Dear Colleagues,

Welcome to our winter 2016 issue of the *SBH Physician*. We are proud to feature a cover story on our expanding plastic surgery services, with Dr. John Sherman and Dr. Amy Kells leading this initiative under the direction of Dr. Ridwan Shabsigh.

We are pleased to introduce new sections in this issue: *An Ethics Case Study* by Dr. Steven Reichert, *A Surgical Case Study* contributed by Dr. Leon Eisen, and a section titled “There’s Always Something New in the Bronx” that focuses on health concerns in our community. We hope to maintain these sections going forward and encourage you to consider participating in future issues.

Finally, we are incredibly proud of our official affiliation with the Sophie Davis School of Biomedical Education and the new CUNY School of Medicine, announced by Governor Cuomo in July. Given our expanding role in training young physicians, we will be devoting considerable space in this magazine to medical education at SBH. This issue highlights portions of the stirring keynote address delivered by Dr. Ed Telzak at the Sophie Davis White Coat Ceremony in September. Reading it will make you proud to be a member of the medical staff.

Sincerely,

David Perlstein, MD, MBA
Executive Vice President
Chief Medical Officer

Ernest Patti, DO, FACOEP
President, Medical Board
Director, Medical Media Affairs
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Plastic Surgery at SBH is in Good Hands

AMY F. KELLS, MD, MBA, PhD

MD, PhD
Vanderbilt University School of Medicine, Nashville, TN

Residencies
General Surgery, Case Western Reserve University, Cleveland, OH
Plastic Surgery, University of Texas Medical Branch Hospitals, Galveston, TX
Cardiothoracic Surgery, Cleveland Clinic Foundation, Cleveland, OH
Cardiothoracic Surgery, SUNY Downstate Medical Center, Brooklyn, NY

Fellowships
Microsurgery, USC Division of Plastic Surgery, Keck School of Medicine, Los Angeles, CA
Microsurgery, Division of Plastic Surgery, University of Mississippi Medical Center, Jackson, MS
Hand Surgery, Department of Plastic Surgery, New York University, New York, NY
Trauma/ Critical Care Shock Trauma, University of Maryland, Baltimore, MD

By Steven Clark

The word “superstar” frequently comes up in describing the surgical talents of Dr. Amy Kells, the hospital’s new chief of hand surgery. Fellowship-trained in both hand and plastic surgery, the MD/PhD graduate of the Vanderbilt University School of Medicine has, since arriving in July, become one of SBH’s busiest surgeons.

“She’s arguably the best hand surgeon in the tri-state area,” said Dr. Ridwan Shabsigh, the chairman of surgery, who recruited her from the Washington University School of Medicine in St. Louis. Already, Dr. Kells has played a key role in several of the hospital’s most complicated surgical cases (see page 6).

Her expertise is particularly important at a Level 1 trauma center like St. Barnabas, where hand-related injuries comprise one of the leading reasons for ER visits. Dr. Kells routinely treats hand problems due to any one of a number of different factors (degenerative, congenital, trauma, infections, industrial). This ranges from tendon and nerve injuries, to birth defects, to the severing of fingers. Recently, for the first time at SBH, she performed “free flap” microsurgery on an orthopedic patient.

In addition, Dr. Kells offers a resource to patients from throughout the metropolitan area who suffer more prosaic hand and wrist injuries – for example, due to repetitive wrist and hand injuries (from golfers to musicians).

She has been joined on the surgical team by Dr. John Sherman, one of Manhattan’s best known plastic surgeons.

With tongue firmly planted in cheek, Dr. John Sherman uses the Yiddish word “bashert” to describe the destiny that brought the plastic surgeon and SBH Health System together. Last May, Dr. Sherman was named division director of plastic, hand and reconstructive...
surgery at SBH Health System. A successful plastic surgeon with a large private practice on Manhattan’s Upper East Side, he has quickly jumped in by not only assembling a plastic surgery team that he describes as “first class,” but by reinvigorating the hospital’s plastic surgery fellowship program.

According to Bill Collins, administrator of surgery, it’s the community surrounding the hospital that stands to benefit the most from these recent moves.

“Patients fly in from around the world to Dr. Sherman’s private practice and SBH welcomes the opportunity to provide our patient community with his and Dr. Kells’ expertise,” says Collins. “In a short time, they have already made a huge difference.”

For Dr. Sherman, it’s a welcomed return to the Bronx, where years ago he completed his surgical residency training at Montefiore (prior to completing surgical fellowships at New York Hospital-Cornell Medical Center and Memorial Sloan-Kettering Cancer Center). “Once the Bronx is part of you, it’s always a part of you,” says Dr. Sherman. “Being back here is a very strange feeling. It’s like I never left.”

An attending surgeon at NewYork-Presbyterian Hospital and Lenox Hill Hospital, and an assistant clinical professor of surgery at Weill Cornell University Medical Center, he is consistently listed in Castle Connolly Top Doctors, New York Magazine Best Doctors, The New York Times Super Doctors and other publications as being among the top plastic surgeons in the nation. His students regularly cite him as one of the medical center’s best teachers.

In addition to his administrative duties at SBH—which have included adding Monday morning lectures and rotations at Montefiore for the hospital’s three plastic surgery fellows—Dr. Sherman performs head trauma/maxillofacial surgery (at times with oral and maxillofacial surgeon Dr. Allen Glied) and breast cancer reconstruction, and sees outpatients in the clinic.

One of his first additions to his team was Dr. Kells—who Dr. Sherman refers to as “a superstar who is incredibly qualified.”

The plastic surgery team sees patients following facial bone fractures and hand injuries due to motor vehicle accidents, assaults and, as was heavily reported in the national media recently, pit bull attacks. These are all injuries that previously, in many cases, could not be adequately treated at the hospital. The plan also calls for shortly offering aesthetic procedures to what Dr. Sherman calls “a very cosmetic-oriented community,” at fair and reasonable fees.

He says the nice thing about working at SBH is that “there are no barriers. The doors are always open here. It’s very much a person-to-person institution, not a place where everyone has a specific niche.”

When he’s run into a problem, he said he’s found Dr. Scott Cooper, President/CEO; Dr. David Perlstein, the Chief Medical Officer (who Dr. Sherman once taught as a resident); and Dr. Shabsigh to be very responsive. In fact, it’s reached the point, he says, that he’s now starting to get calls from other specialists who are interested in coming to the Bronx.

“We’re bringing state-of-the-art care to the community, where before we would send in an ambulance and ship the patient somewhere else,” he says. “In plastic surgery, you can now quickly deliver care at a community hospital that was previously only available at major medical centers. That’s what we’re starting to do here. The bar should be set at a certain level whether it’s here in the south Bronx or on the Upper East Side.”

JOHN E. SHERMAN, MD
Division Director, Plastic, Hand & Reconstructive Surgery

MD
New York Medical College, NY

Residency
General Surgery, Montefiore Hospital and Medical Center, Albert Einstein College of Medicine, Bronx, NY

Surgical Fellowships
New York Hospital-Cornell Medical Center and Memorial Sloan-Kettering Cancer Center, New York, NY

Clinical Professor of Surgery
Weill Cornell University Medical College

President
NYS Chapter of the American College of Surgeons
As luck would have it, one early Saturday morning after a night of in-house trauma call, the victim of a motor vehicle accident was rushed into the SBH emergency department. Once I walked into the trauma bay, I knew my plans to tidy up loose ends and go home would have to be put on hold. The patient was a 21-year-old man who had the misfortune of driving too fast on the northern end of the FDR. The car, as a result, flew into the guard rail, a portion of which penetrated the driver side's compartment.

Upon arrival, he was in critical condition and required emergency resuscitation. He had suffered massive blood loss as a result of a severe left leg injury. Most of the leg including the tibia and fibula was severed, leaving only the posterior skin and muscle attached. The leg was pulseless and ice cold.

Due to the nature of his injury, the EMS team had planned to take him to Bellevue which has New York City’s only limb re-implantation program. However, the injured driver insisted on being taken to SBH which is where he receives medical care in the clinics. A CT scan was performed to ensure no other life-threatening injuries and to help determine a plan for treatment. (see fig 1,2) The patient was then taken to the operating room for emergency surgery.

As the leader of the surgical team, I was faced with the dilemma of whether to attempt to save the leg or perform an above knee amputation. Most trauma surgery is about damage control. Stabilize the patient and get him out of the operating room as quickly as possible. Every additional time spent in the OR with a sick patient could jeopardize his overall survival. As a vascular surgeon I have performed countless revascularizations for acute ischemia. This situation was unique due to the severity of his soft tissue and skeletal injuries, combined with prolonged shock. All these factors diminished the chance for a successful vascular reconstruction so I did not want to subject him to a prolonged surgery that would ultimately prove futile. However, in conjunction with the anesthesia and orthopedic teams, a decision was made to proceed with limb salvage. Given that this was a young, otherwise healthy adult, the anesthesia team felt they could keep him stable during what would most certainly be a lengthy operation.

The first portion of the surgery was to expose the damaged vessels and control any ongoing bleeding. The adjacent tibial nerve was noted to be bruised, but intact. Preparations for performing a bypass were made. Healthy arteries above and below the zone of injury were identified and isolated. A sufficient length of saphenous vein, which would be used as our bypass graft, was exposed.

Prior to performing the bypass, it was necessary to have the orthopedics team expeditiously stabilize the fractures using external fixation so the leg could extend out to full length. The saphenous vein was then harvested and used to bypass from the below knee popliteal artery to the posterior tibial artery. Approximately five hours after arriving in the OR, blood flow was finally restored to the lower leg. The leg immediately went from white to pink. As expected, there was also new bleeding from the injured tissues now that blood was once again flowing. Throughout the course of his surgery, the patient received 20 units of blood from the anesthesia team, which worked diligently to maintain his blood pressure and keep him stable. The wound edges were re-approximated wherever possible, but a large defect remained overlying the fractured bone.

Upon completion of the surgery he was taken to the ICU for further resuscitation and monitoring by the trauma and ICU
teams. Over the course of the next several days, his condition stabilized and the leg remained viable. Even more encouraging was his ability to move and feel his toes. It became apparent, however, that keeping the leg would depend on being able to cover this area of exposed bone. Over the next several weeks, plastic surgery under the direction of Dr. Amy Kells led the effort in this phase of trying to save the leg. Throughout the next month, he returned to the OR several times a week for wound irrigations and further attempts to bridge the gaps exposing the bone. However, as time went on, it became apparent that a more radical procedure would be needed.

The decision was made to take the patient to the OR in order to perform a rectus muscle free tissue graft. The healthy muscle would be grafted to the lower leg in order to provide coverage over the exposed bone. The muscle was harvested, with care taken to preserve its critical blood supply. It then had to be connected to an artery and vein near the injured leg. Since the lower leg vessels were not available due to his extensive injury, an artery and vein circuit had to be created which could then be plugged into the muscle flap.

We harvested a portion of saphenous vein from the right leg. The vein was connected to his popliteal artery and vein above the knee creating a new inflow and outflow vessel for which to plug in the vessels from the flap. This vein loop was then placed near the area of the wound. Dr. Kells performed a highly challenging microvascular anastomosis connecting both the tiny artery and vein from the flap to its new blood supply. The success of the entire operation rested on precise placement of sutures finer than a human hair.

This task was made easier by SBH’s recent acquisition of a new state-of-the-art Leica surgical microscope. A small doppler wire was left on the vein in order to continuously monitor the flow. Once the clamps were released, a strong doppler signal could be heard confirming excellent blood flow to the muscle flap. The muscle was secured to the tissues surrounding the exposed bone providing well vascularized tissue, which would allow the bone to heal. The blood flow to the flap remained strong and the patient returned to the OR several days later for skin grafting of the flap.

He remained in the hospital for a few more weeks and was discharged to a rehab facility to continue his daily physical therapy sessions. He obviously still has a long road ahead before he is able to walk on his reconstructed leg. Given the magnitude of his injury, however, it’s quite an accomplishment that he did not end up with an above-the-knee amputation. And, with each passing day, the chance of being able to walk is closer to reality. Not just Dr. Kells or I, but the entire SBH community should be proud of the successful outcome in this very challenging case. Results like this require the expertise of a multitude of dedicated physicians, surgical residents, nurses, and support staff, as well as a supportive administration committed to developing a strong surgical department.
A New Era in Care Delivery

Given the rapidly changing landscape in healthcare, with a major focus on the “Triple Aim” of improving overall population health, improving the patient experience, and decreasing the cost of care, healthcare organizations throughout the country are being challenged to change the way patient care is both being provided and measured in terms of value. As we shift away from the “traditional” fee-for-service model towards value-based reimbursement; dynamic legislative reform, spurred nationally by passage of the Affordable Care Act of 2010, and more locally by the NYS Delivery System Reform Incentive Payment program (DSRIP); and an increasing regulatory push towards quality-based transparency overall, the ability to provide integrated care, coordinated across both inpatient and outpatient settings, with special emphasis on access to primary care services and support for chronic disease management, is becomingly increasingly critical in nature. This transformation is a major shift from what much of the healthcare world is used to, and will require both a change in culture, as well as infrastructure, to best understand and foster progress towards the fulfillment of these new mandates and expectations.

In many ways, this transformational change in healthcare delivery is reflective of my own circular journey through the healthcare world over the last 18 years. Having practiced in the ambulatory setting for close to seven years, before developing a division of hospital medicine which grew to encompass over 40 inpatient providers and close to 18,000 inpatient visits per year, I experienced a major shift from what much of the healthcare world is used to, and will require both a change in culture, as well as infrastructure, to best understand and foster progress towards the fulfillment of these new mandates and expectations.

With these challenges and priorities in mind, our vision and development plan is clearly a long-term one, but there are many building blocks in place. We are extremely fortunate to have a dedicated group of faculty hospitalists and ambulatory internists, growing infrastructural support and opportunity for collaboration with Bronx Partners for Healthy Communities within the DSRIP program, strong academic partners in both the Albert Einstein College of Medicine and newly established CUNY School of Medicine, and an institutional commitment to population health management and perpetual service to our community. While the years ahead will certainly be dynamic, I am looking forward with great anticipation to our journey ahead, and have every expectation that we will continue to be a positive force in improving the lives and health of our patients and community together.
When it comes to reducing 30-day hospital readmissions, it’s no longer a matter of hospital “bragging rights,” but one of financial necessity.

As a result of the Hospital Readmissions Reduction Program (HRRP) established by the Affordable Care Act, hospitals now face financial penalties from Medicare for their failure to reduce 30-day patient readmissions occurring after initial hospitalizations for heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), and elective hip or knee replacement.

According to results published earlier this year by the Centers for Medicare & Medicaid Services (CMS), 140 hospitals in New York State were penalized, with an average penalty of 0.75 percent (with some as high as 2.5 percent). At a time when virtually all of the state’s urban hospitals faced higher-than-average penalties, SBH Health System, along with a handful of suburban and rural hospitals, had among the state’s lowest penalty rates (0.19 percent).

This improvement has not happened by chance. Since 2011, the hospital has experienced an across-the-board reduction of more than 14 percent in its 30-day patient readmission rate. “This has been a priority not only for our Medicare patients, but with all our patients,” says Dr. Manisha Kulshreshtha, SBH’s medical director, care transitions and physician practice. “A good part of this effort comes down to doing a better job communicating among ourselves and educating our patients.”

The campaign to reduce hospitalization readmission rates began by breaking down the process from patient admission to discharge and forming a readmission committee (comprised of a diverse group of providers). Closer attention was paid to patients’ medication, with a clinical pharmacist assigned to a high risk patient floor and the hospital offering medication options and/or assisting patients with the cost of their meds when necessary.

According to Rachel Sussman, the clinical pharmacist assigned, “Having a clinical pharmacist on the medical units assists in high risk patient education and in resolving medication access issues, which is a significant barrier to their care.” Additionally, Dr. Kulshreshtha credits these hospital-wide changes for the dramatic turnaround:

- **Introduction of “white boards” used in daily meetings with as many as 15 to 20 clinicians.** “We discuss each patient, with a discharge plan developed at the time the patient is admitted,” says Dr. Kulshreshtha. “The white board is color-coded so clinicians know when patients are being discharged, whether they have been readmitted (which means they are at renewed risk), and their care moving forward. It’s made for far better communications.”

- **Enhancement of Electronic Medical Records.** Made possible through a grant, the improved EMR system has enabled the hospital to focus on such things as creating alerts for 30-day readmissions and high-risk medications, and doing a better job of transmitting clinical discharge summaries to primary physicians and other providers.

- **Improved patient and caregiver education at the patient’s bedside.** This has included a “rounding” process whereby providers educate high-risk patients, including those with congestive heart failure and diabetes and their caregivers, in order to better prepare them for discharge. This has included, for example, “teach back” sessions where nurses have patients tell them what they will need to do following discharge. All exit materials for patients are now prepared in both English and Spanish, with the hospital making additional provisions for communicating to patients originally from such areas as West Africa and Albania.

- **Collaboration with a large private physician practice in making “house calls.”** It is estimated that as many as 25 patients, for the most part elderly and chronically ill, are seen monthly through a collaborative program with Essen Medical Associates. The program facilitates the transition of patients most at risk for re-admission back into the community and consists of regular telephonic follow-up and at-home physician visits for up to 30 days following hospital discharge. Since the partnership’s inception in 2013, EssenMed House Calls has cared for over 2,400 SBH patients.

“Working with high-risk patients, many of whom are not always compliant, can be very challenging,” says Dr. Kulshreshtha. “But not only do our numbers (in terms of 30-day hospital readmissions) continue to trend down, which obviously is important in light of the financial incentives, but we feel that we’ve improved the overall quality of our care.”

Dr. Manisha Kulshreshtha
The SBH OB/GYN department has been selected to participate in a new program called QINCA (Quality Improvement Network for Contraceptive Access). The program is headed by the DOH and involves 10 hospitals across the city with a goal to help decrease the rate of unintended pregnancies.

One of our first steps to address this challenge will be with the use of immediate postpartum placement of an IUD or implant. These LARCs are traditionally placed in the office after the six-week postpartum visit. Evidence shows that placement in the immediate postpartum period is both effective for contraception as well as cost effective, allowing patients to leave the hospital with a form of contraceptive already in place.

Not only is placement of LARCs a much-needed resource, but they are also greatly desired. Patients at SBH have already requested such treatment, but have been deferred to their six-week follow-up visit, as the program is not yet in place. In an era of low follow-up and compliance rates, both the patient and the provider stand to reap significant benefits from this program. Patients will be reassured knowing they will not have an unintended pregnancy, while providers will have the peace of mind knowing their patients are leaving the hospital with a safe and long-term form of contraception.

The implementation of this new standard will be a seamless process, as it does not disrupt the current postpartum routine. In fact, considerable time will be saved by placing the LARC while the patient is already enduring a multi-day hospital stay, as opposed to taking up valuable outpatient clinic time. The IUD may be placed intra-operatively during a C-section delivery and immediately postpartum following a vaginal delivery. The implant may easily be placed any time during the patient’s postpartum recovery period. As intermittent bleeding is to be expected in both a postpartum patient and a patient with a newly inserted LARC, the side effect profile and patient discomfort is greatly minimized. Both IUDs and implants are equally as effective as tubal ligation. The efficacy rate is approximately 99% due to the fact that patient reliability does not play a role. These methods are therefore ideal for high risk and low-income patient populations and should be discussed as a valid option with every pregnant patient.

The major disadvantage is an increased expulsion rate when an IUD is placed in an immediately postpartum patient versus waiting for the six-week follow-up visit. Most patients notice right away after an IUD has been expelled and either a new device may be placed or a different method of contraception chosen at this time. This is not dangerous or a cause for concern, but patients should be warned of this potential complication. The increased expulsion rate is not a contraindication and the benefits continue to outweigh the risks. The complications of unintended pregnancies are far more serious than those of an expelled IUD, especially when most unintended pregnancies have been noted to end in an induced abortion.

This project is certain to make great strides in increasing patient safety and contraceptive access to all methods, and decreasing unwanted pregnancy rates. The OB/GYN community is honored to be chosen to partake in this initiative and invites questions and involvement from other departments.

SOPHIA LUBIN, DO

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Some members of the SBH QINCA team: Ann Hennessy, RN, Director, Maternal and Child Health; Sophia Lubin, DO, OB/GYN; Christine Rapasarda-Giga, RN, OB Safety Nurse Coordinator.
Gary Kaiser, PhD, the new director of the radiology department at SBH Health System, has an ambitious goal.

“We want to be the best department in the hospital and eventually one of the best radiology departments in the country, the kind of department that other hospitals seek to emulate,” he says.

Since arriving in mid-August, Dr. Kaiser has wasted little time in making changes within the 85-person department. This began with the objective of eliminating those roadblocks that previously created problems in scheduling outpatients. Changes have included adding additional time slots (with appointments now starting at 7am and ending at 7pm), increasing the availability of certain technologies (such as the PET-CT, which was only offered twice a week and is now used every day) and offering cross training to techs on equipment like the bone density scanners (which, as a result, can now be taken advantage by women at the same time they have a mammogram). Registration has been moved downstairs to the lobby to alleviate wait times and enable registrars to get additional help. A round of customer service training has helped improve the department’s patient facing skills, says Dr. Kaiser, with quality assurance programs recently implemented for all techs.

“We’ve put out survey boxes for patients, started having walkthroughs and doing self-monitoring,” says Dr. Kaiser, who has more than 30 years of experience in the industry. “There are now peer reviews and scorecards and we’re measuring all metrics. Our goal is to have all our techs (achieve scores) at 95 percent. We’ve put a priority on transparency and open communications. We do email blasts and monthly staff meetings. We want everyone to know the plan so we can achieve it. We’re empowering staff, and they’re buying into this.”

His team is investigating new technologies and opening a dialogue with hospital physicians to gain their input. This includes looking at the feasibility of a range of different technologies, including high field open and wide bore MRIs for claustrophobic and large patients, and digital tomosynthesis for 3D mammogram studies. Dr. Kaiser has tasked his managers and supervisors in such areas as MRI, women’s services (e.g., ultrasound, mammography) and interventional radiology to research new technologies in their areas of specialization.

Much of this is being done in anticipation of the new outpatient imaging and women’s health centers that are being planned as part of the Third Avenue development. The new facility is expected to open in 2017.

As part of this overall effort, Dr. Kaiser’s message to physicians is a simple one: “Let me know what we’re not doing right so we can fix it,” he says. “We’re inviting criticism. We won’t know what we’re doing wrong unless people tell us.”
Transforming Ambulatory Care

By Irene Borgen, RN, MSN, MBA, FACHE, Vice President, Ambulatory Care Innovation and Transformation

The healthcare delivery system is changing from the well-known fee-for-service model to much more complex value- and outcomes-based risk sharing delivery models. Recognizing these extensive developments occurring in our healthcare system, proactive and nimble healthcare organizations are rapidly changing to match new service models.

Goals
SBH has been at the forefront of these changes and I am excited and fortunate to have joined a winning team that is committed to achieve the transformation for SBH. Building on the strength and accomplishments of our organization, our goals are to continue the move in the direction of further clinical integration, population health management, breaking silos in care delivery, and removing barriers to providing the highest quality of care while promoting wellness and prevention.

Healthy Community
Under new care models our focus is on our entire community and its health. Our goal is to prevent our healthy patients from developing diseases through wellness and prevention, while for our patients with existing chronic conditions we aim to prevent further deterioration and provide high quality treatment at the appropriate setting while reducing healthcare costs.

Patient-Centered Medical Home
To support these goals we are working on moving our PCMH (Patient-Centered Medical Home)-accredited primary care practices to continue with their PCMH designation, now based on new and expanded 2014 NCQA standards. Through the PCMH model, we seek to continue improving the quality, effectiveness, and efficiency of the care we deliver to our patients while responding to each patient's unique needs and preferences. Moreover, we aim to expand our efforts further from managing each patient at a time to effectively and proactively managing our entire patient population.

DSRIP
One of the more prominent projects SBH has undertaken as part of our system-wide transformation is the statewide DSRIP (Delivery System Reform Incentive Payment) project. DSRIP is a state-wide initiative focused on fundamentally restructuring the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over five years. NYSDOH has allocated significant funds to support DSRIP with payouts to SBH and our DSRIP partners based upon achieving predefined results in system transformation, clinical management and population health. In my role as the VP of Ambulatory Care Transformation and Innovation, I work closely with our teams to coordinate, monitor progress and ensure success of DSRIP projects at SBH. I also serve as the liaison between SBH and the CSO (Central Service Organization).

Looking Ahead
The next five years will be the years of transformation, clinical improvements and population health management. We believe that SBH, a leader in healthcare delivery in the Bronx, is prepared and ready for the challenge.
THE NEW PSYCHIATRY RESIDENCY PROGRAM at SBH:
What Will it Offer to Its Trainees, the Institution and the Bronx Community?
By Lizica Troneci, MD, Chair, Department of Psychiatry

“We need you more than ever. And quite frankly, we need more of you than exists today.”
–Vice-President Joe Biden addressing the American Psychiatric Association’s (APA) 2014 Annual Meeting

In a time of expansion and increased awareness of mental health needs, the shortage of psychiatrists deepens. Statistics help verify a harsh reality. According to the American Medical Association (AMA) 2014 Physician Specialty Data book:
• There were 37,296 active psychiatrists in 2014
• Considering the US population, 8,476 number of people/active psychiatrists in 2014
• - 4.0% decrease in the number of active psychiatrists (2008-2013) from 38,857 to 37,296

While in Graduate Medical Education (GME):
• There were 1,461 first-year psychiatry residents in 2013
• There was only a 1.2% increase in the number of first-year psychiatry residents (2008-2013) from 1,444 to 1,461

Reducing the Shortage
What helps this shortage? One of the solutions is creating more postgraduate (PG) residency positions and/or accrediting new psychiatry residency programs. A review of the Accreditation Council for Graduate Medical Education (ACGME) revealed an increase in the total number of psychiatry residency programs from 193 for the academic year 2014-2015 to 196 for 2015-2016.

In August 2015, SBH, as a sponsoring institution, received ACGME accreditation for a new psychiatry program and began recruitment for the next academic year 2016-2017. The program will have four residents a year for four years.

Training Community–Based Psychiatrists
One important goal of the new residency program is to train community-based psychiatrists who have the skills to work in an integrated fashion with primary care providers.

On an institutional level, the psychiatry residents will join a rich academic environment which includes residents in other specialties, psychology externs, medical students and mid-level practitioners’ trainees. They will have the opportunity to join interdepartmental grand rounds and case conferences and to work collaboratively with the department’s psychology externs in providing psychological testing and evaluations to the psychiatric patients. The department’s expanding faculty will provide a vast and varied experience and expertise in general adult psychiatry, and subspecialties such as child and adolescent, addiction, forensic psychiatry and psychosomatic medicine. The psychotherapy training will be rendered by the division of psychology.

From a community perspective, they will evaluate and treat a multi-culturally diverse patient population with medical comorbidities and psychosocial stressors (homelessness, unemployment, criminal or legal involvement, etc.). The rapid and ample changes in the healthcare system will provide an environment of inquiry and expansion on the delivery of mental health services.

Candidates for the new SBH Psychiatry residency touring the campus with the department’s administrative manager Nancy Hebrank.

Dr. Lizica Troneci

Collaborative Care
Collaborative care is mental health care in primary care settings. Psychiatric and other specialty residency programs will need to train residents in providing team-based care and serve the most vulnerable in the SBH community-based settings. Residents will learn to use care managers, community workers, and patient peers to deliver team care in the outpatient settings.

In addition to their clinical and educational activities, the residents will be mentored and supported in joining departmental or interdepartmental research projects. I trust you will all welcome and guide our new residents in their journey of discovery, learning and working at SBH, in such a collegial, warm and pleasant environment.
New Faces in the Department of Psychiatry

Vivian Gutierrez, MD

Imram Jamil, MD

Maria Belen Martinez, PsyD

Andrew O’Hagan, MD

Keeping Our Own

“We all grew up here and you can’t overestimate the importance of knowing the history and the culture.”

—Eric Appelbaum, DO, Associate Medical Director, Ambulatory Care

By Steven Clark

Nearly two decades ago, they toiled as overworked, underappreciated residents. Today, they comprise the hospital’s medical staff leadership.

Dr. Eric Appelbaum, associate medical director, ambulatory care; Dr. Manisha Kulshreshtha, medical director, care transitions and physician practice; Dr. Jitendra Barmecha, senior vice president and chief information officer; and Dr. Daniel Lombardi, patient safety officer and director of the emergency medicine residency program all graduated from St. Barnabas Hospital’s residency programs in the mid-1990s.

Add senior physicians like Dr. Ernest Patti, emergency medicine; Dr. Abdurhman Ahmed, nephrology; and Dr. Christopher Grantham, critical care, and younger divisional directors like Dr. Daniel Erichsen, director, sleep medicine; Dr. Sheryl Kho, director, division of developmental behavioral pediatrics; Dr. Mark Curato, director of emergency medical services; and Dr. Scott Leuchten, associate director of emergency medical residency program, and you begin to see a pattern – St. Barnabas Hospital likes to keep its own.

Dr. Eric Appelbaum, Associate Medical Director, first came to St. Barnabas as a medical student in the early 1990s.
Some took other jobs or did fellowship training, before returning. Others never left.

“We all grew up here and you can’t overestimate the importance of knowing the history and the culture,” says Dr. Appelbaum, who completed his five-year emergency medicine residency in 1997. “There is always a debate whether it’s good or bad to recruit people who did their residency here. There are those who say ‘I want new blood.’ But, in the end, the culture we instill in people you can’t always find on the outside and that’s worth a lot.”

According to Dr. Appelbaum, the hospital’s internal recruitment efforts, after several fallow years, have prospered. A new push has enabled it to harvest talent from its “farm system” and, like the crosstown Yankees, helped create its own crop of future Derek Jeters, Mariana Riveras, Andy Pettitites, and Jorge Posadas.

A New Effort
This campaign begins with identifying and planting the seeds in the heads of promising residents as early as their second year. We, we try to get them more involved in hospital-wide committees, and expose them to administrators, senior management, and other physicians. We show them there are other opportunities here that can expand their careers and interests. They learn that if they don’t want to, for example, sit in the ER for the next 20 years, they won’t have to.

Yet, he admits, it can be challenging as many residents are no longer hesitant to explore other parts of the country where salaries are often higher and the cost of living lower.

This is particularly relevant with international residents, who often have no family or allegiance to the New York metropolitan area and think nothing of packing their bags and moving, after graduation, to, say, Georgia or Ohio, or rural New Jersey.

Dr. Kulshreshtha understands this, having started her internal residency at St. Barnabas Hospital at the same time as Dr. Appelbaum. Living as a child in different parts of the world – her father worked for the United Nations – she arrived in the Bronx after graduating medical school in India.

Younger physicians say they choose to stay – or return to St. Barnabas – because both the environment and the opportunities are too great to pass up. Four internal medicine residents from the most recent graduating class now work as attendings at the hospital, two as hospitalists, two in outpatient clinics.

Dr. Erichsen left after he completed his pediatric residency in 2012 to do a fellowship in sleep medicine at the University of Chicago. The opportunity to head the hospital’s new sleep center convinced him to return.

“The hospital was a good environment to practice and that people here are generally friendly and happy,” he says.

Dr. Kho grew up and attended medical school in the Philippines. After completing her pediatric residency at St. Barnabas Hospital, Dr. Kho left for Rhode Island Hospital, the main teaching hospital at Brown University. Here, she did a three-year fellowship in childhood behavior and development. She said she chose to

“Our salaries are now competitive among hospitals in the New York metropolitan area and if we see a great resident, especially one who has roots in the area (and so is more likely to stay), we make a real effort,” says Dr. Appelbaum. “When we find someone we like, we try to get them more involved in

She says that what clinched her decision to stay at St. Barnabas was becoming chief medical resident. Additionally, the hospital has always made it easy for her and other international medical graduates to extend their student visas once they complete their residencies. As importantly, she was also drawn to the camaraderie.

“What’s great here is the family feeling. It’s very inviting here,” she says. “Soon after I came here, it felt like home.”

Today, internal medicine residents will often discuss their career opportunities with her. “They want to know where they should go,” she says. “Those who like New York City stay here. I have friends who went to other parts of the country and said they felt different there. Here, they’re not discriminated against. They’re part of the culture.”

“I always felt the hospital was a good environment to practice and that people here are generally friendly and happy,” he says.

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Dr. Scott Leuchten

Dr. Mark Curato

Dr. Jitendra Barmecha

Dr. Daniel Lombardi

return to the Bronx in 2013 for three reasons: she considered the hospital “as my family,” she wanted to give back to the residency program, and she felt the need to help the area’s underserved community.

Dr. Leuchten said the idea of working in an academic capacity was first raised to him by Dr. Appelbaum during his fourth year of residency.

“He said, ‘why don’t you think about staying here and helping out future residents?’” Dr. Leuchten recalls. “I liked the atmosphere, the sense of community and family here, but I also saw I would have the chance to pursue my goals. It was not a difficult sell.”

Dr. Curato, who served as chief resident, was not interested in staying as an attending.

“To my mind, despite feeling confident that I received outstanding training, I had to see for myself that it was transferable. I wanted to work in an environment where I was all alone and reliant solely on my own knowledge and skills,” he says.

He took a job with a democratic emergency medicine group that had contracts with 20 or so emergency departments in mostly suburban and rural community hospitals in New York and New Jersey. Working at times as the only physician in the entire building except for a single internist covering the nursing floors, he felt it was an important growth period for him.

“A number of facts coalesced in just the right way and resulted in my coming back to St. Barnabas,” he says. “Just after I left, Dr. (Daniel) Murphy, whom I had never met, began as chairman of the Emergency Department and a number of positive changes were set into motion. At about the same time, a full-time faculty position opened up at St. Barnabas with the added role of Director of EMS. This was a great fit because I had a long background in EMS and in teaching paramedic science in community college.”

Sharing a History

According to Dr. Appelbaum, you can’t underestimate the importance of sharing a history and a culture with colleagues. He remembers when he first started working in the ED with the department’s director Dr. Ted Spevack and Dr. Patti, a freshly minted attending and now medical staff president, and was drilled on the simplest of things, like how to answer the telephone.

“You don’t just say ‘ED.’ You need to say ‘St. Barnabas Hospital emergency department, Dr. Appelbaum speaking. How may I help you?’” When I call up and a resident doesn’t answer it the right way, I say ‘Are you a visitor or a guest? Do you work there? By the way you answer the phone, you never would have known.’”

Dr. Appelbaum says that working in the same hospital for over 20 years – doing rotations as a medical student, completing a residency, working as an ER doctor and then running the entire department before being promoted to his present position – is very special to him.

“When I first walked through here as a medical student,” he says. “Yesterday, I had a patient come in who I’ve known since 1997. And the nurse remembers both us from when we first showed up. A number of doctors here tell me they have experienced the same thing. That’s a real special feeling you don’t get at a lot of other places.”
Several years ago the City College of New York and the Sophie Davis School of Biomedical Education, looking to establish the CUNY School of Medicine, searched the greater New York metropolitan area for a hospital that would serve as its partner. Wanted was a freestanding, non-university-affiliated hospital that shared the same vision: to develop primary care physicians – family practitioners, internists, pediatricians, OB/gyns, and psychiatrists – who would serve the city’s underserved communities.

After holding talks with a number of potential mates, CUNY found a suitable match. In July, Governor Cuomo formally announced the establishment of the CUNY School of Medicine in partnership with SBH Health System. Through an expansion of what is now CCNY’s Sophie Davis School of Biomedical Education, the first class is scheduled to begin fall 2016.

Sophie Davis currently offers a seven-year BS/MD program that integrates an undergraduate education with the first two years of medical school, with students then having to transfer to one of five cooperating medical schools to complete their medical education and receive their MD degree. Since its founding in 1973, the school has recruited more underrepresented populations into medicine, increased medical services in underserved areas, and increased the availability of primary care physicians.

The Association of American Medical Colleges’ Center for Workforce Studies has estimated that by 2020 the United States will face a shortage of 45,000 primary care physicians. The shortage of African-American, Hispanic, and other underrepresented medical professionals in the inner city areas is particularly acute.

Since 2013, Sophie Davis’s upper level students have been doing rotations at St. Barnabas Hospital, and a small group of physicians at the hospital have worked as adjunct faculty at the school. Once the new medical school opens, 100 or so SBH physicians will hold adjunct professorships at the medical school and approximately 80 students will receive clinical clerkships annually at the hospital and its primary care medical sites throughout the Bronx, including Bronx Park and St. Barnabas Behavioral Health.

The hospital sees myriad benefits to the partnership. In addition to bringing into its institution “socially aware, mission-driven young men and women with a keen understanding of the patients they serve into our system” – both Sophie Davis medical students and, eventually, its graduates as residents – Dr. David Perlstein, Chief Medical Officer, sees the partnership as beneficial in helping it develop more robust research capabilities to study its patient population, grow its family practice, and gain greater access to funding from grants and donations that historically have gone to the city’s large medical centers.

“We’ve been very engaged in our relationship with Sophie Davis over the past two years and look forward to the future with great anticipation,” he says. “It’s a win-win for both of us.”
Like many of you, I am a first generation American. My mother was born in the former Czechoslovakia and my father in Lithuania. My parents were European Jews during the Second World War where they experienced unbearable hardships and lost many family members, including parents, brothers and sisters. They were victims of Nazi racism which took the form of virulent anti-Semitism. After the war, like some of the parents and family here, they needed a new country, a new homeland, and they never had the opportunity to complete a formal education or develop a profession.

I grew up in a working class neighborhood in the Bronx and returned to the Bronx to attend medical school. In effect, except for the period of time in college, and a roughly 12-year period of medical training and my first attending physician position, I have never left the Bronx.
While I was a first-year resident in internal medicine in Boston in the early 1980s, extremely ill young men were being admitted to the hospital with severe shortness of breath, fever, wasting syndromes and very unusual infections. Many of these young men, not much older than the students in this room, never left the hospital. This was the beginning of HIV and the AIDS epidemic. Early on, there was no known cause though there was a strong suspicion that it was spread from person to person. There was great stigma and discrimination towards these young gay men and great fear both in the public and even in the medical community.

The stigma associated with HIV only increased when intravenous drug users and their sex partners became infected. Perhaps paradoxically, it was the stigma and the marginalization of these populations that attracted me to care for people with this disease. After completing my residency I did a fellowship in infectious diseases, then spent time at the Centers for Disease Control and over 20 years establishing and nurturing an AIDS Program in the South Bronx.

What is the point of this? Well I will emphasize at least three:

Point #1: We are all greatly influenced by our family and most of us owe a great debt to our family for so many things, including our career choices and how we spend our work lives. I personally, and with pride, draw a straight line between parents who experienced great oppression, who raised me to believe in social justice, and who had a belief system anchored in their heritage – and my life caring for patients with HIV and AIDS in the South Bronx.

My advice: Think often of those who have helped you along your journey in becoming a physician and never stop showing and expressing your appreciation. They have made great sacrifices for you. And find strength in your own heritage, especially when times are difficult.

Point #2: One of the fathers of infectious diseases, Dr. Robert Petersdorf, famously predicted the end of infectious diseases as a medical specialty in the mid-1970s. In contrast to these predictions, I have spent my career caring for patients with an infectious disease that is now a worldwide pandemic. HIV and AIDS did not exist when I was a medical student. Prior to effective treatments which took about 15 years to develop, once someone had AIDS there was a 50% chance they would be dead within 18 months. Now, with more than 25 FDA approved drugs, there is every expectation that with proper treatment and adherence, patients with AIDS will lead a full life.

My advice: Be prepared for the unexpected. We do not know what the future holds for us, in life or in medicine. I have spent much of my career caring for patients who developed a disease that did not exist while I was in medical school. The first half was helping marginalized people die, the second half has been developing programs so they can live.

Continued page 30
This kind of thinking followed by Dr. Gerard Baltazar, a general, trauma and critical care surgeon who recently joined SBH Health System’s department of surgery. Dr. Baltazar regularly travels, on his own dollar, to developing countries to provide medical and surgical care. He’s been four times to Haiti since the devastating earthquake in 2010, and has done missions to the Philippines, Guatemala and Peru.

In addition to providing clinical care, he travels with another purpose in mind. “My goal is to leave lasting change in these countries. In Haiti, I help local medical students by getting them interested in doing scientific research and publishing,” says Dr. Baltazar. “I want to do more than just drop in and do operations.”

Earlier this month, he accomplished this by traveling to Chicago with Max Herby Derenoncourt as the Haitian medical student presented his scientific research at the American College of Surgeons’ (ACS) Annual Medical Student Program. It was the first time the ACS selected a Haitian medical student to present.

Derenoncourt’s research focuses on the ability to perform surgery in Haiti in the years after the earthquake. The results emphasize the benefits of long-term partnerships between local hospitals and international surgical volunteers. The article, which will be published in the World Journal of Surgery, was based on more than 3,000 handwritten medical charts reviewed by him and a classmate.

Derenoncourt explained that in light of his achievements, many of his classmates are eager to do research and are seeking opportunities to participate in academia, “Dr. Baltazar helped change the way my classmates think about being doctors,” he said.

This will be the third scientific manuscript Dr. Baltazar has written with a Haitian medical student.

As one of SBH Health System’s surgeons and a clinical instructor at what will become the new CUNY School of Medicine, which is a result of SBH Health System’s partnership with the Sophie Davis School of Biomedical Education, Dr. Baltazar trains medical students and the hospital’s 15 general surgery residents. He works to bring a scholarly culture to SBH, and hopes the hospital will soon offer a global experience as part of its residents’ training.

“A global surgical program in an institution like SBH would make residents aware of how many resources they have here and how much good we can do with them,” he says. “When you travel to a developing country and operate with no lights except for the lamp on your head, you realize that when you come back home and a machine is broken or a battery dies, it’s no big deal. Doing volunteer work makes you feel energized about medicine and making your stateside practice the best it can be.”
The NYMJ, an online medical journal launched in 2006, seeks to enhance resident medical education by allowing them the opportunity to initiate and complete a clinical research project. This includes developing a hypothesis and a data collection instrument, collecting and analyzing data, and ultimately presenting it to our community in a manuscript. It is our hope and expectation that this will enhance the education of all physicians and ultimately improve patient care. It is particularly important to create this opportunity for professionals working in community teaching hospitals.

To date, we have published 18 issues. We are proud of the diversity of cases and research that we have published. We particularly want to thank all of our reviewers who have spent time ensuring the high quality of our journal. Now, it is time to enhance the journal even more. A new section has been added highlighting findings on radiologic exams and we have plans to create a section on quality improvement projects with an emphasis on multi-disciplinary education. In addition, we are looking into a major facelift for the journal.

Please look at The NYMJ (there is a new link on the SBH wiki) and let me know your comments or requests. Consider submitting your case reports, clinical research and quality improvement projects. If you need any help, just email us.

**Resident Dr. Priyanka Makkar Honored as Employee of the Quarter**

We are proud to acknowledge excellence in our residents. Dr. Victoria Bengualid, director of the residency program in medicine, presented resident Dr. Priyanka Makkar with an SBH Employee of the Quarter award stating, “It is remarkable that during her first year I received two letters…praising her for her dedication to patient care. One is from a patient and the second is from a physician. Her professionalism toward patients and our staff as well as her enthusiasm serves as a role model for all of us.”
Successful ICD-10 Implementation!

With ICD-10 transition effective October 1, 2015, SBH Health System and its affiliates will be deploying the cutover strategies as the industry fully migrates to ICD-10. This transition may bring new context and challenges to existing and historically effective revenue cycle operations. The sheer number of additional codes (ICD-10-CM 68,000; ICD-10-PCS 87,000) makes the learning process complex, increases the scope for errors, and complicates the denial management process.

To meet this challenge, SBH Health System and its affiliates hit the ground running, strategically forming workgroups with respective ICD-10 project charters outlining goals and objectives to assure a smooth transition. Within these workgroups, ICD-10 project strategies addressed revenue mitigation, coding integrity productivity mitigation, clinical documentation improvement strategies, education & training, report remediation (mapping & translation), system remediation, internal/external, end-to-end testing, communication & awareness, and cutover.

Highlights of these efforts included:
- An enhanced clinical documentation improvement program
- Engaged physician champions
- Deployment of an effective communication and awareness strategy
- Deployment of an effective training strategy
  - 100% SBH physician completion of assigned training modules
  - 100% SBH non-physician completion of assigned training modules
- Tracking across 72 vendor/application systems – those impacted by ICD-10 and “systems impacted by systems impacted” by ICD-10 – assuring ICD-10 readiness and cutover

In as much as October 1, 2015 marked the end of ICD-10 implementation efforts, it is the beginning of employing strategies and post-transition changes to monitor the impact of ICD-10. Most importantly, this process is about the clinical data and how it provides an accurate clinical picture to support the quality and effectiveness of healthcare we provide here at SBH Health System and its affiliates.

Technology Update

Faculty Practices Becoming Paperless

eClinicalWorks v10 Electronic Health Record (EHR) went live in December, 2015 within the faculty practices located at Arthur Avenue Comprehensive Heath & Bronx Park Medical Pavilion. This implementation is an expansion from the current pediatrics faculty providers to all the multi-practice faculty providers affiliated with SBH Physicians PC.

Upgrading Labor and Delivery Information Systems at SBH Health System

GE Centricity Perinatal (Labor & Delivery) system went live during the first of week of December with the latest version enhancing improved work flow, clinical documentation, reporting and safer care.
As a practicing emergency medicine physician in the Bronx, I am seeing more and more patients brought to the ED after using synthetic marijuana, better known as K2 (aka Green Giant, Geeked Up, Caution, Snacked, Wicked X, AK-47, or legal marijuana). These patients usually come in restrained, and many times are accompanied by the police because of their volatile and aggressive behavior.

Since the beginning of the year, there have been more than 4,500 synthetic cannabinoid-related emergency department visits according to the city's health department. The city saw a dramatic increase over the summer, with more than 2,300 ER visits occurring. The Centers for Disease Control and Prevention reported the death of 15 people in the first half of 2015 due to the drug – triple the number in the same period a year ago. Poison control centers across the country also reported a 229 percent increase in phone calls related to use of the synthetic marijuana in the first half of the year.

The drug is often purchased at local bodegas, where it is sold in packages that say “not for human consumption.” The packaging, colorful and attractive, catches the attention of buyers, who many times are children. Others prefer to buy it on the street from dealers. Although Mayor de Blasio recently signed a law banning the manufacture and sale of synthetic cannabis, and many shops have had it confiscated from their shelves and been fined, its presence in the community continues to increase. Recently, the NYPD busted a very large K2 manufacturing ring in the Bronx.

The product is usually ground up plant material (resembling potpourri), that is sprayed with hallucinogenic chemical compounds, or synthetic cannabinoids. The signs and symptoms of synthetic cannabinoid use include agitation, anxiety, nausea, vomiting, high blood pressure, tremor, seizures, hallucinations, paranoia, and violent behavior. These effects can be similar to those of (PCP) or phencyclidine. Undetectable with normal urine drug screens, the drug has no known antidote. Treatment of agitation and restlessness with benzodiazepines is an acceptable and effective initial intervention, with supportive care, observation, and mental health counseling and behavioral intervention indicated for long-term care.

Many children are using this drug as well as a large percentage of our homeless population because it is cheap and readily available. Some mistakenly think it is “legal,” thinking the “high” is like real marijuana, mellow and calm. Meanwhile, others have compared the high to “like going to the moon.”

Legionella Outbreaks  By Edward Telzak, MD, Chair, Department of Medicine

The South and Central Bronx, long known for extremely high rates of asthma, diabetes and other chronic diseases, recently contend with the largest outbreak of Legionnaires Disease (LD) in New York City's history. This past summer, from early July through early August, more than 120 Bronx residents developed pneumonia as a result of an infection with Legionella pneumophila; 12 patients died as a result of this infection. Sixteen of these patients were diagnosed and treated at SBH.

Legionella species are naturally occurring organisms that thrive in warm water. Numerous investigations of outbreaks have associated LD with contaminated aerosol-generating devices such as nebulizers, cooling towers, showers, hot tubs, whirlpool spas, respiratory therapy equipment and room-air humidifiers. Because of the distribution of the patients infected, cooling towers were suspected to be the source of the infection. The City Health Department did a thorough epidemiologic and environmental investigation and though many of the cooling towers that were tested grew the Legionella, the outbreak was ultimately traced to a contaminated cooling tower on top of the Opera House Hotel on East 149th Street. Paradoxically, this hotel opened two years ago with great fanfare as it represented a multimillion-dollar investment and renovation of a historic theater in one of the City’s poorest neighborhoods.

Certain host factors, such as age, diabetes and immunosuppression place persons at greater risk for both infection after exposure and for a more severe outcome including death. Once the outcome was recognized, SBH began treating all patients with pneumonia with appropriate antibiotics and obtaining the appropriate diagnostic workup which includes both a urine antigen test and, when available, a respiratory specimen for culture.

It is never quiet in the Bronx. As of the time of this writing, yet another outbreak of LD was reported in the Morris Park section of the East Bronx. We remain prepared.
Discrepancies in medication therapy have been proven to lead to negative patient outcomes. Medication reconciliation, as defined by The Joint Commission, involves a clinician comparing the medications a patient is taking (and should be taking) to newly ordered medications. Medication reconciliation should be completed when a patient changes levels in care such as, at admission, transfer, and discharge. In this process all discrepancies should be resolved and allow for safe prescribing of medications. The safety issues surrounding medication reconciliation are recognized by The Joint Commission and addressed in the National Patient Safety Goals.

To optimize the medication reconciliation processes at SBH, we formed a Medication Reconciliation Subcommittee in September 2015. This committee, which I chair, reports to the Medication Safety Committee. We are working as an interdisciplinary team to ensure that SBH is in line with The Joint Commission Standards.

The subcommittee will form multiple workgroups assigned to specific focus areas under the medication reconciliation umbrella. The disciplines composing the workgroups will vary depending upon the area of focus and include involvement from information services, nursing, medicine, critical care physicians, emergency department physicians, quality, procedural area staff, transitions of care, surgery, and more. Together the team will be working on policies and procedures, implementing workflows using the electronic medical record, educating multiple departments, and ensuring systems are in place to monitor compliance. Our goal is to improve patient care.


A New Anticoagulation Subcommittee

Anticoagulation therapy is used for multiple indications including: deep vein thrombosis, pulmonary embolism, atrial fibrillation and mechanical heart valves. Although anticoagulation therapy is effective, its use is not without risk. As the result of complex dosing, monitoring and inconsistent patient follow-up, the potential for adverse events related to anticoagulants is high. The Joint Commission created National Patient Safety Goals (NPSG) to assist accredited organizations in addressing specific areas of concern relating to patient safety. National Patient Safety Goal 03.05.01 specifically addresses safe practices associated with anticoagulants with a goal of decreasing harm associated with these therapies.

To improve patient care and ensure compliance with NPSG, we have established a multidisciplinary anticoagulation subcommittee at SBH. As the clinical pharmacy coordinator in critical care, I co-chair this subcommittee with Dr. Ivette Vigoda, an attending physician in hematology/oncology. The membership includes representation from hematology/oncology, cardiology, surgery, medicine, nursing, nutrition, pharmacy, lab, pediatrics, OB/GYN, ambulatory care and IT. In the coming months, our subcommittee will be assessing our compliance with NPSG 03.05.01 and working to improve patient care related to anticoagulant use.
The high volume and fast-paced environment of the Emergency Department (ED) requires split-second decision making, often relying on verbal communication among providers and nurses. Any misstep in the process subjects patients to potential harm and medication errors. Over the past several decades, the number of clinical pharmacists in EDs has been on the rise. In many institutions, what initially started as decentralized pharmacy services transformed into true bedside clinical pharmacy for patients in the Emergency Department.1

In August 2015, I joined the SBH Health System team as the pharmacy clinical coordinator of emergency medicine to establish pharmacy services in the ED. The role of an emergency medicine pharmacist is multi-factorial. Although the traditional responsibilities of a pharmacist still exist such as order verification and therapeutic monitoring, emergency medicine pharmacists are more integrated with the interdisciplinary teams.

Benefits to Providers
With respect to providers, emergency medicine pharmacists are able to make recommendations in real-time at bedside regarding medication selection and route based on patient specific factors. This allows the pharmacist to discuss treatment regimens with providers before orders are entered, which not only reduces potential medication errors, but decreases the number of phone calls from the main pharmacy for order clarification (e.g., allergies, renal function, vancomycin dosing). The emergency medicine pharmacist is involved with time-dependent emergencies like medical, trauma and stroke codes as well as intubation and procedural sedation for both pediatric and adult patients.

Benefits to Nurses
From a nursing standpoint, the emergency medicine pharmacist serves as a reference regarding drug indication, IV compatibility, adverse effects, monitoring, titrating continuous infusions, and routes/rates of medication administration. The pharmacist also assists with bedside medication preparation, smart pump programming, expediting medication delivery from the main pharmacy to the ED, and Pyxis troubleshooting.

Benefits to the Department
Having a pharmacist located in the ED also benefits the main pharmacy department because it provides them with a point person they can contact for questions or clarification of medication orders. The emergency medicine pharmacist will be able to troubleshoot problematic orders in a more time efficient manner, which will help expedite patient medication delivery and care. Likewise, the emergency medicine pharmacist can also communicate to the main pharmacy department when STAT medications are needed and Pyxis stock outs, in addition to determining if medications are ready for pick up.

Current Projects in the ED
- Increased compliance with The Joint Commission’s medication management standards.
- Resolving IT-related issues in the ED related to the configuration of medication dispensing in the EMR.
- Creating processes to ensure the expeditious dispensation of medications.
- Expanding the inventory of the Pyxis to include additional medications, as well as the removal of unnecessary medications.
- Developing a monitoring system to ensure that verbal orders given under emergent circumstances are followed up with written orders in the EMR.
- Expansion of the override list in the ED to include additional medications needed in medical and trauma emergencies.
- Updating of current order sets and development of necessary guidelines or protocols.

I look forward to working with the dynamic staff of SBH Health System and improving the lives of our community!

Reference:
obstructive pulmonary disease and severe congestive heart failure who was brought to the emergency department for severe shortness of breath. He has a history of severe end stage heart failure resulting in frequent hospitalizations over the past six months. At his baseline, he is severely deconditioned. He lives with a 24-hour home health aide in senior citizen housing. He is dependent upon his aide for assistance with most activities of daily living, requiring assistance for everything but feeding. He is alert and able to visit with family; however, he is unable to leave his apartment without a wheelchair and oxygen.

During a family conference in his last hospitalization the patient expressed a desire to avoid aggressive care at the end of his life. He stated that he was tired and knew he was near the end of his life. He trusted that God would take care of him when he died and he wanted a natural end of his life without prolonged suffering or machines. His desire was to avoid hospitalization and eventually die at home. He rejected placement in a nursing home stating that he would rather “be with God.” He did not sign a DNR order or complete a living will. His only surviving family is his daughter, who lives in Brooklyn and visits periodically.

Upon admission he is in severe respiratory distress and is intubated and admitted to the ICU with a diagnosis of severe congestive heart failure. Unfortunately, after seven days of aggressive therapy he remains intubated and removal of the ventilator will result in his death. His only hope of continued life requires a tracheostomy, surgical feeding tube and prolonged artificial life support in a nursing home. He does not have the capacity to make decisions at this point.

A family meeting is conducted with the patient’s daughter to discuss the patient’s prognosis, options for care and end-of-life wishes. While the daughter remembers the prior family conference and her father’s wishes, she requests a tracheostomy and feeding tube insertion. She states that she cannot “pull the plug on her father” and that God will heal his heart and make him better.

The clinical team requests an ethics consultation to assist with decision making.

**ETHICAL ISSUES:** In this case, the clinical team is challenged with respecting the decision making of the patient’s daughter vs. the prior expressed wishes of the patient, who can no longer speak for himself. The daughter does not appear to be making decisions in accordance with the patient’s goals of care. In medical ethics the first priority is to respect the autonomy of the patient. Autonomy is the right of the individual to self-determination. Due to competing interests or personal morals, paternalistic decision making (“The doctor is always right”) has been replaced with patient-centered decisions. As this patient no longer has the capacity to make decisions and has not appointed a healthcare proxy, New York State law allows a surrogate to make decisions on behalf of the patient. In this case, the daughter becomes the decision maker, who is expected to make substituted judgment based upon her understanding of his wishes.

Given her request for prolonged artificial life support, the physicians have a justifiable concern regarding the beneficence of a tracheostomy. Beneficence, the promotion of well-being, becomes problematic in advanced critical illness as each person has differing perspective on wellness and suffering. Some may elect aggressive medical care to all extremes, while others may reject restorative care in place of comfort-based care. The daughter’s request for a tracheostomy appears to reject the principle of beneficence.

Lastly, the treating team must be concerned regarding non-maleficence (First, do no harm). While a tracheostomy and feeding tube will certainly prolong his life, given his end stage illness, the patient has no chance of returning to his home and dying a natural death as he had requested. The prolonged life support could be viewed as causing suffering and prolonging the dying process instead of improving quality of life.

**RESOLUTION:** While the ethical principles of respecting patient autonomy, promoting well-being and avoiding harm appear clear in this case, the reality of the situation is that the surrogate decision-maker is empowered to make decisions in this situation. A decision to withdraw support against her opinion would be problematic and confrontational. The ICU team, pastoral care team and palliative care team work with the patient and his daughter over the next two weeks. The patient does not regain capacity to make decisions. Over time, the daughter’s feelings of anticipatory grief, guilt about removal of the ventilator, spiritual needs and fears of suffering at end-of-life are addressed. In the end, she decides to transfer her father to the hospice unit where he is removed from the ventilator. He dies in peace, surrounded by family and prayer three days later.
Finding a medical interpreter has become easier with the installation of Cyracom®, a new system recently implemented at SBH that connects medical staff and patients to an interpreter with the push of a button. Cyracom’s signature blue dual handset phones provide faster access (no dialing necessary), better clarity of sound, and are located throughout patient units, in ambulatory care and in the emergency department.

According to Lynette Alvarado, our director of language, culture and intergovernmental affairs, SBH averages 700 requests for interpreting every month. The languages in highest demand are Spanish, French Creole, Albanian, Arabic, Mandarin and Vietnamese. For the hearing impaired, sign language is available on rolling monitors that connect through Wi-Fi, allowing access from almost anywhere.

Accurate medical interpreting is critical for patient safety. For information or to schedule training on Cyracom call Ms. Alvarado at extension 9158 or visit the SBH Wiki.

Patient Safety Update

Patient safety commands full attention throughout SBH under the leadership of Patient Officer Dr. Daniel Lombardi. Here are some recent initiatives that promote patient safety.

CPOE Entry Errors
With the introduction of Electronic Health Records (EHR) at SBH, Computerized Physician Order Entry (CPOE) errors have emerged. Medication orders and other physician instructions are entered electronically rather than on paper charts, which have led to patient identification errors and near misses. To reduce errors in patient identification, a double patient identification system has been piloted in the Emergency Department to reduce physician order entry errors in the EHR. If successful, this process will be implemented to other units with the institution and eventually the entire health system.

Patient Identification Verification
Also, with the help of the newly formed Patient Safety Liaison Committee and the communications and marketing team, bilingual patient identification verification signage has been created and will be posted in every patient room to raise awareness among patients and staff of the importance of patient identification.

Metric System
There has also been a new and directed focus on recording a patient’s weight in our EHR. The hospital has decided to go to a new all metric system requiring frontline staff education and multiple back-up processes to ensure patient safety. A performance improvement project has been implemented involving IT, nursing and pharmacy to improve the accuracy of patient weights entered in our EHR system.
New Faces

Amanda Ascher, MD, Medical Director, DSRIP

Gerard Baltazar, DO, Critical Care Surgeon

Irene Borgen, RN, MSN, MBA, FACHE, Vice President Ambulatory Care Innovation and Transformation

Vanaya Gaduputi, MD, Gastroenterology

Howard Geller, MD, Toxicology

Rajan Gurunathan, MD, Director, Division of General Internal Medicine

Vivan Gutierrez, MD, Psychiatry

Imram Jamil, MD, Psychiatry

Massoud Kazzi, MD, Pulmonary Critical Care

Amy F. Kells, MD, PhD, Plastic Surgery, Chief of Hand Surgery

Maria Belen Martinez, PsyD

Allyson Miller, Vice President Business Development
Publications and Presentations

PUBLICATIONS


PRESENTATIONS

Cassandra Andrews Jackson, Compliance Officer Compliance and Managing the EHR Risks Webinar for the Health Care Compliance Association (HCCA), August 27, 2015.

VPaul Chu, DDS, Director, Pediatric Dental Residency Program Pediatric Dentistry: A Multidisciplinary Approach to Patient Management. Pediatric grand rounds lecture at Greenwich Hospital, September 17, 2015.

Daniel Erichsen, MD Oral Appliance Therapy for Adult Obstructive Sleep Apnea. Webinar for the Academy of General Dentistry, September 22, 2015.

Rajan Gurunathan, MD Division Director, General Internal Medicine Co-Course Director and Planning Committee Member for the 10th Annual Mid-Atlantic Hospital Medicine Symposium: Mastering the Care of the Hospitalized Patient at the Icahn School of Medicine at Mount Sinai, New York, New York.

Yumi Lee, PharmD, BCPS, AAHIVP, Clinical Coordinator, Infectious Disease Medical Residents’ Perspective on Antibiotic Rounds. Poster presentation

Raid Sadda, DDS, MS, MFDRCS Implant Surgery Complications, Etiology and Management. Presentation to faculty residents and dental students at Erbil/Ishik University Dental School, June 1, 2015.
Announcements

SBH Health System President/CEO Dr. Scott Cooper was named a member of the board of the American Hospital Association’s new Task Force on Ensuring Access in Vulnerable Communities.

Chief Medical Officer/EVP Dr. David Perlstein was named chair-elect of the American Hospital Association’s Committee on Clinical Leadership.

Dr. J. Ronald Verrier was named director of the general surgery residency program.

Dr. Rajan Gurunathan was named Divisional Director of the newly formed Division of General Internal Medicine, which combines both the Hospitalist Division and the Division of Ambulatory Care within the Department of Medicine.

Dr. Fausto Vinces was named director of trauma services.

Dr. Mihai Smina was named section chief of pulmonary medicine within the division of pulmonary and critical care medicine.

Dr. Ernest Patti was named a distinguished lecturer at the Sophie Davis School of Biomedical Education.

Chief Pharmacy Officer Ruth Cassidy, PharmD, FACHE, Vice President of Clinical Services has been elected to the New York State Council of Health System Pharmacies Board of Directors as Director, Industry Affairs.

The department of medicine is proud to announce that Drs. Sharat Rokkam, Shilpi Aggarwal, and Raquel Olivo have been awarded Board-Certification in Internal Medicine from the ABIM.

Emilio Goez, DPM, was elected to the Board of Directors of the American Society of Podiatric Surgeons. Dr. Goez is Director of Podiatry and Associate Medical Director of Wound Care.

St. Barnabas Hospital received a certificate of achievement from the NYCDOH MH Bureau of Immunization for successful implementation of a universal birth dose policy and excellence in achieving hepatitis B birth dose coverage of 90% or better.

Charles Gropper, MD, director of dermatology, was invited to join the Manhattan Metropolitan Dermatologic Society, a small, invitation only society of the top dermatologists in the New York Region. He was also named to the 2016 listing of New York Super Doctors to be published in the New York Times on May 15, 2016. This is the seventh consecutive year he was named to this listing of the top Dermatologists in New York.

Historic White Coat Ceremony

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Which leads me to my third point.

[Point #3] I cherish the time I spent with patients prior to the development of effective treatment for AIDS. Don’t get me wrong. I would never want to go back to those bad days. Many of these patients were alone, addicted, angry, isolated and rejected by their families. Some were so enraged that they were unapproachable.

For many, however, though I could not treat them in the traditional medical sense with drugs or surgery, I spent time with them as their physician. Often, over many months, I spoke with them and listened to them and gradually learned their voice. Remember, each patient has a voice. I learned of their families, their loves, their disappointments and yes, their hopes. I spoke of them often to my wife and young children. I was with them during their last weeks and days. Though I could not treat their primary illness I worked very hard to ease their physical pain and mental anguish and I believe, in retrospect, this has been the most satisfying part of my career.

As for what you should expect from yourselves – this is straightforward. Knowledge is power and there is no substitute for a well-educated physician. You must know your medicine, your community and most of all, your patient. Every patient is a son or daughter, mother or father, grandchild or grandfather, sister or brother, cousin, aunt, uncle or closest friend. Learn who they have been and learn who they are in this world. Learn their concerns, their hopes and their disappointments. Learn of their families. Learn their voice. This will make you a much better and more satisfied doctor.

So, in conclusion, you are embarking upon one of life’s great adventures. For me, being a physician has been one of the greatest gifts I could have hoped for — I have never stopped loving my work. I wish all of you joy and richness in this adventure ahead. And my deepest and most heartfelt congratulations.
SBH Health System mourns the loss of Thomas Hughes, Chairman of the Board of Trustees of St. Barnabas Rehabilitation and Continuing Care Center, and a long-time member of the St. Barnabas Hospital Board of Trustees and the Auxiliary. Mr. Hughes passed away in July after a long illness.

In 1986, Mr. Hughes enthusiastically responded to an invitation to join the Hospital’s Board of Trustees and for many years was a pivotal member of and an asset to the governing body. In recognition of his outstanding service to St. Barnabas, he was appointed Chairman of the Board of St. Barnabas Nursing Home in 1994, now known as St. Barnabas Rehabilitation and Continuing Care Center. Tommy’s boundless energy and unyielding optimism were principal among his many qualities. He will be missed by all who knew him.

Thomas J. Murray
Director, Community Affairs
SBH Health System’s Communication and Marketing department has been busy developing the new sbhny.org website. Our soft launch will be in Jan. 2016, with an official launch scheduled for April 2016.