staffed by a mostly bilingual team that both answers the phones and pays face-to-face visits to more than 300 primary care physicians in the Bronx. This includes both solo practitioners and multi-physician practices and health centers.

"We provide interaction with patients 24/7," says Isabel Pastor, CPRO manager. "We accept virtually all insurances and provide a 'high touch' to both big and small providers. We made 10,000 patient referrals in 2017 and have increased our number of providers about 50 percent over 2016."

Pastor previously worked for three years as director of the Referral Department at Morris Heights Health Center, a Federally Qualified Health Center that is one of CPRO's largest providers, and so has walked in the other sides' shoes. "In that role I would feel frustrated at times in how other hospitals worked in terms of making referrals to their specialists," she says. "Providers want an extension of their offices, a service that offers administrative gateway and specialty care for their patients. We do that here. Our goal is to listen to these providers and schedule appointments for patients in an expeditious fashion, which we do very well."

In addition to providing providers quick access to appointments and follow-ups with their patients, CPRO sends appointment information and clinical results to providers' offices and acts as a liaison between doctors and their patients' emergency room visits. Referrals to all major specialties are scheduled, as are appointments for behavioral health services, dialysis, lab services, radiation oncology, radiation therapy, radiology, and wound care and hyperbaric therapy, as well as a long list of specialty services.





# CRITICAL TIME INTERVENTION (CTI) PILOT REDUCES HOSPITALIZATION RATES FOR HIGH UTILIZING PATIENTS

**By Luci de Haan**

When Victor P.* first met with Daiana Mendez, a case manager at Mosaic Mental Health in the Bronx, he was homeless and in a state of mental decompensation.

"I didn't know what I needed anymore," he says. "I needed someone to advocate for me because I didn't know how to say it."

Today, Victor's mental health has stabilized and he is following his medication regimen. He has both a primary care and a mental health provider whom he sees regularly. He has a place to live and wants to go to school to be a patient navigator. "I learned I can be an asset to my community," he says. "I could be stronger and better."

Patients who use the majority of healthcare services and costs make up a small fraction of the patient population. Like Victor, they often have complex health conditions that are compounded by such circumstances as financial and housing instability, and the absence of family or social structures.

Last year, Bronx Partners for Healthy Communities (BPHC), the DSRIP Performing Provider System led by SBH Health System, began a pilot program to provide intensive care coordination services to patients with serious mental illness (SMI) and unstable housing situations. The project applies "Critical Time Intervention (CTI)," a time-limited, evidence-based model started in New York City in the mid-1980s to provide people who are homeless and living with mental illness with sustainable healthcare and community support systems.

The goal is to help patients achieve long-term health improvements, become integrated back into the community, and reduce their stays in the hospital and other acute care settings. To date, the first cohort of 80 patients realized a 55 percent reduction in the number of days spent in a hospital setting in the six months following the start of CTI. This is according to utilization data obtained by the Bronx RHIO from the Statewide Health Information Network for New York (SHIN-NY). "Our initial goal was to reduce hospital utilization by 25 percent so we are very excited by these promising results," said Irene Kaufmann, BPHC executive director.

BPHC has partnered with four community-based organizations (CBOs) on the CTI pilot: Coordinated Behavioral Care, Mosaic Mental Health, SCO Family of Services, and Visiting Nurse Service of New York.

Patients eligible for CTI have a diagnosis of SMI and a history of repeated hospital stays and precarious housing or homelessness. Referrals come from SBH and other hospitals, shelters, Health Homes, psychiatric inpatient units and CBOs. CTI is divided into three phases that begin with intensive support by the case manager who works closely with the patient to identify goal areas that may include medical and behavioral health treatment, medication adherence, employment, housing, money management, and/or family intervention.

Case managers like Daiana Mendez play a key role among an extensive network of providers including physicians, hospitals, specialists, therapists, housing services, food programs, job training and more. Their smaller caseloads allow them to accompany patients to their PCP or behavioral health providers and help put family and community support structures in place. It can be challenging to engage in the care of many patients. Case managers will meet with patients in all kinds of settings where they live or spend time in their communities.

"No two cases are the same," says Mendez. "We meet people at a critical point in their lives and are able to give them the time and support to connect them to the care and services they need."

As the patient becomes connected to care and support, case managers focus on strengthening those links and empowering the patient to be more self-sufficient and adherent to his or her medical and behavioral health treatment plan. Gradually, the patient is transferred to a Health Home with a strong support system in place.

"We are proud of our partner organizations' relentless work and commitment to helping patients improve their health outcomes and transition to the community," says Kaufmann.

BPHC leads the hospital's DSRIP program, the state's five-year Medicaid transformation initiative to create a community-based provider network that is coordinated, patient-focused and improves health outcomes.

**The name has been changed to protect patient privacy.*

# ‘Stop The Bleed’

This is a program that is intended to stabilize a patient with an open wound until First Responders arrive. **By Steven Clark**


*"The only thing more tragic than a death…is a death that could have been prevented."*

This is the final slide in the “Stop the Bleed” presentation of Erik Marketan, SBH’s injury prevention coordinator and one of the course’s certified instructors. While not nearly as disturbing as the graphic photos of severe open wounds, it is the slide that perhaps resonates most with the group of a dozen or so SBH security officers and CUNY School of Medicine students taking the 90-minute lecture/hands-on class that will soon be available to all SBH employees as a “lunch and learn.” Earlier classes have been attended by surgery residents, nurses and various community groups, including the staff of B.R.A.G. (Bronx Rises Against Gun Violence), the hospital’s “cure violence” partner.

“This is an American College of Surgeons (ACS) Injury Prevention initiative that comes as a result of ‘The Hartford Consensus,’ which has continued to bring together leaders from the medical community, the federal government and first responder agencies to discuss lessons learned, conduct research and make recommendations resulting from both the active shooter disaster at Sandy Hook Elementary School in Newtown, Connecticut and the Boston Marathon bombing,” says Marketan, who spent 20 years as a New York City paramedic. “In Boston, the immediate presence of first responders and the use of tourniquets became a perfect storm of survival that led to most of the victims (many with below-the-knee and near amputations) surviving, whereas in many situations artery ruptures like this would cause victims to go into shock and perhaps not survive to the ER and OR. So there was a revisiting of what tourniquets can do and the role they play in trauma care.”

“IN BOSTON, THE IMMEDIATE PRESENCE OF FIRST RESPONDERS AND THE USE OF TOURNIQUETS BECAME A PERFECT STORM OF SURVIVAL THAT LED TO MOST OF THE VICTIMS (MANY WITH BELOW-THE-KNEE AND NEAR AMPUTATIONS) SURVIVING …”

A curriculum has been created, says Marketan, which is very “digestible” for the lay rescuer and for the healthcare practitioner to become certified as an instructor. “If I train you today (as a lay rescuer) and you were to be, let’s say, in an airport in five years and something were to occur, such as somebody falling through a plate of glass, you could say ‘I remember direct pressure, how to strap on a tourniquet and turn it, or how to pack a wound.’ It’s very intuitive. There’s not a lot of complex task and skill memory.”

“Stop the Bleed” shows how to control life-threatening bleeding while waiting for first responders to arrive. This, says Marketan, can be beneficial in the case of work-related or home injuries or motor vehicle accidents – not just bombings or mass shootings.

The class learns the “ABCs of bleeds” – alert 911, find the bleeding injury, compress (apply pressure to stop the bleeding). Marketan explains the differences between arterial bleeding and venous bleeding and recognition when a tourniquet is the immediate “go to.” For a severe bleeding injury to a limb, he teaches how to administer a Combat Application Tourniquet (an easy-to-use, well-designed strap with Velcro, a windlass stick to tighten, and a notch to keep the tourniquet in place, that is accompanied in the “Stop the Bleed” kit with such other essentials as disposable gloves; compression bandages; hemostatic gauze, with agents that help in clotting; and even a Sharpie – to write such things as time placed and “TK” on the victim’s forehead, indicating to emergency personnel the use of a tourniquet on the victim).

“Once you identify the wound, place the tourniquet several inches above the injury (or above, not on, a joint, such as an elbow or knee) and turn the tourniquet windlass to the right until bleeding stops,” he says. “Don’t loosen it if the victim says it hurts. It should hurt. No one will fault you for being too aggressive with a tourniquet. In some cases, patients go to the OR with a tourniquet on.”

He demonstrates how gauze or a cloth needs to be applied with pressure to a bleeding wound located on the victim’s torso, head, abdomen or groin, where a tourniquet could not be applied. The class takes turns applying the tourniquets and maintaining continuous pressure to the mannequin and the simulated “arm,” and packing the “wound” with gauze (“like kneading dough with your fingers”) using a simulation wound skin pack.

Marketan brings with him years of training as an educator as well as a critical care paramedic. He has been additionally trained in CBRN (Chemical, Biological, Radiological and Nuclear) and has worked as an external provider through the United Nations with the Organization for the Prohibition of Chemical Weapons (OPCW), based in The Netherlands, where he provided medical training for teams deployed around the world.

Of course, as he notes, disasters happen when they are least expected and so lay personnel are not always going to have “Stop the Bleed” kits at their beck and call (although there are recommendations for having such kits in easy-to-access hospital locations and with security, as there are now for fire extinguishers and defibrillators). This is why he spends time discussing makeshift tools for stopping the bleeding. This can include tying a cloth, a roll of gauze, or a necktie and using pens, knives or a small flashlight to use as a tourniquet to stench the bleeding. The class learns that a cloth with a thin layer of cotton (e.g. an undershirt) works more effectively than a towel with heavy absorbing material; and that a belt should be employed only as a last resort for a tourniquet (which can’t be tightened enough to compress the arteries).

Minutes, says Marketan, can be the difference between life and death. “If someone is losing blood, single minutes of that blood loss can be fatal,” he says. “What we’re doing is buying a victim enough time until a trained medical professional arrives.”

# The Evolution of SHARING PHYSICIAN NOTES WITH PATIENTS

**By Jeeny Job, DO, Chief Medical Information Officer, SBH Health System**

The idea of sharing the physician note with patients instinctively felt reckless. And yet, in 2017, SBH had begun to explore the possibility of using the Follow My Health Portal for patients to get access to their progress notes. Pat Belair, SBH's senior vice president of Ambulatory Services and Strategy, was the first to propose the idea. She saw the possibility from the patients' perspective – a project that could enhance the patient experience and impact patient safety.

But as I heard the proposal, my reaction was less than enthusiastic, even pessimistic. After all, my thinking went, the clinic note wasn't meant for patients. It was a document intended to communicate clinical assessment and plans to other providers using technical medical terms, while fulfilling ever expanding regulatory and billing mandates. The note's utility and readability, especially in the age of EMR, was raising questions even among clinicians. It seemed improbable that patients could use the note. But as I researched the topic, I was faced with growing evidence that patients also benefitted from access to the note. Equipped with the latest research and best practices, the burgeoning patient safety movement known as "Open Notes" was looking for clinical partners to share notes with patients. And with SBH's chief medical officer Dr. Eric Appelbaum's agreement and encouragement, the decision was made to join the movement and analyze and report back its findings. My initial hesitation, however, wasn't born just out of my own bias. A look at the development of the SOAP note (an acronym for subjective, objective, assessment, and plan) reveals the initial goals of medical documentation were focused on provider needs and not patient centered. Instead, the note served to standardize and refine the clinician's thinking while also innovating in the field of medical education. Although the patient stood to benefit from the improvement of this standardization, the note wasn't developed for the patient's consumption.

Of course, the SOAP note was pioneered during another era in medicine. It was in the late 1960's when Lawrence Weed, the dean of healthcare information technology, first introduced the problem-oriented medical record. American healthcare, in the intervening time, has transformed several times over. Today, the term "patient" can be substituted with "consumer." The term "change" goes beyond mere semantics and signals the changing role of the patient in medical decision-making while hastening the end of paternalism. Furthering this trend, the publication of "To Err is Human," the Institute of Medicine's seminal work on medical errors, forced the healthcare industry into necessary introspection. The patient's central role in their care could no longer be minimized. With digitization of health records that paved the way for patient portals, patients were now equipped with tools that could bolster their new central status. Put together, these trends advanced the notion that the physician note could be a resource for patients to further their care.

"The patient's central role in their care could no longer be minimized. With digitization of health records that paved the way for patient portals, patients were now equipped with tools that could bolster their new central status. ."

In the fall of 2017, SBH joined a collaborative of New York hospital systems to learn more about Open Notes and lessons learned on implementation. The first forum set out to address questions from each of the participating organizations. Wouldn't patients be confused by the note with its complex medical terminology? What about non-English speakers? There were concerns about liability and possible malpractice implications. But the most pressing issue was how this would impact clinician workflow in an already challenging documentation environment. After all, the more time spent with an EMR meant less time for patients.

For the workflow concerns, a study surveying PCPs who had implemented Open Notes showed very few changes to the practice of medicine. In a one-year analysis on Open Notes, 140 PCPs from three geographically distinct regions were surveyed about the impact to the practice; few doctors reported longer visits (0 to 5 percent) or more time addressing patients' questions outside of visits (0 to 8 percent). Three to 36 percent of doctors reported changing documentation content; and 0 to 21 percent reported taking more time writing notes. To further this point, the authors of the study reported some PCP's questioned whether the project went live, noting that that they saw no impact to the practice.

While the PCP experience was minimal, patients seemed to gain significant benefit. In the largest Open Notes study, 5,000 patients in three separate hospital systems were surveyed about the impact of reading the doctor's note. In it, 85 percent of patients said Open Notes helped them feel more in control of their care. A remarkable 60 to 78 percent of those taking medications reported increased medication adherence. Only a minority of patients, from 1 to 8 percent, reported that the notes caused confusion, worry, or offense. The data demonstrated that benefits far outweighed the harm.

In another survey, 99 percent of patients valued access to notes. The top reasons listed included: remembering next steps, quicker access to results, greater confidence in clinicians, and the ability to share with care partners.

Based on this data, and a commitment to improving the patient experience, SBH will be one of the first New York sites to participate as an Open Notes healthcare system. Part of this project will be soliciting clinical input to guide implementation. A survey for physicians will establish baseline attitudes regarding the sharing of notes and perceived concerns. In addition, physician champions will represent each department and serve as sounding boards for the project. The following champions have agreed to lead the effort: Gerard Baltazar, D.O., George Manis, M.D., and Thomas Rechtschaffen, M.D., from the Department of Surgery; Tina Chee, M.D., from the Department of Medicine; Paula Amendola, D.O., from Family Practice; and Lisette Robledo, M.D., from Pediatrics. Working to gain the patient's perspective on Open Notes will be Caroline Davis, Director of Patient Engagement and Community Outreach. Lastly, the IT department, led by Dr. Jitendra Barmecha, M.D., will provide the technical expertise and project management to facilitate all teams working together to meet the project's goals.

# G-NITE Program Initiated to Enhance Patient-Centered Care

**By Edward Telzak, MD, Chair, Department of Medicine, SBH Health System**

Improving the "patient experience" is a fundamental institutional goal. How can we make St. Barnabas Hospital and SBH Health System a patient-centered environment where patients and their families feel they are always treated with respect and dignity, where their culture is appreciated and taken into consideration when discussions occur and decisions are made, and where they are communicating effectively with their physicians?

The entire institution is committed to achieving these goals and though the patient experience is much more than the interaction with physicians, we, as physicians, have an essential role in assuring that patients and their families feel very well cared for throughout their hospital stay.

Among the programs recently initiated and piloted by the Department of Medicine is the introduction of a more standard method of physician-patient communication called G-NITE. This acronym stands for: Greeting; New medication and treatments; Information; Tomorrow; and Expectations. Normally, our hospitalist teams spend several hours each morning rounding as a group on patients whose care is entrusted to them. Each team, which is responsible for the care of approximately 15 patients, generally consists of an attending, a second- or third-year resident, two first-year residents, and typically two medical students. The attending physician is ultimately responsible for the care of the patient. Each patient is seen by the team during morning rounds and, depending on their particular condition and situation, may be seen in the afternoon by individual members of the team and by consultants that are requested to advise on patient care issues.

When large groups of physicians and students enter a patient room it is often not clear to the patient who these doctors are, what roles they play in the patient's care, or who is responsible for their care. G-NITE gives the physicians an opportunity to be with each and every patient in the late afternoon, often with their families present. During a five to ten minute interaction, the physician will introduce him or herself to both the patient and families, if present; explain their role in caring for the patient; update the patient and family about test results; and discuss treatments that have already occurred and/or plans for the next day or longer depending on the particular situation. It is also an opportunity to better understand what services will be required for the patient to assure a safe discharge once the patient is ready to leave the hospital.

**Four statements indicative of a patient-centered focus:**

I know who my doctors are and feel well informed about my medical condition during my time in the hospital.

My doctors explain medications that are part of my treatment regularly with me during my time in the hospital.

I have a good idea of what tests and procedures are planned for me each day in the hospital.

My doctors update me every day in the afternoon about what is going on with my medical condition during my time in the hospital.

To determine if G-NITE was effective in accomplishing some of these goals, we identified three medical units with similar baseline physician communication scores on HCAHPS. G-NITE was implemented on two floors and the third unit was used as a control. Approximately 12 to 15 patients were divided each afternoon among the team members and a focused five to ten minute interaction occurred with each patient and, if present, their families as well. Compliance with the G-NITE tool was monitored regularly on the selected units. The patient experience was measured independently by dedicated patient relations staff and the resident experience was measured by self-report.

Patients who were exposed to the new intervention, i.e., G-NITE, were much more likely to strongly agree and/or agree with the four statements that were indicative of a patient-centered focus than the unit that did not get the intervention. With the overall provider experience, the physicians felt that G-NITE was an effective tool, was user friendly to physicians, and was appreciated by their patients for the interaction and information conveyed.

Our conclusion is that by utilizing G-NITE during afternoon rounds we can provide a far more satisfying and patient-centered experience. G-NITE demands that physicians spend additional time with patients and their families and provides patients what they deserve: a close identification with a physician; a conversation about their particular condition and situation on a daily basis; and an opportunity to ask and get any questions answered. We in the department are very encouraged by these results and plan to make it the standard of care for all medical patients. Our script will change and evolve to address issues related to new or changing doses of medications and pain management goals. The challenge is to "hardwire" this practice into our day, and continually evaluate our process and results to assure that we are enhancing both the patient and the provider experience at SBH.





# Department of Emergency Medicine Adds Scientist to Staff

**By Steven Clark**

Earlier this year, SBH Health System made a hire that, at least on the face of it, may have seemed like fitting the proverbial square peg into the round hole.

The SBH Department of Emergency Medicine welcomed to its staff Dr. David Parker, who holds a doctorate degree in epidemiology and biostatistics and most recently was a tenured professor of epidemiology in the School of Public Health at West Virginia University. Prior to this, Dr. Parker had been director of research in the Department of Internal Medicine at the University of South Carolina School of Medicine.

Looking a little deeper into the weeds, however, the hiring of Dr. Parker to the position of senior research scientist makes plenty of sense. For Dr. Daniel Murphy, chair of the SBH Emergency Department, it was a sense of déjà vu.

"My early career involved the growth and evolution of a research division within the department of emergency medicine at Cook County Hospital in Chicago, and that division was successful in developing grants and important research for two reasons," says Dr. Murphy. "First, it was blessed to serve a very particular inner city urban patient population that had a high volume of illnesses and injuries. Second, we had a wonderful academic relationship with the University of Illinois School of Public Health, including some PhDs in healthcare management and epidemiology who helped us structure our research designs and our statistical wherewithal. They also helped us to develop our team approach to research in such a way that enabled five, six, seven years of academic and operational productivity. So, fast forward 20 to 25 years later, I come to St. Barnabas, and a similar patient population is here with its unique challenges and needs. As we elevate and transition the emergency medicine residency program to comply with ACGME expectations, an important ingredient is higher level research."

Although it's been a short time since Dr. Parker's arrival, he says he's already very encouraged.

"What we've been pleased with these last few months is David's high energy level, his productivity, his ability to throw together high level drafts in almost no time, and work not just on NIH or foundation level academic research ideas, but on capital grants that target the Department of Health in Albany and beyond," says Dr. Murphy. "The ideas and challenges he's brought us have exceeded our expectations. So, we're very excited."

With a primary interest in public health, Dr. Parker has developed a number of programs in this area over the years. More specifically, this has included providing services to people who have mental illness and/or face housing and substance abuse issues.

"My concentration has been primarily in applied research, which has included working with clinical practices to figure out how to better improve outcomes for patients, how to figure out ways to cut

costs, and how to reallocate monies to improve public health," says Dr. Parker. "The Bronx was very interesting to me because it has high rates of unemployment, economic repression, substance abuse, infectious diseases and serious and persistent mental illness, with a lot of people not connected to care." These are issues, he adds, that have significant overlap not only with emergency medicine but overall utilization of hospital resources.

According to Dr. Jeffrey Lazar, vice chairman and director of the Department of Emergency Medicine, who with Dr. Murphy was instrumental in bringing Dr. Parker to SBH, the fit is a natural one.

"I think what separates the middle tier from the top tier of emergency medicine academic departments is that the middle tier just practices emergency medicine, while the top tier advances its practice through research and study," says Dr. Lazar who trained at the Yale School of Medicine. "And so if you look at any of the top programs, besides clinical doctors they also have PhDs working behind the scenes to figure out how to better practice emergency medicine and address the needs of the surrounding community. Especially given our location in a community that has such significant needs in the area of population health and an ED that is significantly impacted by substance abuse, hunger and homeless issues, psychopathology, and sexually transmitted diseases, this is a ripe location to apply the expertise of an individual and to make inroads on how to tackle problems that are bigger than a single patient and any single doctor, but affect the whole community. So, when you look at these other hospitals you see a group of David Parkers and research assistants. My hope is that in a few years down the line we'll have a similar roster here."

The Bronx is also underserved when it comes to research, he adds, with a diverse population in need, health disparities and a need to address this by taking a more global view. "We can treat one patient at a time, but such issues as population health need to be considered and addressed on a larger scale," says Dr. Lazar.

While Dr. Parker is just beginning to familiarize himself with the landscape not only within the Department of Emergency Medicine but also throughout the institution – as his responsibilities include the IRB and the research enterprise of SBH as a whole – he sees the potential to grow funding through increased research and program evaluation. This is an area he has considerable experience in, having been responsible for generating some $20 million in grants over the past decade.

"Historically, the people who live in this area have been underrepresented in about every aspect of research that's ever been conducted," he says. "We want to begin by focusing primarily on opportunities that will benefit our patients."

While he admits bringing in a scientist was a bold move on the part of SBH leadership, Dr. Murphy sees huge opportunities in the future.

"Considering our location, our needs, our mission and our vision, this could be a great fit," he says. "Instead of hearing us on WINS or 880 radio every morning about a fire or a murder, it will mean getting our name out there on an academic level. He's already proven to be a very productive guy and the sky's the limit."





# HIPAA, Technology and Patient Care

Technology is moving at the speed of light and privacy professionals are working overtime to interpret HIPAA and New York State privacy laws in this accelerating environment.

**By Cassandra Andrews Jackson, SBH Compliance and HIPAA Privacy Officer**

On a snowy March day, I was peppered with privacy, technology and patient care questions from one of your own. Can I use my personal cell to text patient information? How about FaceTime with patients and their family members? What about Google Translate to talk to patients? Can I respond to patients who text me? Why can't I just use the available apps to get in touch with patients? And what if the patient waives their rights to privacy?

Patients are more and more accustomed to speedy convenience – aka, microwave healthcare - but patient care is the priority. Most times, patients aren't aware of and don't understand some of the risks associated with speedy convenience.

SBH is a HIPAA-covered entity, which means SBH and its employees are bound by the HIPAA privacy standards. It's your responsibility as an employee to comply with HIPAA. Here are answers to some frequently asked questions.

***Can I use my personal cell to text patient information?*** CMS clarified that while texting patient orders is still prohibited regardless of the platform, members of the healthcare team are allowed to text patients. While recognizing that texting "has become an essential and valuable means of communication among the team members," CMS said in order to meet federal regulations, hospitals must use a messaging platform that is "secure, encrypted, and minimizes the risks to patient privacy and confidentiality as per HIPAA regulations."

SBH's secure platform is IQMax. You must have a valid SBH Email account to access it. iPhone users can go to the app store to download the IQMax mobile app, and the Google Play Store to download this app for Android users. User id is your SBH email, e.g. ola@sbhny.org, the password is your network/email password and the system id is M14.

In general when you are logged on/authenticated, a Push notification message will display, simply select yes, then go to settings, select push notifications, by default you should see email, arrow down and select the push notification option, set the message timing to alert you after 0 - 5 seconds, and make sure settings are saved.

A message notification option in IQMax can be set up by going to settings, sound and select a ringtone/sound of choice. User discretion is advised here. Report all IQMax-related issues to Customer Support at ext. 6686.

***How about using FaceTime with patients and their family members?*** FaceTime is a video calling technology from Apple Inc. The same principles apply to video calling as to a telephone conversation with patients and their family members. That is: verify that the patient authorizes the conversation and the information that may be shared with the family member. For example: Auntie agrees you can talk to her niece about scheduling appointments, but not about her HIV diagnosis.

As an additional caution, use video calling discretely. Video calling may show your surroundings. Don't disturb others,

"Although medical devices and apps inarguably provide the HCP with many advantages, they are currently being used without a thorough understanding of their associated risks and benefits."

and ensure that patients or employees engaged in patient care are not in the video.

***What about using Google Translate to talk to patients?***
At SBH, we have Cyracom for language interpretation services. Cyracom provides 24/7 access to HIPAA-compliant interpretation services. Their staff knows medical terminology, anatomy and physiology, and other topics essential for healthcare interpreting. SBH prohibits the use of Google Translate to communicate with patients. Here's why:

*"Even though [Google Translate] has improved a lot over the years, there's still no real guarantee of accuracy. There's still a worry that, on [vacation] if you visited a doctor with a sore throat and used Google Translate to list your symptoms, he would end up amputating your legs."* (The Guardian)

*"The news that 'your wife needs to be ventilated' often became 'your wife needs to be aired,' which just adds insult to injury."* (Scientific American)

*"A typical error for 'your husband had a heart attack' was to have it come out as 'your husband's heart was attacked.'* (Scientific American)

*"Ten medical phrases were evaluated in 26 languages (8 Western European, 5 Eastern European, 11 Asian, and 2 African), giving 260 translated phrases. Of the total translations, 150 (57.7 percent) were correct while 110 (42.3 percent) were wrong."* (National Institutes of Health)

If you or your staff needs training or a refresher on Cyracom, please call Lynette Alvarado, Director of Language, Culture and Intergovernmental Services at ext. 9158.

***Can I respond to patients who text me?***
Patients will text you over their carrier's network, which does not meet CMS standards for HIPAA secure texting. As such, if you respond, you cannot include Protected Health Information. It is a violation of SBH policy to text PHI in an unsecured manner. If you include PHI in a text message you will violate SBH's policy on sharing PHI and potentially cause a breach.

***Why can't I just use "apps" to communicate with patients?***
The use of mobile devices by health care professionals (HCPs) has transformed many aspects of clinical practice. Mobile devices have become commonplace in health care settings, leading to rapid growth in the development of medical software applications (apps) for these platforms. Numerous apps are now available to assist HCPs with many important tasks. These include information and time management; health record maintenance and access; communications and consulting; reference and information gathering; patient management and monitoring; clinical decision-making; and medical education and training.

Several issues challenge the future integration of mobile devices and apps into health care practice. While the majority of HCPs have adopted the use of mobile devices, the use of these tools in clinical care has been debated since their introduction, with opinions ranging from overwhelming support to strong opposition. Among the concerns raised regarding mobile devices are the following: their reliability for making clinical decisions; protection of patient data with respect to privacy; impact on the doctor-patient relationship; and proper integration into the workplace.

In addition, HCPs have expressed concerns about lack of oversight with respect to standards or content accuracy, especially for apps involved in patient management. Older HCPs, as well as those who are intimidated by or less inclined to use new technologies, may be at a disadvantage if the use of mobile devices becomes a requirement within the health care fields. Although medical devices and apps inarguably provide the HCP with many advantages, they are currently being used without a thorough understanding of their associated risks and benefits.

***What if the patient waives his or her rights to privacy?***
A patient may waive his or her rights to privacy but should provide written authorization for SBH to release/use their information. The consent has to list the recipients, the information and the circumstances. Patients who want to waive their HIPAA privacy rights should speak with the HIPAA privacy officer at ext. 3389 before acting on that waiver.





# Some SBH Doctors Take a Less Traditional Route

By Steven Clark

On September 13, 1984, "The New York Times" gave a lukewarm review to an off-Broadway play performed by the Jean Cocteau Repertory Company, calling it "a cross-cultural experiment [it was written by a Russian playwright] that certainly is worth encouraging even though it is puzzling and often silly." Actors appearing in "Theatre in the Time of Nero and Seneca" reportedly "cavorted as historical personages in ancient Rome," with one actor wearing the head of a decapitated horse. Among the performers was a young actress playing Venus who the critic singled out for her "bumping and grinding." Her name was Mary Gratch.

Meanwhile, at around the same time, an idealistic young man from a working class family in the Bronx was teaching science in an elementary school in East Harlem. Four years later, he would leave that job to work as an EMT and paramedic, and then as an instructor. Becoming a physician was the furthest thing on his mind. His name was Brian Delaney.

And, a newly-minted college graduate was moving to Boston to start her career by working on the Governor's Task Force on environment, becoming its chairwoman, on a committee that examined such health perils as lead paint. She would later return to New York to obtain a graduate degree in environmental health sciences and take a job on its city planning commission. Her name was Dara Rosenberg.

In addition to these baby boomers, a generation later a young man in quest of adventure would embark on a kayaking trip to Alaska in waters known as its "Inside Passage" (traveling from Juneau to Ketchikan). He would stay in the "Land of the Midnight Sun" for four years taking on a number of different jobs – in forestry, as a member of a bluegrass band, as a teacher, at a ski resort – before moving to Oregon and working as an emergency room tech. His name was Ethan Abbott.

While it's difficult to put a number on how many Americans undergo a career change – the Bureau of Labor Statistics doesn't include one, as defining what a career change entails remains elusive – it is hardly common for doctors to pursue medical careers in midstream because of the years spent in medical school and training (not to mention the time needed to take mandatory classes in a post-baccalaureate program and prepare for MCATs). Yet, Dr. Mary Gratch, now an obstetrician/gynecologist at SBH Health System; and her colleagues Dr. Brian Delaney, family medicine; Dr. Dara Rosenberg, chair, Department of Dentistry; and Ethan Abbott, emergency medicine and the department's assistant residency program director, have all taken a less than traditional path.

## THE ACTRESS

When Dr. Gratch was in her final year of medical school, "The New York Times" featured her in the lead of an article entitled "The Less-Traveled Road to Medical School." It read: "Mary Gratch spent 10 years trying to become an actress, but once she reached her goal, she decided it was not enough. So now she is trying to become a doctor."

Now celebrating her 20th year at SBH, and beginning her first as medical staff president, Dr. Gratch landed in New York City as an actress (and a waitress) after graduating from college in Washington D.C. Eventually becoming a member of the Jean Cocteau Repertory, a classical theatre company, she says she often found herself typecast as either a young prince, an old lady, or a woman of ill repute.

"Once I got where I wanted to be, I realized it wasn't enough," she says. "It wasn't challenging enough mentally or emotionally. I wanted more. Art is a kind of luxury and health care is a necessity."

She credits her theatrical training for helping her overcome "stage fright" when she first took on her new role as a physician. This, she says, also helped her on an interpersonal level in working with more challenging patients. "At one point I said just play the doctor like it's a character," she says. "It gave me confidence not to feel overwhelmed by the seriousness of what I was doing. I had to grow into the role of being a doctor."

## THE TEACHER

Dr. Delaney remembers how intimidating it was at first to make the move to medicine. "It was a major culture shock," he remembers. "I was in a classroom competing with graduates from Harvard and Princeton and Yale at Einstein School of Medicine [he attended Iona College] and I was the old man" – but soon realized the advantages he had in the clinical setting. "I knew how to do things and had a little bit of perspective," he says. "It turned into a positive for me."

As a 30-year-old husband and father, he felt like a fish out of water in his class at Einstein – a school where he now teaches. He recalls being a couple years ahead of another miscast – a member of Sha Na Na, the popular rock group of the time that performed in gold lamé and leather jackets, and slicked their hair into pompadours and ducktail hairdos.

Dr. Delaney's aunt, who he was very close to, had concerns about his change in careers. "She thought I was crazy for giving up my teaching job," he says.

As it turns out, he actually became a trendsetter in his own family. His daughter, once a voice coach and performer in musical theatre, is now a resident.

## THE ENVIRONMENTALIST

The last thing Dr. Rosenberg had on her mind after graduating from college in Stony Brook was becoming a dentist. Her father was a dentist, working from their home in Kew Gardens, and her maternal grandmother was one of the first women dentists in New York City, with an office for years in Harlem.

"I was trying to stay away as long as possible because everyone in my family was doing this [her sister is also a dentist]," she says. "It was not what I was interested in at all. But after working for the New York City planning commission for a while I said, 'I should do this on my own on the side and what I need is a job I can make sufficient money in so I can do what I really want.' I figured you can work as a dentist for somebody a few days a week, and then you're free."

So, she went to dental school, and then did health services research in Los Angeles, getting a Master's in Public Health at UCLA, before returning to New York. In 1988, 17 years after she graduated college, she received a call from Dr. Ronald Gade, the president/CEO at St. Barnabas Hospital, to treat patients – the hospital had one dental chair at the time – and start its residency program. Today, the Department of Dentistry has about 40 attendings and 52 residents in orthodontics, anesthesia, pediatrics and general dentistry, making it one of the largest dental residency programs in the country.

"When I decided to go to dental school I told my parents that I had good news and bad news," she says. "So they said 'What's the good news?' and I said 'I'm going to dental school.' My mother said, 'Really? You have a master's and this and that, why do you want to go to dental school? What's the bad news?' I said, 'Warren (now her husband) and I are moving in together.' That she was thrilled about. So I got it all wrong. Who knew?"

## THE ADVENTURER

After his kayaking trip, which Dr. Abbott calls "a spectacular, amazing, incredible experience" that he actually received a scholarship to pay for, he wasn't sure about his next step. "I guess I hadn't prepared for the reality of life," he admits, so he spent another four years in Alaska doing everything from collecting core samples from trees to working with emotionally disturbed children. He lived for a time on a 27-foot sailboat.

"I've always been interested in medicine – my father has been a family physician for about 40 years," he says. "I come from a long line of physicians. My grandfather was a urologist, and I have other family members who are psychiatrists and surgeons, so it's in the blood. I think I was just feeling a little distracted at the time."

After four years as an ER tech in Portland, he took his prerequisite courses and applied to medical school in New England. Although he says residency, which he did in the Bronx, was definitely more difficult being a little bit older because of the hours, and the financial burden was more intense because of the shorter period to pay off student loans, he feels the life experience has been beneficial.

"It gives you kind of a different perspective than going straight from college to medical school to residency and to your practice," he says. "In terms of contributing to how I think about the world, I think it's been very valuable."





# "Relay" Program Addresses Opioid Overdose Problem

By Steven Clark

Relay, part of the New York City Department of Health and Mental Hygiene's HealingNYC initiative to reduce the opioid overdose epidemic, arrived at SBH Health System in February, making it the fifth hospital site since being launched in June 2017.

"Relay was conceived as a way to fill what we saw as a gap and a missed opportunity to reduce opioid overdose deaths in the city through a harm reduction approach that meets these folks where they're at, supports them, and links them to appropriate care," says Dr. Hillary Kunins, the health department's assistant commissioner of the Bureau of Alcohol and Drug Use Prevention, Care and Treatment. "From the scientific literature, we know that people who experience non-fatal overdoses are at risk of subsequent overdoses. Our thinking was to reach them in a targeted fashion, find them information, and connect them with services that will move them along the behavior care continuum."

Reducing unintentional drug poisoning (overdose) deaths is a leading priority for the health department. There were nearly four drug overdose deaths daily in New York City in 2016 and the rates have increased 143 percent from 2010 to 2016. The Bronx has the second highest rate (a 24 percent increase over the previous year), and the largest number of overdose deaths in the city.

Relay has a wellness advocate, someone who has first-hand experience with substance use and has been trained as a peer advocate, arrive at the hospital within an hour of being called in by the department after a non-fatal patient overdose. The advocate offers overdose risk reduction counseling and opioid overdose rescue training, connects them with appropriate services, and stays in contact with the individual for up to 90 days. This time period is key, says Dr. Kunins, as it gives sufficient time to form relationships, navigate the care system and provide support.

Additionally, the patient is provided with a Naloxone kit to help reverse any future events. The kit includes two doses of Naloxone: "give one dose and wait two to three minutes; if it doesn't work, give the second." The drug is administered via a nasal spray that is absorbed through the mucosa.

"It is recommended for lay people to administer because regardless of whether the cause of the overdose turns out to be opioid-related, it can't hurt you," says Dr. Kunins, who previously worked as an addiction specialist in the Bronx.

SBH was selected as Relay's latest site because of the high rates of opioid overdose deaths in the south Bronx. The increase in the number of deaths here and throughout the city is largely due to the growing presence of the illicitly manufactured drug fentanyl, a potent opioid found in heroin, cocaine, methamphetamine and ketamine, as well as in painkillers acquired from non-pharmaceutical sources.

Dr. Howard Greller, SBH's director of medical toxicology, is the hospital's Relay liaison. In the first month, according to Dr. Greller, the hospital had a total of 38 non-fatal overdoses, 36 of whom were engaged by the program. This, not surprisingly, makes it one of Relay's busiest sites. According to Dr. Greller, "it speaks to the pervasive nature of the problem and how significant it is in the Bronx, particularly in the area we serve."

Dr. Greller is already a strong advocate of Relay. "Direct intervention was a way that was previously lacking," he says. "It's a way of confronting the problem and establishing a pathway for continued help. It provides those patients who are most vulnerable with services and information, rather than just sending them off in the wild."

Dr. Kunins says she is fully aware that the patient Relay may have seen in emergency rooms in Staten Island or Manhattan may be very different than one in the south Bronx. "It's often more complex in the Bronx," she says. "There are high rates of homelessness, poverty, and mental illness that shapes our approach in connecting these people to services. We want to help them in the context of what else is going on in their lives by giving them the resources to take care of their health and ultimately reduce their likelihood of overdosing in the future."

She adds, "We're cautiously optimistic that Relay is having a positive effect." Data for 2017 shows that overdose rates have flattened in New York City, where they were up more than 45 percent in the previous year.

# DOCTORS and CHARITIES

**By Howard Hook, CPA, CFP**

*Howard Hook, a CPA and Certified Financial Planner, has been named one of America's "Best Financial Advisors for Doctors" by Medical Economics every year since 2010.*

I've been having more conversations lately with my doctor-clients about charitable giving. While I have found medical professionals to be very generous in their charitable giving, the uptick in conversation is likely due, at least in part, to an overriding concern about a lack of civility in the world. Yet, while specific giving opportunities have arisen recently and the desire to give exists, there seems to be a lack of understanding on how best to do so.


As SBH Health System is about to begin a capital campaign to raise money to support the services of a unique health and wellness center on its campus for its community that is presently under construction, this discussion seems particularly timely.

A capital campaign, unlike solicitations for general donations, tends to attract more interest from donors due to the more permanent nature of what the money is being directed towards. Whether it is to build an endowment or a building, the funds are perceived to have a lasting quality to them.

Capital campaign gifts tend to be larger than general donations. Sometimes, this is because with larger gifts come naming opportunities. Other times, it's because the specific use of the funds appeals to the donor.

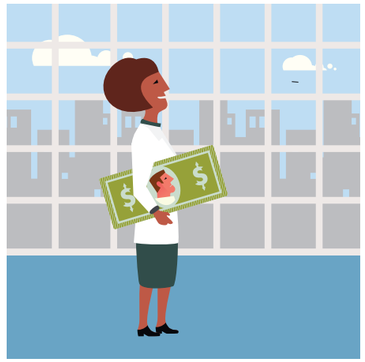
The recent change in the tax law and the run up in the stock market over the past nine years have created an interesting opportunity for those wishing to give to charity, in particular those wishing to make larger gifts, such as to a capital campaign.

Beginning with the 2018 tax year, increases in the standard deduction and reductions in the amount of allowable itemized deductions is expected to result in 90 percent of all taxpayers taking the standard deduction on their federal income tax return. What this means is that many people will no longer receive an income tax deduction for making charitable donations. Only in those years when the amount of charitable giving is quite large will it result in a tax deduction. A large gift to a capital campaign in one year, for example, may result in a tax deduction for that year.





*"Instead of rebalancing the portfolio by selling stocks, the individual can gift some of the stock that has appreciated greatly to a charity of their liking."*



The stock market bottomed out in March 2009. From that point on, the market has gone up tremendously. This has created a situation where investors are sitting with investments that contain large amounts of unrealized gains that if they sold those investments they would pay a significant tax. The easy answer is to continue to hold on to those investments.

Here is where charitable planning can assist. Instead of rebalancing the portfolio by selling stocks, the individual can gift some of the stock that has appreciated greatly to a charity of their liking. This way, the person gifting the appreciated shares directly to a charity can take a tax deduction equal to the fair market value of the stock on the date it was given (assuming the shares given were held for more than one year prior to being gifted). An added benefit to doing this is that the person does not pay any tax on the gain built up in the position over the years. It is possible that the value of the tax deduction is equal to the original purchase price of the stock when it was first bought.

An example can help illustrate how it works: Dr. Brown wishes to contribute $25,000 to the hospital's capital campaign for the new building, using funds from her brokerage account to do this. She has identified stock in ABC Corp which she has owned for nine years, was purchased for $6,000 and is now worth $25,000.

If Dr. Brown sells the stock before giving it to the capital campaign she will have realized a gain on the sale of $19,000 and will pay income tax on the gain on the sale. Depending upon her tax bracket, this could be as high as 23.8 percent federal and 12 percent New York State / City. This level of charitable gifting would be sufficient such that Dr. Brown would be able to itemize her deductions, and thus be able to deduct an amount equal to the amount of cash given to the capital campaign.

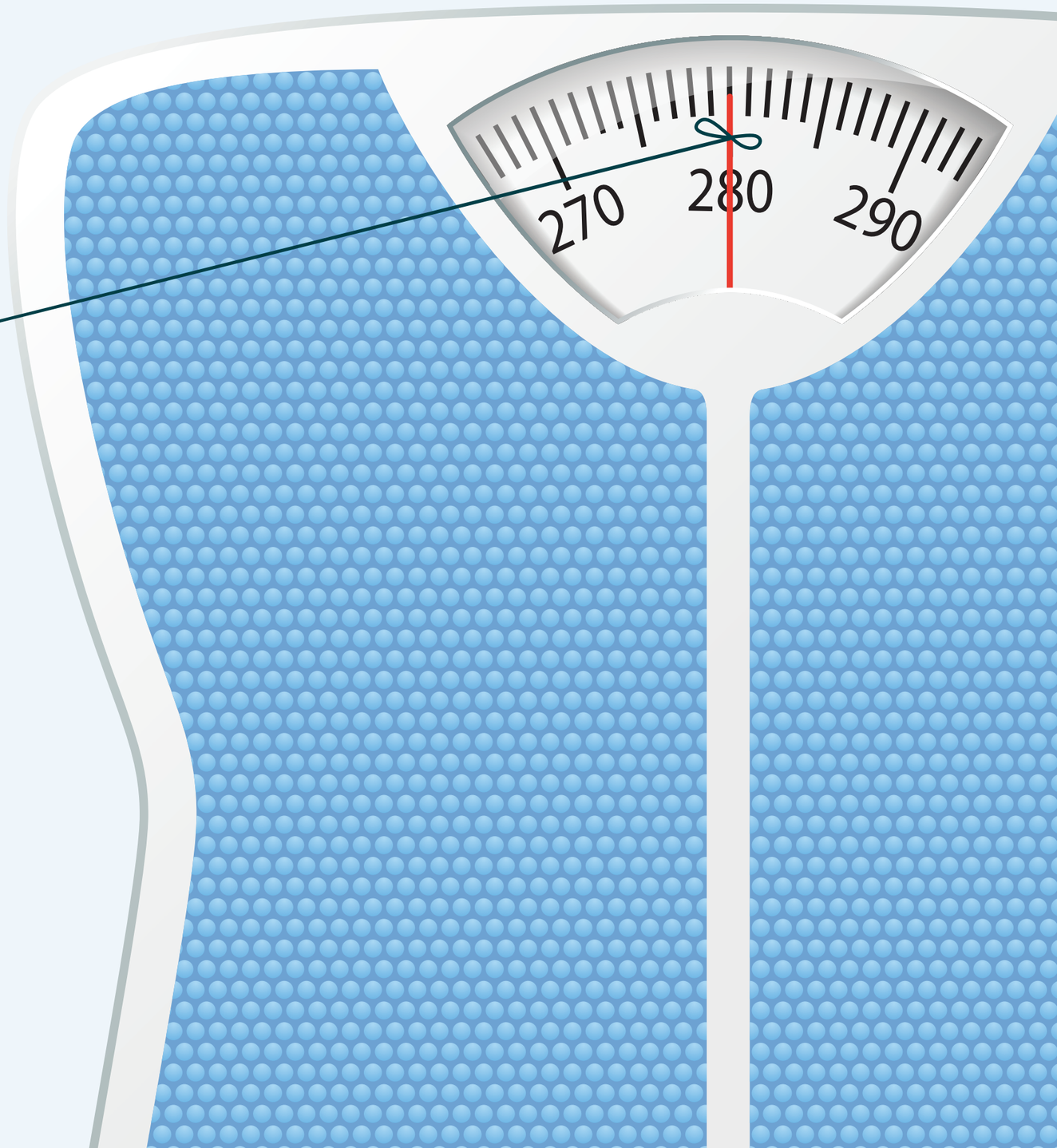
If instead, however, she gave the shares directly to the capital campaign she would avoid paying any income tax on the transaction and would still receive a tax deduction for the amount given to the campaign. If she was in a 33 percent combined federal and state tax bracket the amount of tax she would save would be $8,333 ($25,000 x 33 percent), which is more than what she paid for the stock in the first place.

But what if you cannot identify a stock to sell because you like them all and do not wish to donate any of them? In that case you can still donate stock, but make a plan to start to buy back the stock with money you originally may have intended to use to make the donation in the first place.

Using the example from above, Dr. Brown chooses to buy back the stock of ABC Corporation she donated gradually over a period of years with her tax savings of $8,333. Buying the stock this way can help protect against a decline in the price of the stock.

The above technique is just one of many that can be used to effectively achieve one's charitable goals.

# NEW BARIATRIC CENTER HELPS WITH PATIENT TRANSFORMATION




"Transformation" is the word that best describes how Dr. Nissin Nahmias, Medical Director of the SBH Center for Bariatric Surgery, sees the newly-opened center.

by Steven Clark

Obesity is a disease that affects about 78 million Americans, according to the Centers for Disease Control, one that has been linked to more than 40 diseases including type 2 diabetes, heart disease, stroke, osteoarthritis and cancer. It's a problem that is particularly evident in the communities surrounding the hospital. According to a recent report issued by the New York City Department of Health and Mental Hygiene, two of every three adults are overweight or obese in the South Bronx – a percentage significantly higher than in New York City (with 39 percent of adults 45 to 64 considered obese here vs. 26 percent throughout the city).

Obesity is the result of a cluster of factors, says Dr. Nahmias. "It is certainly behavioral in some part, but it's also genetic and cultural and socio-economic. While it may be hard to pinpoint the number one culprit for any individual, what we do know is that there is an epidemic here that the services offered at our center can dramatically impact."

The new center, he stresses, will be comprehensive and patient-focused rather than "cookie cutter" in approach, restricting itself to treating adult patients up to 350 pounds. A registered dietitian will work closely with patients to educate them on healthy eating, and a mental health professional will screen them to make sure the procedure is appropriate for them. Patients will be closely monitored up to and for years following surgery. Those who qualify for surgery will have tried to lose weight multiple times before, and view surgery as a last resort.

"We're not interested in five- or 10-year outcomes, but in lifelong alterations," says Dr. Nahmias. "This is not a quick fix solution. It can be a fantastic operation, but transformation happens over a long period of time and not everyone is right for it."

"It's an opportunity for those who feel like they are in a difficult situation, where they feel hopeless and have no options, to transform their lives. Over the years I've seen people who feel they are unfit and unqualified, and at times discriminated against because of their weight, take this opportunity to change the way they feel about themselves and how others see them."

— Dr. Nissin Nahmias, Medical Director,
SBH Center for Bariatric Surgery


## "PATIENTS CAN EXPECT TO LOSE 60 TO 80 PERCENT OF EXCESS WEIGHT WITHIN THE FIRST YEAR TO YEAR AND A HALF."

Dr. Nahmias, who is bilingual, is fellowship-trained in advanced laparoscopic and bariatric surgery. He has performed more than 1000 bariatric procedures and is recognized by The American Society of Metabolic and Bariatric Surgery as a "Bariatric Surgeon of Excellence." He is a Diplomat of the American Board of Surgery, and a Fellow of the American College of Surgeons and the American Society for Metabolic and Bariatric Surgery. His scientific work includes several peer-reviewed publications, two book chapters and over 15 presentations in national and international meetings. He recently spoke at at the IBC World Congress at Oxford University in London, England.

### The Surgeries

The center will incorporate two procedures: the gastric sleeve and gastric bypass surgeries. The sleeve, says Dr. Nahmias, is a simpler operation with fewer complications, which makes it more appealing to patients. The operations are similar in how they are performed and in terms of post-surgical diet and exercise regimens. For both, the expected hospital stay ranges from two to three days and the procedures are not reversible. In each case, patients reduce the amount of food they can eat before feeling full.

With the gastric bypass procedure, or roux en y gastric bypass, a small stomach pouch, approximately one ounce or 30 milliliters in volume, is created by dividing the top of the stomach from the rest of the organ. The surgeon then divides the first portion of the small intestine, and connects the bottom end of the divided small intestine to the newly-created small stomach pouch. The top portion of the divided small intestine is then connected to the small intestine further down so that the stomach acids and digestive enzymes from the bypassed stomach and the first portion of the small intestine will eventually mix with the food. This newly-created stomach pouch is considerably smaller and so facilitates significantly smaller meals, which translates into less calories consumed. Patients can expect to lose 60 to 80 percent of excess weight within the first year to year and a half.

With the sleeve, also known as the laparoscopic sleeve gastrectomy, the surgeon removes approximately 80 percent of the stomach, converting the remaining stomach into a tubular pouch that resembles a banana. The new pouch holds a considerably smaller volume than the normal stomach, which helps to significantly reduce the amount of food (and thus calories) that can be consumed. By affecting the gut hormones, the surgery impacts on hunger, satiety, and blood sugar control.

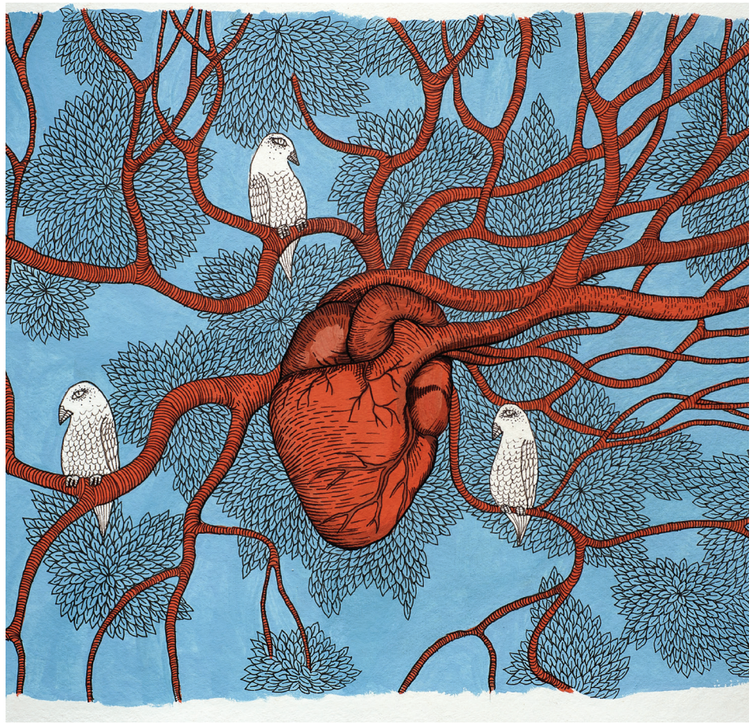
Short-term studies show that the sleeve is as effective as the roux en y gastric bypass in terms of weight loss and improvement or remission of diabetes. Studies also suggest that the sleeve, like the gastric bypass, is effective in improving type 2 diabetes, independent of the weight loss. Patients typically lose weight at a slightly slower, steadier rate, approximately 60 to 70 percent of excess weight within 12 to 18 months. Both procedures can also help improve such obesity-related conditions as high blood pressure, high cholesterol and sleep apnea.

"We work closely with our patients' primary care physicians, discussing expectations and what they should be expecting to see with their patients," says Dr. Nahmias. "Patient support groups are very important for keeping patients in check after the so-called 'honeymoon' stage – which is about 18 months after surgery – passes, a time when patients can start to gain weight. These support groups are not just 'let's gather hands and talk about our experiences,' but involve bringing in, say, a person from a dress shop to talk about how to dress after you lose surgery, or a cookbook author to discuss cooking habits. Patients will know that there's someone looking out for them and sharing their experiences throughout the journey."

The referral number for SBH's Center for Bariatric Surgery is 718-960-6127.

# Link Exists Between Sleep Apnea and Cardiac Disease

Studies reveal that when left untreated, obstructed sleep apnea (OSA) can double the risk of a patient dying from cardiac disease. **By Mediha Ibrahim, MD, Medical Director, SBH Center for Sleep Medicine**



OSA has been linked to the risk of heart failure, hypertension, type 2 diabetes, elevated blood pressure, atrial fibrillation and stroke.

It's been shown that there is nearly a 60 percent greater risk of developing heart failure in middle-aged men with severe sleep apnea and twice the increased risk of those with severe OSA suffering a stroke. As many as 4 in 10 of those with high blood pressure also have OSA. Studies have also shown that this risk is reduced to normal levels when those patients with sleep apnea are treated with PAP therapy.

Sleep apnea is defined as a common sleep-related breathing disorder characterized by regular episodes of reduced inspiratory airflow due to upper airway obstruction during sleep. OSA is associated with a significant increase in sympathetic activity during sleep, influencing heart rate and blood pressure.

It's the connection between OSA, cardiac disease, and the benefit of the most common treatment for the sleep disorder (the use of the PAP therapy) in reducing it that makes it so important for primary care physicians and cardiologists to screen patients with cardiac disease for suspected OSA. According to the National Healthy Sleep Awareness Project, this begins by determining whether patients demonstrate any of these five warning signs and risk factors for OSA:

***Snoring***

***Choking or gasping during sleep***

***Fatigue or daytime sleepiness***

***Obesity (with a BMI of 30 or higher)***

***High blood pressure.***

Since most patients may not necessarily be forthcoming about their sleep problems, believing it is normal to feel tired, doctors need to proactively raise the issue. As a means to this end, physicians should consider offering patients this five-question questionnaire provided by the National Sleep Foundation.





"At-risk populations, those with a preponderance of cardiac comorbidities like hypertension, atrial fibrillation, diabetes, heart failure, hypertension, high BMI and stroke, such as found throughout the Bronx, are in particular need of OSA screening."

***Do you regularly have difficulty getting to sleep or staying asleep?***

***Do you have a problem with snoring? Has anyone ever told you that you have pauses in breathing or that you gasp for breath when you sleep?***

***Are your legs "active" at night? Do you experience tingling, creeping, itching, pulling, aching or other strange feelings in your legs while sitting or lying down that cause a strong urge to move, walk or kick your legs for relief?***

***Are you so tired when you wake up in the morning that you cannot function normally during the day?***

***Does sleepiness and fatigue persist for more than two to three weeks?***

If there is a concern that a patient has one or more of these risk factors, a sleep evaluation should be recommended to investigate whether there is a sleep disorder.

## SLEEP STUDY

A sleep study, or polysomnogram, is a noninvasive, pain-free procedure that requires the patient staying overnight in a sleep center (although a home study is also possible). During the study, brain wave activity, eye movements, muscle tone, heart rhythm and breathing are monitored. Are they struggling to breathe? Have they stopped breathing at certain times? What is their oxygen status? All of this helps determine if the patient's airway is being obstructed while asleep. The patient's sleep position is also observed, as sleep apnea tends to be worse when the patient lays supine.

After recording a full night's sleep, the technologist tabulates the data and presents it to a physician for interpretation. Should it be determined that the patient has sleep apnea, a titration study will be conducted to find the right amount of air pressure needed to prevent the patient's upper airway from becoming blocked and eliminate breathing pauses in their sleep. As with the earlier polysomnogram, sensors are again attached to the patient's body to monitor their sleep, as they are fitted with a nasal mask that is connected by a hose to a small electric unit. The fitting process is an important first step in the PAP titration. At certain intervals throughout the night, the technologist will remotely change the air pressure received through the mask. Pressure starts at a very low level and gradually increases as needed to eliminate any apneic events. The study is completed the next morning. Other treatments, if deemed necessary, may also be explored.

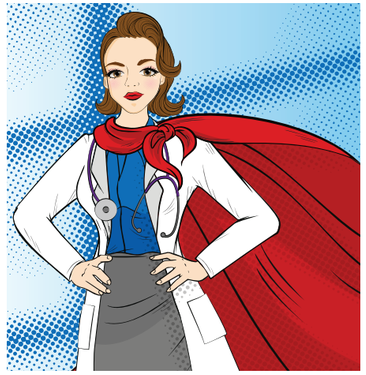
At-risk populations, those with a preponderance of cardiac comorbidities like hypertension, atrial fibrillation, diabetes, heart failure, hypertension, high BMI and stroke, such as found throughout the Bronx, are in particular need of OSA screening. As one cardiologist said, not screening for sleep apnea is akin to an auto mechanic fixing three tires on a car and never checking the fourth but simply hoping for the best.

For more information on the Center for Sleep Medicine at SBH call 718-960-3730.

# My Secret Identity

*Reprinted from feminem.org, Females Working in Emergency Medicine.*

**By Marianne Haughey, MD, Director, SBH Health System Emergency Medicine Residency Program**



"What should I call you?" It seems like a simple question, no? After all, I was a 36-year-old woman when this question was asked by my daughter's pre-school teacher. I should know my own name. I am about to talk with her class of four-year-olds about how important hand washing is for keeping healthy. But it turns out it is a complicated question. My worlds are colliding. I am wearing my white doctor coat at my daughter's school. At a school where I am known as Mrs. Barrios. My work identity of Dr. Haughey is a bit of a secret here. Most of the other parents and teachers know I am a doctor, but the complicated issue of an actual name to call me is complex.

I have just spent the weekend at New York Comic Con, surrounded by superheroes and their alter egos. The costumes were magnificent, on both sides of the dyad. There were Clark Kents and Supermen, Wonder Women and Diana Princesses, Batmen and Bruce Waynes and even some Cat Women and a Selina Kyle. True, there were far more of the dramatic superhero versions, but the true fans also enjoyed the subtleties of eliciting the details of the "plainer" version of their favored character.

When I married, it seemed very clear to me I was not going to change my name to my husband's last name. My husband jokes that I just didn't love him enough. I love him plenty and deeply, but had already gone through a strange transformation with my name. Somehow, upon starting internship I was not most commonly called "Marianne" as I had been for my whole life, but now "Dr. Haughey." It felt a bit fake at first. The name seemed to fit me as awkwardly as that weird long white coat. The coat was clean, without coffee stains, with pockets filled with all sorts of handbooks and notes to help me actually fill the role of "Dr. Haughey;" hopefully among all those pieces of paper I would find the answer to any life-threatening questions that might arise. (This was before smartphones and Google.) I had adjusted, with difficulty, to this new name and reality by the time we married. During my fourth year of residency, which is when we married, I was turning my head when people called "Dr. Haughey" immediately, rather than not really connecting with the name. I had even published under this name, so I felt odd about going through another change to my identity.

I discussed with my husband that this choice might prove more challenging once we had children, but I felt confident that we would negotiate any challenges. As the children entered pre-school and the teachers assumed I was called Mrs. Barrios, it felt awkward and unnecessary to correct them to my true legal name. So, I continued to share the name of my husband and children in this new setting for us. I grew more comfortable with my alter ego presence, but I was never sure which was the more real name, or even the more real me. Was one role the super hero, the other the alter ego? If so, it was impossible to tell which version had the superpowers. Was it when helping my daughter crying out over a skinned knee and being able to hold her in a way that calmed her tears? Or was it being present in the moment I had to share bad, life-altering news with a patient during a shift in the ED? When the teacher asked what she should call me, I was flummoxed.

As the four-year-old faces were turned up towards me from their seats on the carpet, excited to hear from this white-coated person they recognized, I realized there was common ground in the two names, just as there was common ground in the superhero/alter ego paradox.

"How about Dr. Marianne?" I said. I was introduced and then we started talking about washing hands to fight germs. You know, just another day for a superhero.





# SBH Partners in Study on Use of PrEP by High-Risk Teens

The Pediatrics Department at SBH Health System has partnered with the CUNY School of Medicine and the Yale University School of Public Health on a project that explores the attitudes and opinions of providers, parents and adolescents on prescribing oral antiretroviral pre-exposure prophylaxis (PrEP) to decrease the transmission of HIV among teens.

PrEP – a combination of two HIV medicines (tenofovir and emtricitabine, sold under the name Truvada) – was approved by the FDA in 2012 to reduce the chances of high-risk adults becoming infected with HIV. It's been shown that daily use of PrEP can lower the risk of getting HIV from sex by more than 90 percent. Although currently approved by the FDA for use by adults only, PrEP has been found in recent studies to be safe for use by gay and bisexual teenaged boys as well (including one published in JAMA Pediatrics).

According to Dr. Paulo Pina, the pediatrician who has been heading the study at SBH, with co-investigators Dr. Tashuna Albritton from CUNY and Dr. Tamara Taggart from Yale, adolescents who have sex with men and young Black and Latino men continue to be at high risk for HIV. Youth ages 13 – 24 accounted for an estimated 22 percent of all new HIV diagnosis in the most recent data (as well as for nearly half of the 20 million new cases of sexually transmitted infections).

"We need some kind of intervention and what we've done up until hasn't been working, particularly here in the Bronx," says Dr. Pina, who has provided PrEP to several high risk teens. "The modality of taking a daily oral contraceptive (OCP) to prevent pregnancy has been working well for teens, which is why PrEP offers a promising prevention strategy for teens at high risk for HIV because of sexual behavior."

The objectives for Who's on Board: A Feasibility Study of Pre-Exposure Prophylaxis (PrEP) Uptake Among Black and Latino Adolescents are to explore individual-, interpersonal- and community-level factors that influence implementation and delivery of PrEP to adolescents; and to identify provider- and organizational-level factors influencing PrEP implementation and delivery to adolescents.

The study reveals that providers (pediatricians and family medicine physicians), teens and parents/guardians all lack knowledge about the medication with only about a quarter of teens saying they had ever heard of it. Major themes that emerged among providers are lack of knowledge about PrEP, concerns over age of the patient and teen compliance, difficulty in identifying high-risk adolescents, awkwardness about discussing PrEP with adolescents, and judgment from family and friends of teens taking PrEP compared to OCPs. Parents, meanwhile, expressed skepticism about the medication, the promotion of sex among teens, low adherence, and possible side effects.

Plans are to increase PrEP educational training for providers and to provide more community health education for parents and teens, as well as to use preliminary data to secure future grants to conduct additional focus groups.

"Teens are getting infected at a significant rate and we need to think of different ways to help them," says Dr. Pina. "We need to tackle the issue from all angles, including promoting abstinence, using condoms, and making PrEP available."

# “Mad Scientists” Create Testing Prototypes for EM Residents

Doctors in the emergency medicine department are using 3-D printing to develop anatomical parts for resident training purposes. **By Steven Clark**

A medical student, brought to an office on the fourth floor of the Braker Building to interview for the hospital’s Department of Emergency Medicine residency program, looks around the room with a puzzled expression before saying to the interviewer, “What is this place?”

Good question.

The office of Dr. Mina Attaalla, director of the department’s Simulation Education and Informatics (now located in the Simulation Lab in the annex), bears a passing resemblance to Dr. Frankenstein’s laboratory. Tools and computer parts jockey for position with plastic models of various body parts on the floor and atop desks and shelves.

It’s here, in what Dr. Attaalla and Dr. Jeffrey Lazar, the department’s vice chair and medical director, playfully call “paradise for nerds,” where the two self-acclaimed “mad scientists” create life-like models with 3-D printers.

“We produce different body parts that are relevant to emergency medicine and can be used by our residents to practice their skills at a fraction of what it would normally cost,” says Dr. Attaalla, who spends about 30 hours a month building the 3-D models – in many cases on his own time when he’s not busy with administrative, clinical and teaching responsibilities. These body parts, which can range from a thorax to a skull to a spinal canal, can take anywhere from 30 minutes to several days to produce and can cost thousands of dollars less than mass-produced training and educational models.

“It’s an intersection between art and science which is how I see medicine,” says Dr. Lazar, a working artist who expresses himself in such mediums as abstract sculpture, Japanese printing and paper collage. “These models are not only functional but beautiful to look at.”

Models are covered with materials that simulate the feel of human tissue, providing a real-world experience for residents practicing procedures that range from lumbar puncture to cricothyroidotomy.

The latter is an emergency procedure used to create an airway when other, more routine, methods are ineffective or contraindicated. This is a skill that emergency medicine physicians must master to prevent patient morbidity or mortality. “We want our residents to feel what it’s like to do this, and it’s certainly better to let them practice on a model than on a patient, when it can be a matter of life and death,” says Dr. Attaalla.

In fact, when asked how confident they were in doing this procedure before the simulation exercise, residents reported 3 out of 10 with 10 being the most confident. Practicing on the home-bred model raised their confidence level to an 8.5.

Dr. Attaalla, who is now working with his counterparts at New York Presbyterian Medical Center in Manhattan and St. John’s Riverside Hospital in Yonkers to develop more sophisticated models (including one that can induce bleeding), says he is planning soon to offer these prototypes for training and educational purposes throughout SBH.





# Emergency Medicine Resident Creates “Escape the Room” Scenario for Final Project

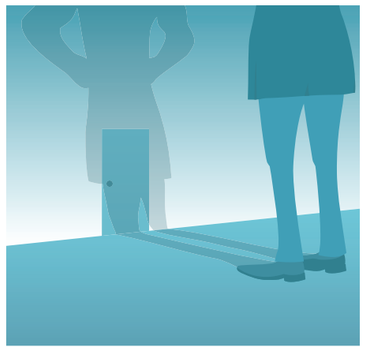
Fifth-year emergency medicine and family medicine resident **Dr. Christina Hajicharalambous** at SBH develops project to improve interdisciplinary communication efforts.

Graduating residents in the emergency medicine program typically do a senior talk as part of their final project, perhaps discussing a volunteer experience abroad or a case study they had a particular interest in.

Dr. Christina Hajicharalambous, a fifth-year resident in emergency medicine and family medicine, had a different idea. “I wanted to do something interactive,” she says. “I’m a strong believer in learning things hands-on rather than through lecture in the classroom. I think that if learning doesn’t evoke a response, such as an emotional one, or doesn’t make you think while you’re learning, you’ve never going to retain it permanently. So, in the ER, unless there is fear or anxiety or uncertainty, as a resident you’re going to forget it.”

So, with this type of thinking, she created an “escape the room” scenario whereby her fellow residents working in teams (and not being able to use their cell phones) could not leave a room until they uncovered a series of clues, each one dependent on the previous one that would ultimately determine the patient’s diagnosis and treatment. This included figuring out Morse code, identifying lab results of patients written on paper scattered throughout the room, unlocking a Power Point presentation with a patient’s x-ray, uncovering clues written by invisible markers that could only be seen using black lights, solving EKGs hidden in separate bone and pill boxes, and so forth.

“Basically, the approach was ‘This is a piece of information you want them to find out and you are presenting them with obstacles they are going to have to



overcome,’” says Dr. Hajicharalambous, who will be doing a fellowship next year at Mt. Sinai Medical Center in simulation education. The emphasis, she says, was on team communication. Each group had to recognize that the other half of their team was in another room trying to communicate with them and only by working together could they uncover all the clues needed to escape their respective rooms.

“In the emergency department, interdisciplinary communication is vital to ensure patient care and this exercise was no exception,” she says. “Once the two rooms worked as one team and gathered all the clues, EKGs, x-rays and blood tests, they consulted our toxicologist, Dr. Angela Regina. If the consult was adequately presented without missing information, the residents successfully escaped the room.”

The response from the students, she says, was positive, with residents generally meeting expectations in their decision-making. “As I expected, the medical part was not difficult for them. As residents the medicine is emphasized, but the communication was a challenge, as it was meant to be.”

It was similar, she says, to what happens when you have a patient that requires multiple teams in the emergency department. “The emergency physicians, surgeons and anesthesiologist, for example, have to work together and communicate clearly, otherwise the patient can suffer. I think they understood what I was trying to emphasize.”

Did the lessons stick? “That’s a good question,” she says. “The ultimate sign of that would be to see better communication within the department and throughout the hospital with the ultimate goal to improve patient care and minimize medical errors.”

# Social Media and the Battle Against Sexism in Surgery

**By Gerard A. Baltazar, DO, FACOS**

In 2015, a social media hashtag campaign began to take hold, drawing needed attention to the growing number of female professionals and the barriers women still face in the professional world as a result of their gender.

Among those hashtags, #ILookLikeASurgeon became arguably the most viral after "The New Yorker" in 2017 featured the animated cover "Operating Theatre," showing four female members of a surgical team gazing down over a patient on an operating table. Inspired by this cover, University of Wisconsin endocrine surgeon Dr. Susan Pitt and colleagues replicated the image in real life, posting their picture online and sparking hundreds of surgeons from around the world to do the same.

The campaign took on a new life, reaching a much wider audience and stimulating interest in women's issues in the medical field and in general. According to healthcare social media analytics website Symplur.com, just since the start of 2018, #ILookLikeASurgeon has on average 15 tweets per hour and has garnered almost 90 million impressions. And more than 19,000 people have participated in the campaign.

While many professions have over time approximated 50 percent female membership, the medical profession and the surgical specialties in particular have lagged behind this progress. In contrast, the SBH Health System general surgery residency is ahead of the curve, creating cohorts of residents that reflect actual gender distributions—the general surgery residency has been at least 50 percent female since 2014, and the contingent of females seems to be increasing.

Historically known in the medical profession as a "boys club," the surgical specialties have become more inclusive of women and minorities. Since #ILookLikeASurgeon took off, associations such as the American College of Surgeons, academic journals and media outlets around the world have promoted the campaign, truly turning it into a global movement. Celebrating women and diversity in surgery, SBH is ahead of the curve, achieving at least 50% female general surgery residency contingent in 2014, before the #ILookLikeASurgeon social media campaign became viral.

Dr. Heath Logghe, founder of the #ILookLikeASurgeon movement, published a commentary in the October 2017 issue of British Medical Journal, outlining some real-world changes that have occurred, including the launch of Women in Surgery Africa. Dr. Logghe also notes that studies have shown female surgeons may excel in some areas compared to males, including communication, collaboration and patient centeredness.

As is common with social media campaigns, the hashtag has experienced some negative backlash but also some ingenious responses to naysayers. Most famously, in response to Nobel laureate Tim Hunt discussing the "trouble with girls" in the science lab, the #DistractinglySexy feminism campaign spread across the internet highlighting female scientists effectively performing their duties.

A survey published by Adesoye, et al,. in JAMA Intern Med last summer, found that 66.3 percent of women physicians experienced some form of gender discrimination during their careers, and 35.8 percent reported maternal discrimination. In response to these remarkable statistics, Dr. Jessica Gold compiled firsthand accounts of such discrimination in a widely-accessed "Huffington Post" article.

Indeed, while the numbers of female surgeons is increasing, disparities in the workplace still exist. Analyses note that female surgeons are paid significantly less than males in the same specialty, in some reports 60 cents on the dollar. Over a general surgeon's career, this pay gap could result in a deficit of millions of dollars.

Much progress continues to be made, and in the SBH general surgery residency the goal is to be inclusive and respect diversity – the quality of surgical patient care and academic achievement are paramount and exclusive of gender.





# What if the Patient Refuses Surgery That Will Save His Life?

**By Steven Reichert, MD, Director, Palliative Care, SBH Health System**

Mr. L is a 50-year-old man with a history of diabetes mellitus, who is admitted from home with gangrene of his right leg. Upon arrival in the emergency room he is found to be critically ill and is immediately sent to the ICU. His past medical history is limited and a dutiful review of records reflects that the patient has no family, friends, surrogates or health care proxy.

Further testing reveals that the patient has COPD and mild malnutrition, but he is otherwise healthy and has had no major illnesses. He is started on broad spectrum antibiotics and is evaluated by the vascular surgical team. He is recommended for surgical amputation and revascularization to save his remaining leg. Although the patient is weak and lethargic at times, he refuses surgical intervention. He states that he would rather die than live with one leg.

The medical and surgical teams implore him to agree to surgery, as his likelihood of post-op survival is excellent and he would likely live many years, albeit with one leg. Psychiatric evaluation finds the patient to be a bit depressed, but with full understanding of the situation and full capacity.

The patient continues to refuse surgical intervention, and his sepsis worsens. Overnight he is intubated for respiratory failure and is moved to ICU. In the ICU he is delirious and severely septic, requiring vasopressors. The ICU team considers mandating an emergency amputation.

## How should they proceed?

The four basic tenets of medical ethics include: Beneficence (only do good things), non-maleficence (don't do bad things), autonomy (the patient decides important things), and justice (be fair to everyone). When faced with a patient who appears to be making a decision that is poor (refusal of life-saving surgery) is a doctor obliged to save the patient's life and do what will be good in the sense of prolonging life, or must he or she respect the patient's rights to make a decision even if it demonstrates poor judgment?

This patient presents with a critical illness. However, with surgical intervention, his life can be saved and he would likely live for years to come. Permitting him to die in this situation could be perceived as maleficence (doing a bad thing); however,

"COURT CASES HAVE ESTABLISHED THE PATIENT'S RIGHTS TO REFUSE MEDICAL CARE (INCLUDING FOOD AND HYDRATION), PROVIDED THAT THE PATIENT DEMONSTRATES ADEQUATE CAPACITY."

not following his wishes would deprive the patient of his autonomy regarding his life.

Court cases have established the patient's rights to refuse medical care (including food and hydration), provided that the patient demonstrates adequate capacity. Capacity is defined as sufficient understanding and memory to comprehend in a general way the situation in which one finds oneself and the nature, purpose, and consequence of any act or transaction into which one proposes to enter. If this patient understands the consequences of his decisions, his right to refuse surgical intervention must be respected. Surgical intervention, albeit potentially lifesaving, is inappropriate and would be a violation of the patient's stated wishes.

Unfortunately, a code status was not determined prior to the patient's deterioration and he no longer has capacity, nor a family member or friend who could act as a surrogate. The patient is treated with broad spectrum antibiotics for several days, but remains critically ill on vasopressors, intubated, without capacity and with a gangrenous leg, which is not going to be removed. He has also developed renal and hepatic failure.

## How should the ICU team proceed?

An ethics meeting is held to discuss the patient's dire situation. The committee unanimously agrees that his autonomy must continue to be respected. He demonstrated full capacity to refuse surgery and understood that this decision may result in his death. Even with aggressive care, he has continued to deteriorate and the ICU team states that dialysis or additional vasopressors in the absence of amputation would be medically futile.

The committee recommends that a DNR order be placed in the chart based upon medical futility and that no further escalation of care occur. The patient dies two days later.

## Summary

Although a poor choice, the patient chose not to opt for surgery. With few specific exceptions (e.g. decision making for minors) patient autonomy must be respected regarding decisions to forgo treatment. In this situation, once the patient's wishes were made clear and his capacity confirmed, a further discussion regarding aggressive life support could have avoided the aggressive and futile care at end of life. A transition to comfort-based or hospice care at that time could have spared him the burden of intubation and prolonged dying in the ICU.





# Medical Staff Recognizes Top Physicians

The 2018 SBH Doctors' Service and Recognition Awards recognized several of the institution's long-time and most beloved physicians at its recent ceremonies.

Dr. Richard Hwang, director of pathology, received the Ronald Ciubotaru Physician-to-Physician Award. The award was established in 2014 in memory of the late physician who embodied the hospital's highest values and standards. The award acknowledges the recipient as "an exceptional clinician, dedicated mentor and valued colleague, characterized by integrity and humility and deeply committed to the delivery of compassionate care to our patients that embodies the very foundation of SBH Health System."

**Dr. Hwang,** whose work touches every clinical department, has spent 17 years at SBH. He and his team have been responsible for updating the lab and maintaining its certifications. He was said by a colleague to personally embody the values of the organization's DRIVE to Patient-Centered Excellence – Diversity, Respect, Integrity, Vision, and Excellence.

**Dr. James Croll,** medical director of the SBH Hemodialysis Center and director of the Nephrology Department, was the recipient of the Staff Service Award. He was introduced by his long-time colleague, Dr. Malcolm Phillips, who called his hiring of Dr. Croll in 1988 as section chief of nephrology, "one of the best decisions I ever made as a director." Dr. Croll's colleagues referred to him with such adjectives as "incredibly hard working," "the first to come to work and the last to leave," "humble, sensitive, compassionate," and "a doctor who knows everything about his patients, including their families." In accepting the award, Dr. Croll said, "When I came here that day in 1988, I never knew this would become my family."

**Dr. Dara Rosenberg,** chair of dentistry, received the Medical Staff Achievement Award. She was praised by her colleague, Dr. Rachel Rosen, who spoke about how in 30 years Dr. Rosenberg grew the department from two residents to a highly respected and sought after program with 50 residents in general practice, periodontics, anesthesia and orthodontics, how she had been instrumental in obtaining over $8 million in grants and had continually introduced cutting edge technology. "But these are not the only reasons for the award," said Dr. Rosen. "Dr. Rosenberg is a true leader who knows that her job is not telling people what to do, but rather to coach, inspire goodwill, and generate enthusiasm."

**Dr. Scott Leuchten,** associate director, Emergency Medicine Residency Program, received the Emerging Leader Award. Dr. Leuchten has been at SBH as a medical student, resident and attending. Dr. Jeffrey Lazar, vice chair and director of Emergency Medicine, called him "a bedrock, who has given the department a sense of continuity and stability during transitions." Dr. Lazar recalled that when he first came to SBH three years ago he remembers thinking that "Scott was always here. Even if he was working 3 a.m. until midnight, he would be here early the next morning. And I'd say, "What are you doing here?' and he'd say, 'I have a committee meeting.' And after working all weekend, he'd be in Monday morning for another meeting."

# Congratulations to all SBH Graduates

## Dental

**Aeen Aflaatuni**
Residency in Pediatric Dentistry
University of Southern California

**Lorraine Brenner**
Private Practice
NYC Area

**Sylvana Chimenti**
Private Practice
NYC Area

**Amanda Curlin**
Private Practice
North Carolina

**Nithya Chalikonda**
Private Practice
NYC Area

**Christina Chung**
Residency in Orthodontics
Montefiore Medical Center

**Lawrence Chen**
Private Practice
NYC Area

**Saudamini Gadgil**
TBA
Pennsylvania

**Thomas Hendley**
TBA
Pittsburgh Dental Anesthesia Group

**Mariam Khan**
TBA
Illinois

**Carmen Lam**
Chief Resident
Mt. Sinai Hospital General Practice Residency

**Ariel Levy**
Private Practice
NYC Area

**Iris Lo**
TBA
TBA

**Michael Moshenayov**
Oral Surgery Internship
Long Island Jewish Hospital

**Ari Mosheyev**
Private Practice
NYC Area

**Mari Murakami**
Private Practice
Oklahoma

**Joseph Nam**
TBA
New York

**Lisa Nam**
TBA
New York

**Alexis Otero**
Private Practice
Miami, Florida

**Suvidha Polu**
Private Practice
DC Metro Area

**Renee Rosenberg**
Residency in Pediatric Dentistry
Maimonides Medical Center

**Nicholas Ruhrkraut**
Private Practice
Los Angeles, California

**Blair Schlusselberg**
Private Practice
NYC Area

**Albert Soulema**
Private Practice
LA Area

**Michael Suh**
TBA
California

**Elisha Taavar**
Private Practice
NYC Area

**Edmund Wu**
Chief Resident
St. Barnabas General Practice Residency

**Elie Weiss**
Residency in Orthodontics
Maimonides Medical Center

**Peri Weingarten**
TBA
New York

**Dana Zwiebel**
Private Practice
NYC Area

## Emergency Medicine

**Sarah Flanagan, DO**
Attending Physician
Jackson South Medical Center
Miami, Florida

**Matthew Friedman, DO**
Attending Physician
Northwell Health – North Shore
Manhasset, New York

**Christian Gianopoulos, DO**
Attending Physician
Broward Health Medical Center
Fort Lauderdale, Florida

**Katrina Hutton, DO**
Attending Physician
TBA

**Joseph Basil, DO**
Attending Physician
TBA

**Daniel Katzin, DO**
Attending Physician
Memorial West Hospital
Pembroke Pine, Florida

**Abraham Korn, DO**
Attending Physician
TBA

**Mikhail Leykin, DO**
Attending Physician
Adirondack Health
Saranec Lake, New York

**Endry Martinez, DO**
Attending Physician
Seirra East Medical Center
El Paso, Texas

**Alan Mashraghi, DO**
Attending Physician
Broward Health Medical Center
Fort Lauderdale, Florida

**Cynthia Sanchez, DO**
Attending Physician
Broward Health Medical Center
Fort Lauderdale, Florida

**Christopher Scavelli, DO**
Attending Physician
NYU Winthrop University
Mineola, New York

**Joseph Sedlock, DO**
Attending Physician
Valley Hospital
Ridgewood, New Jersey

**Angela Vohs, DO**
Attending Physician
Envision Physician Services
Centerpoint Medical Center
Independence, Missouri

**Henry Workman, DO**
Attending Physician
TBA

**Justin Yuen, DO**
Attending Physician
TBA

**Christina Hajicharalambous, DO**
Attending Physician
Mt. Sinai Medical Center, New York

## Pediatrics

**Lizette Antig, MD**
Private Practice
Seattle, Washington

**Karen Castro, MD**
Junior Chief Faculty Resident
St. Barnabas Hospital
Bronx, New York

**Deidre Chang, MD**
Pediatric Critical Care Medicine Fellowship
Nicklaus Children's Hospital
Miami, Florida

**Ruben Colman, MD**
Pediatric Gastroenterology Fellowship
Cincinnati Children's Hospital MC
Cincinnati, Ohio

**Luis Rivera, MD**
Neotatal-Perinatal Medicine Fellowship
Loma Linda University
California

**Chirlyn Urena, MD**
Private Practice
Orlando, Florida





## Internal Medicine

**Ekta Aneja**
Hospitalist
Olathe Medical Center
Olathe, Kansas

**Fabio Berrera**
Hospitalist
Binghamton Lourdes Hospital
Binghamton, New York

**Cristian Carbuccia**
Primary Care
Southern Regional Medical Center
Atlanta, Georgia

**Maria Malena Cardozo**
Hospitalist
West Florida Hospital
Pensacola, Florida

**Beatriz Garciaprieto Carmona**
Primary Care
TBD

**Jennifer De la Rosa**
Hospitalist
Leesburg Regional Medical Center
Leesburg, Florida

**Patricia Eugenia Flores Dominguez**
Hospitalist
TBD

**Ivan Dominguez**
Private Practice
Miami Metropolitan Area

**Ankit Dwivedi**
Hospitalist
Miami Valley Hospital
Dayton, Ohio

**Ahmed Ebraheem**
Hospitalist
Springfield Medical Center
Springfield Ohio

**Sandra Rodriguez Fernandez**
Primary Care
DaVita Medical Group
Brandon, Florida

**Liliya Gandrabur**
Rheumatology Fellowship
Westchester Medical Center
Valhalla, New York

**Octavio Chavez Herbas**

**Sarah Flanagan, DO**
Attending Physician
Jackson South Medical Center
Miami, Florida

**Matthew Friedman, DO**
Attending Physician
Northwell Health – North Shore
Manhasset, New York

**Christian Gianopoulos, DO**
Attending Physician
Broward Health Medical Center
Fort Lauderdale, Florida

**Katrina Hutton, DO**
Attending Physician
TBA

**Joseph Basil, DO**
Attending Physician
TBA

**Daniel Katzin, DO**
Attending Physician
Memorial West Hospital
Pembroke Pine, Florida

**Abraham Korn, DO**
Attending Physician
TBA

**Mikhail Leykin, DO**
Attending Physician
Adirondack Health
Saranec Lake, New York

**Endry Martinez, DO**
Attending Physician
Seirra East Medical Center
El Paso, Texas

**Alan Mashraghi, DO**
Attending Physician
Broward Health Medical Center
Fort Lauderdale, Florida

**Cynthia Sanchez, DO**
Attending Physician
Broward Health Medical Center
Fort Lauderdale, Florida

**Christopher Scavelli, DO**
Attending Physician
NYU Winthrop University
Mineola, New York

**Joseph Sedlock, DO**
Attending Physician
Valley Hospital
Ridgewood, New Jersey

**Angela Vohs, DO**
Attending Physician
Envision Physician Services
Centerpoint Medical Center
Independence, Missouri

**Henry Workman, DO**
Attending Physician
TBA

**Justin Yuen, DO**
Attending Physician
TBA

**Christina Hajicharalambous, DO**
Simulation Education Fellowship
Mt. Sinai Medical Center, New York
TBD

**Likitha Kanuganti**
Primary Care
St. Barnabas Hospital
Bronx, New York

**Venkata Sandeep Koripalli**
Hospitalist
CHI Health - Creighton University
Omaha, Nebraska

**Laura Leyton**
Hospitalist
TBD

**Pamela Lobo**
Primary Care
TBD
California

**Dana Manuel**
TBD
TBD

**Alfonso Moreno**
Hospitalist
Florida Hospital
Orlando, Florida

**Bharat Mitra Meenavalli**
TBD
TBD

**Fendy Jn Pierre**
Hospitalist
Christiana Hospital
Newark, Delaware

**Losty Tatiana Torres Potter**
Endocrinology Fellowship
University of South Florida (USF)
Tampa, Florida

**Libardo Rueda Prada**
Hospitalist
Mayo Clinic Health System
Eau Claire, Wisconsin

**Nancy Gutierrez Rivera**
Primary Care
Adventist Health
California

**Katerina Rusin**
Primary Care
Bartow Regional Medical Center
Bartow, Florida

**Mounika Sankaramaddi**
Primary Care Physician
Geisinger Holy Spirit
Harrisburg, Pennsylvania

**Shorabh Sharma**
Chief Resident
St. Barnabas Hospital
Bronx, New York

**Evan Siau**
Chief Resident
St. Barnabas Hospital
Bronx, New York

**Juan Vera**
Hospitalist
Avera McKennan Hospital & University
Sioux Falls, South Dakota

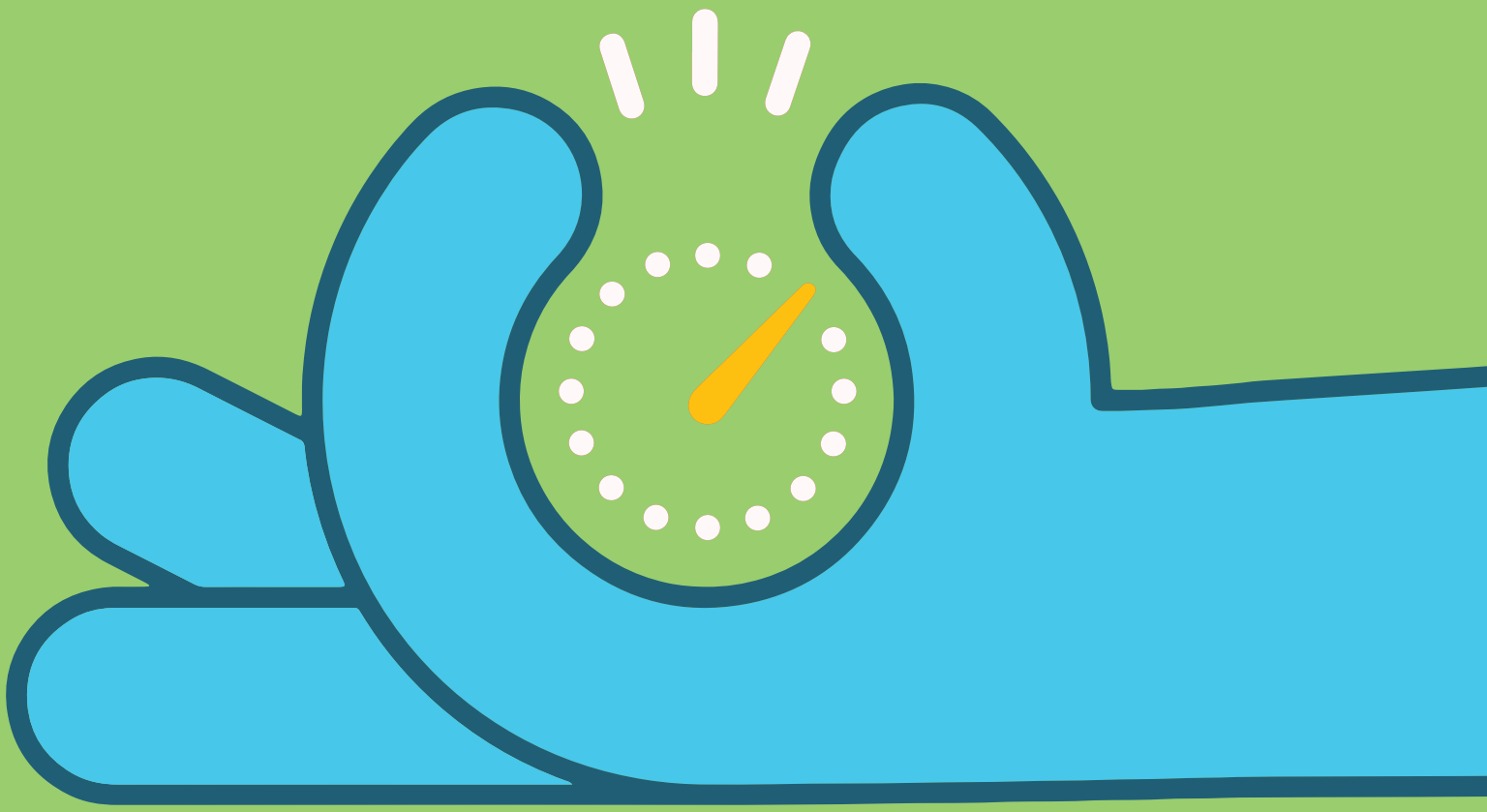
**Youqin Zhou**
Hospitalist
Wakefield-Melrose Hospital
Boston, Massachusetts

**Evgjeni Xhoxhi**
Hospitalist
St. Barnabas Hospital
Bronx, New York

SBH
Health System
BRONX

Affiliated with:
Albert Einstein College of Medicine
Sophie Davis School of Biomedical Education/CUNY School of Medicine
NYIT College of Osteopathic Medicine

Workplace
by facebook



# Want to become more involved in Workplace, but don't have the time?

## Schedule a one-on-one training by calling Marketing and Communications at 718-960-5090.

Claim your account today at sbhny.facebook.com