SPECIAL 150TH ANNIVERSARY EDITION

SBH-PHYSICIAN

THE MAGAZINE OF SBH HEALTH SYSTEM MEDICAL STAFF **FALL 2016**

THEN+NOW

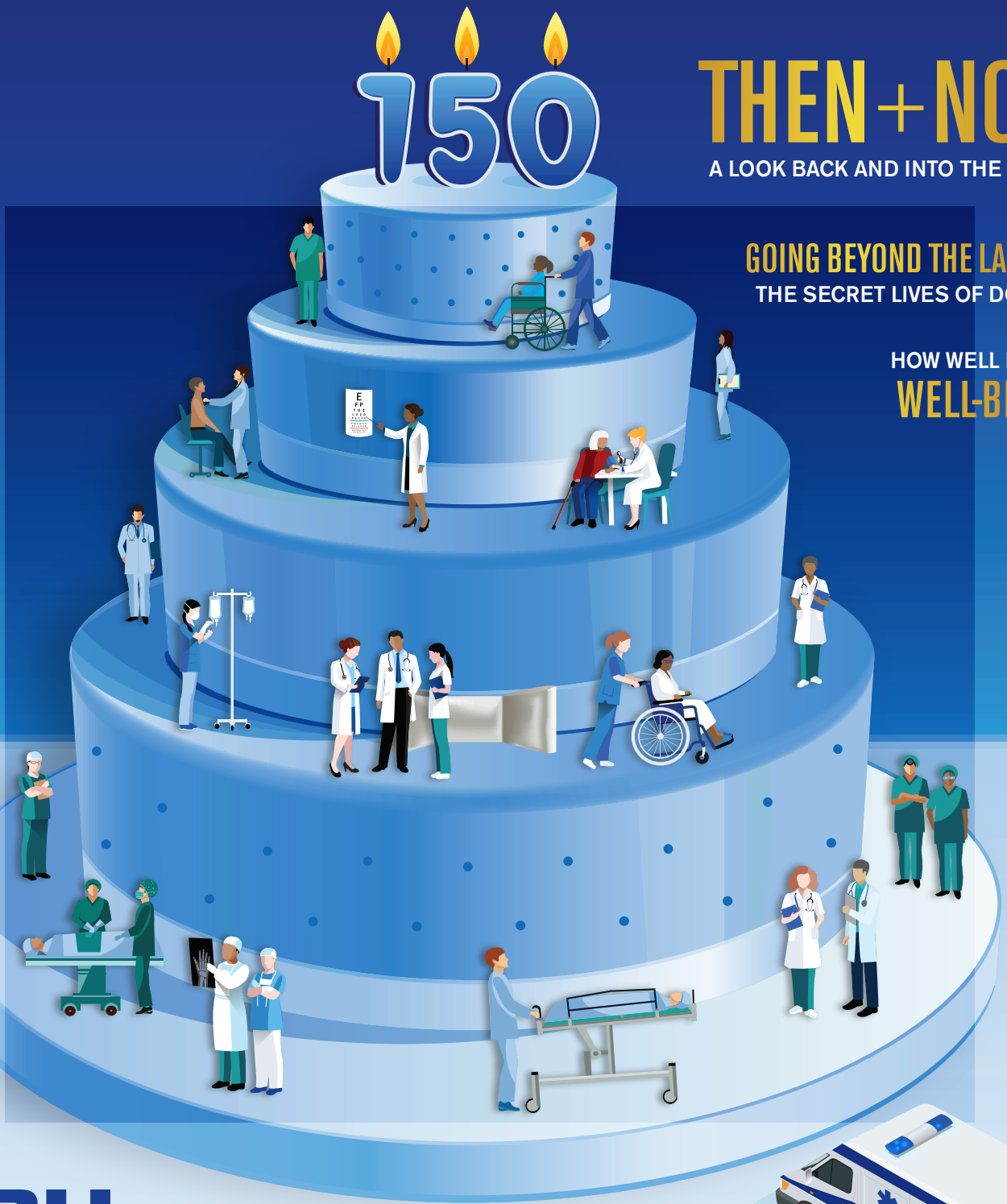
A LOOK BACK AND INTO THE FUTURE

GOING BEYOND THE LAB COAT

THE SECRET LIVES OF DOCTORS

HOW WELL IS YOUR

WELL-BEING?



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SBH-PHYSICIAN

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Dear Colleagues,

It gives me great pleasure to introduce the Fall 2016 issue of *SBH Physician*. 2016 is a very special year for the SBH community as we celebrate our 150th year serving the Bronx community. Our lead story "SBH Then and Now" pays tribute to three physicians who have helped to lead our organization's journey to becoming a premier provider of healthcare in the Bronx. Their stories will give you a glimpse into the vast changes that have occurred at SBH and in healthcare, and will reveal the foundation that has developed here and that continues to evolve to best serve our patients.

One of the bright stars of our future is neurosurgeon Dr. William Wirchansky who introduces us to a minimally invasive spine surgery option for patients with back pain, allowing easier recovery. We also have a newsworthy medical update about the Zika virus from our chair of internal medicine, Dr Edward Telzak, in the "What's New in the Bronx" section. In our Ethics Column, Dr. Steven Reichert tackles the controversial topic of medical futility and in our Case Study section we see the benefits of hyperbaric oxygen therapy in our wound center.

Finally, we get a view inside the lives of our physicians outside the walls of SBH in a story entitled "Beyond the Lab Coat." Here, we get a behind-the-scenes look at the talents and hobbies of some of our medical staff that helps to balance out the typically busy life of a physician.

Looking forward to the next 150 years!

Sincerely,

Eric C. Appelbaum D.O.

Eric Appelbaum, DO
Senior Vice President – Chief Medical Officer

THE SPECTRE OF ZIKA

By Edward Telzak, MD, Chair, Department of Internal Medicine

The south and central Bronx, with a large and diverse Hispanic population, continues to work with, and prepare for, both immigrants and travelers from Zika endemic areas coming to the Bronx and New York City with Zika infection. Zika is currently affecting parts of Central and South America, Mexico and the Caribbean, and, most recently, two neighborhoods in the greater Miami area. Of particular concern are the large outbreaks occurring in Puerto Rico and the Dominican Republic, given the extensive travel between New York and these Caribbean islands, and the recently documented transmission of Zika virus infection in south Florida. As of August 19, 505 cases of Zika, including 51 in pregnant women, have been reported in New York; more than half acquired their infection in the Dominican Republic. All investigated cases have been travel associated. Three cases have developed Guillain-Barre syndrome as a complication of Zika infection. To date, more than one-third of all New York City cases (n=181) have occurred in the Bronx. Infected individuals returning to the Bronx raises the possibility of Zika virus transmission occurring within New York.

People usually get Zika through the bite of an infected mosquito. Only certain types of mosquitoes can spread Zika: the Aedes aegypti is the major vector of transmission in Latin America and South Florida. The Aedes albopictus, a much less efficient transmitter of Zika, is found in the Northeastern U.S. Zika can also be spread through sexual contact with an infected person and through blood contact. Once a person is infected, the overwhelming majority (approximately 80%), remains asymptomatic. For those who do develop symptoms, most are mild and commonly include fever, rash, arthralgias and conjunctivitis. Severe symptoms, such as Gullain-Barre Syndrome, are rare. Symptoms typically start 2-12 days after being bitten by an infected mosquito and can last up to one week.

Testing, though imperfect, is available for Zika virus infection through blood or urine specimens. Most people do not need to get tested for Zika virus, even if they have traveled to a Zika endemic area. Zika testing is particularly important, however, for pregnant women. The NYCDOHMH recommends using the health department

laboratories if Zika virus testing is clinically indicated for only certain groups: pregnant woman, infants, persons with Guillain-Barre syndrome or other neurological complications and suspected cases of local mosquito-borne transmission. For other cases, providers should use commercial clinical laboratories. Presently, there are no medications to treat Zika infection and no vaccine exists to prevent the Zika virus disease.

The major and most significant complication of Zika occurs among pregnant women. Zika virus can be passed from a pregnant woman to her fetus during pregnancy or at delivery.

For women who are pregnant and do not live in an area with Zika, CDC recommends avoiding travel to an area where Zika transmission is ongoing. Pregnant women with male partners who have lived in or traveled to an area with Zika should use a condom every time they have sex or maintain abstinence. For those trying to conceive, it is also strongly recommended that they not travel to a Zika-affected area. For women who have traveled to a Zika-affected area, it is recommended that they wait at least eight weeks after their last Zika exposure before trying to conceive. If their male partner has or might have Zika, they should wait six months before trying to conceive if he is symptomatic and at least eight weeks if he is asymptomatic. In addition, pregnant women who have recently traveled to an area with Zika should speak to their obstetrician or other healthcare provider about their travel even if they do not feel sick.

Guidance for non-pregnant women and men available as is guidance for donating blood. New Yorkers traveling to Zika-affected areas should take steps to avoid mosquitoes. They include but are not limited to using insect repellent containing DEET, wearing long sleeves and pants and clothes treated with permethrin, staying in places with either air conditioning or window and door screens, and getting rid of standing water around your residence that attracts mosquitos.

Zika virus infection, its transmission, clinical symptoms and complications are just beginning to be understood. Recommendations will evolve and change. Mosquito control is becoming more sophisticated. Vaccine development is on the horizon. Yet, it's one more challenge – one we are embracing.

Embracing Partnerships With Our Patients And Community

An excerpt from an interview with Irene Kaufmann, Executive Director of Bronx Partners for Healthy Communities (BPHC).

BPHC is comprised of more than 200 community-based organizations, including SBH Health System and Montefiore Medical Center, and helps implement and manage the New York State DSRIP Program. DSRIP offers us the opportunity to transform the delivery of healthcare in the Bronx by making deep changes, something that's very difficult to accomplish. With its focus on wellness, health promotion and prevention, DSRIP will bring a new view of what a community healthcare provider is and how that provider's care can successfully integrate with other community services.

We are confident we will achieve our goals for two reasons: First, because SBH leadership strongly believes in this change and is sitting behind the wheel to help drive it. Senior management understands that these changes will benefit not only the SBH organization, but the community itself. Second, we can accomplish this transformation because of our size. Being lean allows us to be nimble, and to implement new ideas more quickly, and perhaps more successfully, than larger healthcare systems.

There is a palpable sense of energy and potential around BPHC that I don't sense when I meet with other Performing Provider Systems (PPS). But while we're very eager and enthusiastic, big change can also be a very scary thing. We are about to enter this new world and, understandably, there is some anxiety about what it all means. It comes at a time when we are learning how to embrace partnership with two very different types of partners: our patients and our community.

Healthcare transformation requires a great deal of patient participation. Here's one example: there is a requirement now for creating patient care plans, but rather than physicians telling a patient what they should want, it's incumbent on the patient to express his or her own health goals. This level of empowerment recognizes the patient as a true partner. What does this mean on a practical level? In the case of a patient with diabetes, the physician might have once said, "My plan is to lower your A1C." The patient may be able to relate to that. Yet, if creating her own care plan, she is more likely to say, "My goal is to be able to go to my daughter's wedding this summer and I want to wear that nice dress. So tell me how can I do that?"

That's a very different way of looking at wellness, a very different motivational factor. The clinician and care team need to look at a health goal the way the patient expresses it. This changes the dynamic and puts the patient in charge of where the care plan is going and why.

In the past, we invited community organizations to come to the table and participate with us - to be members of committees we run. That's changed. Now, as more care and wellness services move into the community, their voices and leadership are critical and they're coming to the table as co-chairs and as leads. This means that now we learn to work with them as partners who are not subservient to our cause because they're smaller and/or not clinical.

When you speak to people in healthcare they acknowledge that these organizations have a cultural competency that serves the community better than we can. They're better attuned, they speak the language, and they provide niche services effectively to specific community populations. Instead of pulling cultural competency from them into hospital programs, it seems to make more sense to build on the competency they already have and support them to educate our community to better navigate the healthcare system and get the most out of available services.

We've seen a disconnect between our changing system and our community's expectations of care. Who's educating our community about the new care system being built? Well, we've stepped to the plate and started to collaborate with our community organizations on ways to educate and prepare their clients to access and make better use of redesigned services. The idea is to educate before individuals are in a time of crisis and need, and provide them with guidance at a time when they're more relaxed and can absorb information better.

We're teaching community organizations about basic health literacy and the navigation skills their clients will need in this new environment. This includes answering the questions: What's a primary care provider? Why do you need one? When do you use a primary care provider as opposed to one who provides urgent or emergency care? Before patients need a care plan, they should understand what it looks like, what information it includes and how they can use it.

We're also working to engage provider organizations in our PPS in a logical sequence - starting with primary care, then following with behavioral health and social services and finally with long-term care and home care providers - and helping to support them as they adopt and implement evidence-based processes and workflows that can help standardize care across the PPS, improve quality and forge more robust connections between organizations. While DSRIP offers us opportunities to integrate and improve patient care, it also helps us to support these linkages with more efficient information sharing tools and processes which will help people collaborate better within and across partner organizations. It's a journey that will take time, but one that we believe will certainly be worth the effort.

Neurosurgeon Offers Minimally Invasive Option to Spine Patients

Dr. William Wirchansky, neurosurgeon at SBH Health System, discusses an innovative approach for reducing pain. **By Steven Clark**

The patient, overweight and in his 40s, had suffered years of lower back pain due to spinal stenosis. Encouraged to try such conservative modalities as oral pain medication, injections and physical therapy, he had experienced little relief.

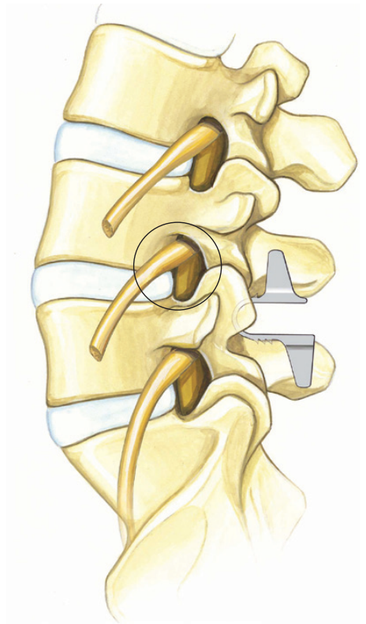
"The pain and dysfunction were impacting on his professional and personal life and he had reached the point where surgery seemed the only option available to him," says Dr. William Wirchansky, a neurosurgeon at SBH Health System. "Fortunately, he seemed like a perfect candidate for one of the minimally invasive procedures that I use for patients with his condition."

The gold standard for moderate to severe spinal stenosis has long been a fusion technique that uses metal rods and screens. This requires an open procedure and typically comes at the expense of range of motion in the spine.

Dr. Wirchansky chose to use a new minimally invasive device called Coflex, which is a titanium metal implant that stabilizes the spine after a surgical decompression.

"Unlike with a fusion, the Coflex maintains mobility and function, allowing the patient to bend forward and backward without pain," says Dr. Wirchansky. "It helps uphold the normal foraminal height of the spine and enables other segments in the spine to maintain their natural motion." The device is designed for placement on the laminar bone, the strongest part of the spine. "It's an easier surgery, with the implant placed through the same small incisions as the surgical decompression," he says. "And, it minimizes injury done to the tissue and muscles near the spine."

"Unlike with a fusion, the Coflex maintains mobility and function, allowing the patient to bend forward and backward without pain."



Dr. Wirchansky also employs the following minimally invasive tools:

- Interbody stand-alone fusion devices for lumbar fusion procedures. This allows surgeons to perform TLIF (Transforaminal Lumbar Interbody Fusion) with 2.5 to 3 centimeter incisions using a single, expandable interbody device. "As a result, patients get pain relief very quickly and often leave the hospital the same day after surgery," says Dr. Wirchansky.

- A computer-assisted Spinal Navigation System for minimally invasive spinal surgery. The image-based technology uses scans of the patient's anatomy and instruments that are tracked by the Navigation System's camera. Navigation helps surgeons more precisely guide their instruments in more advanced and complex procedures.

- Percutanous pedicle screws. The use of pedicle screws for spinal stabilization has become increasingly common. Open pedicle fixation and spinal fusion, however, have been associated with extensive blood loss, lengthy hospital stays, and significant cost. The use of percutaneous pedicle screws, says Dr. Wirchansky, eliminates the need for a large midline incision and significant paraspinous muscle dissection. As a result, patients experience shorter periods of hospitalization and recovery. Blood loss and tissue trauma are also minimized.

"Minimally invasive spine surgery is not available for every patient," warns Dr. Wirchansky. "Yet, like the patient who expressed a tremendous amount of satisfaction and pain relief a short time after we used the Coflex treatment, it gives many surgical patients some real options."

Coflex offers the following patient benefits:

Faster symptom relief.
Patients show relief of their symptoms within four to six weeks, much faster than those who underwent fusion.

Shorter operating time.
Studies show the average time for surgery is 90 minutes vs. 153 minutes for fusion.

Greater patient satisfaction.
After two years, 94 percent of Coflex patients reported being satisfied compared to 87 percent of fusion patients.

Shorter hospitals stays.
Coflex patients averaged 1.9 days in the hospital as compared to 3.2 days for fusion patients.

More natural movement.
While fusion patients saw a 25–50 percent increase in unnatural motion in the areas below and above the treatment, Coflex patients retained their post-operative range within 15 percent.

Beyond the Lab Coat

THE LAB COAT OR SCRUBS THEY WEAR DO NOT DEFINE WHO THEY ARE.

Many SBH physicians have special passions, talents, and accomplishments that exist outside the hospital. As you'll read here, these extracurricular interests are as wide ranging and diverse as the hospital itself.

By Steven Clark

THE IRONMEN

Dr. Mark Klion gets philosophical when it comes to discussing endurance competitions. "I like to say that pain is inevitable, but suffering is optional," says the orthopedic surgeon. "For every bad minute during a race from an endurance standpoint, there is a good moment. And if you can get through those difficult moments, you'll be better for it."

Dr. Klion speaks from experience. At last count, he has completed 11 Ironman Triathlons (for the uninformed, an Ironman consists of a 2.4 mile open water swim, a 112 mile bicycle ride and a 26.2 mile run), including competitions in Hawaii (the granddaddy of Ironman competitions), Florida, Idaho and New York. He trains for these events in ways that would make most people shake their head. He runs to work – 21 miles from his Westchester home – bicycles through the likes of Bear Mountain, and competes in 50 kilometer runs (which have included the Grand Canyon Rim to Rim to Rim Run from the South rim to the North rim and then back to the South rim). To prepare for the swim, he uses a dryland swim trainer in his home. In addition to his life as an Ironman triathlete, he's co-authored a book for healthcare professionals, titled *Triathlon Anatomy: Human Kinetics* and helped create the BodyworksMD DVD series. He serves as medical director for the New York City Triathlon.

And, while Dr. Klion is SBH's #1 Ironman in terms of number of events and best time (10 hours and two minutes), he's not alone. Dr. Eric Appelbaum, Chief Medical Officer, and critical care physician Dr. Christopher Grantham have a total of five Ironman competitions under their belt (all in Lake Placid, New York).

"I ran my first Ironman on a dare," says Dr. Klion. "I've always been a runner and loved cycling, but I lasted just one week on my high school swim team. Someone dared me in the summer of 1997 and I soon fell in love with the sport and the community. It was so intriguing to be part of something that was brand new. You start to thrive on the endurance stuff, being out there for hours and being introspective and evaluating life."

Dr. Grantham, a swimmer in high school and at the University of Miami, actually got his start in endurance sports by running marathons. He's competed in about 15 marathons, including those in New York City, Washington D.C., East Hampton and San Jose, California.

Finding the time to train is a major concern for all Ironman triathletes – particularly busy physicians. As the result of a growing family, Dr. Appelbaum has put his Ironman days on hold for the time being. According to Dr. Grantham, "You have to put in the time. It's not a good thing to do otherwise." He knows this after being in a weakened state after the first two legs of his first Lake Placid race. "I was dehydrated and really hurting at the beginning of the run. Only after I packed ice in my shirt and hat did I start to feel better."

SBH Ironmen (beginning clockwise) are Drs. Appelbaum, Klion and Grantham.

Dr. Klion trains upwards of 18–22 hours weekly. Regardless of how extensively he prepares, he knows injuries are part of the landscape.

"I've had muscular/skeletal injuries and plantar fasciitis, which I ran through for two years before having surgery," he says. "I had a gallbladder attack during a race and later had it removed."

He doesn't believe the extensive training or competition are deleterious to one's health. In fact, it's the multisport, cross-training aspect of Ironman training that he says enhances one's cardiovascular health without the pounding that can cause repetitive stress injuries.

"There is no definitive study that says endurance training causes arthritis; there's a genetic component and I consider myself lucky that I have good genes," he says. "Yet, I run every race like it's my last, knowing I could succumb to a meniscus tear or another injury at any time."

THE PALEONTOLOGIST

Paleontology, or so it would seem, appears to be a rather safe and sedentary hobby. Only tell that to Dr. Jeffrey Lazar.

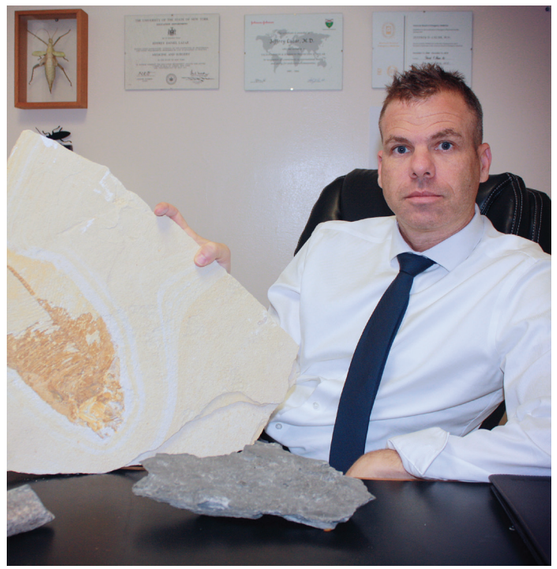
"I was fossil hunting around the Chesapeake Bay in Maryland," says Dr. Lazar, vice-chairman and medical director of the Department of Emergency Medicine. "While driving out to where I'd need to make a five-mile hike to get to some cliffs, I noticed a large number of pickup trucks sporting gun racks. When I stopped at a gas station to grab some coffee, I learned it was the first day of deer hunting season, and realized I would soon be tromping through the woods… wearing a dun-colored jacket and brown pants, afraid of looking way too much like a deer. I spent most of the hike chanting aloud, 'Not a deer. Not a deer.'"

Dr. Lazar's fascination with paleontology dates back to schoolboy field trips to the Museum of Natural History and a learning-to-read book with a Stegosaurus on the cover. A fan and student of Charles Darwin and evolutionary science, he began to dig for fossils a decade ago. Since beginning a formal collection, his travels have taken him to places like Lower Silurian Rochester Shale in upstate New York, to the high desert of Wyoming's Green River Formation, and assorted sites in Kentucky, Texas, Florida and New Jersey. He's currently preparing to do some diving off Florida's gulf coast to search the sea floor for fossilized teeth from the Megalodon, an extinct species of shark that last lived over two million years ago, and could grow to an estimated length of 60 feet.

"I do a lot of advance research and reading and seek out local experts for tips," he says. His tools of the trade could include crowbars, shovels, mallets, picks and/or goggles depending on the terrain. He's collected fossils from the Cenozoic through the Paleozoic eras: a time span that ranges from 40 to 400 million years ago. He keeps pieces from his collection in his office and in display cases in his apartment. He's fond of the quotation by the American paleontologist Robert T. Bakker: "Fossils have richer stories to tell – about the lub-dub of dinosaur life – than we have been willing to listen to."

He finds the hobby very rewarding, but admits that he needs to remain vigilant at all times.

"I was wading through the Peace River (on the mid-western coast of Florida), not too far from an area where a person had recently been eaten by an alligator," he says. "Needless to say, I kept my guard and stayed in clear, shallow waters. Happily, the trip paid off; I had some great finds."



Left: Dr. Lazar with one of his recent findings. Above: Dr. Karpinos and his daughter biked through 48 states in three weeks.

THE BIKER

Last summer, Dr. Robert Karpinos, an anesthesiologist and SBH's director of perioperative services, left his home in northern New Jersey with his 19-year-old daughter Rebecca on the backseat of his Honda Gold Wing motorcycle for a three-week adventure that took them to America's 48 contiguous states. The 10,000-mile odyssey, which saw them average about 500 miles a day, was relatively uneventful, save for the minor inconvenience of having the bike break down in South Dakota on the return ride home.

"It was great spending uninterrupted time with my daughter, exploring, and doing something we both love to do," says Dr. Karpinos.

Dr. Karpinos rides daily to work – "I ride if it's 40 degrees or warmer and dry when I leave the house; if it rains during the day, that's the cost of doing business" – and spends most weekends biking either on racetracks, winding roads or riding the open highway.

The trip last summer was not his first endurance endeavor. Several years ago he and a friend competed in the Iron Butt Association's 50CC, which challenges bikers to cross the country in under 50 hours (requiring them to collect seawater from the Atlantic and Pacific oceans). He traveled the 3,000 miles in 47 hours, stopping only to nap in Oklahoma (although he admits that both he and his friend had some hallucinatory moments when traveling through the desert).

He's looking forward to riding in the association's Ultimate Coast to Coast to Coast Insanity Challenge. That journey goes from Key West, Florida, to Dead Horse, Alaska, within 30 days.

Dr. Sender has performed everything from opera to show tunes.

THE OPERA SINGER

As a young child, Dr. Joel Sender, division director, Geriatrics and medical director of the St. Barnabas Rehabilitation & Continuing Care Center, took singing and piano lessons. He performed in plays and concerts at school and in synagogue. His musical interests were eclectic, ranging from Broadway show tunes to classical music.

As a teenager, he considered attending a music and arts high school, but his parents – "while sympathetic to my love of music were practical people from the old world" – steered him towards a more stable career.

Later, as a medical student, he often studied and fell asleep listening to records by Jussi Bjorling, one of the great tenors of the 20th century. Anyone looking for him on weekends at Albany Medical College merely had to follow the music – he played the piano for hours at a time in the school's lobby.

That spark, lit as a child, ignited when, at the age of 43, he was given the opportunity to audition for Richard Cross. A bass-baritone who has performed at leading opera houses around the world for over 40 years, Cross has long been a highly sought after opera coach who teaches Bel Canto – the Italian vocal technique and style of the 18th and early 19th centuries, emphasizing the beauty of sound, and literally meaning in Italian "beautiful singing" – to students with professional aspirations in such places as the Yale School of Music and the Julliard School. Taking on a student like Dr. Sender, one with a rather serious day job, was certainly not typical. "After I finished auditioning for Richard, he said 'Let's do it.'"

That was 22 years ago. To further enhance his singing technique, Dr. Sender later added a second coach (a voice teacher to go with a vocal coach), his dear friend Beverly Myers. "It's been a great education and I can sing some arias, but it's been about more than just singing better," he says. "It's about learning to respect the music and being able to interpret it. My appreciation and pleasure have only grown over time."

Dr. Sender plans to perform with an accompanist at his Passover Seder next year before family and friends. Years ago, at the grand opening of the nursing home, he sang songs from Camelot. His goal is to learn some complete roles, like Rodolfo in *La Boheme* or the Duke in *Rigoletto*. For now, he says he's content to keep learning and enjoying the experience.

THE ACTOR

An orofacial pain specialist, Dr. Uyanik splits his professional time between seeing patients at SBH Health System and in his Tribeca private practice, and teaching residents as an associate clinical professor at NYU College of Dentistry.

Cem Uyanik, meanwhile, is a working actor, performing in off-Broadway theater, movies and on TV, and regularly attending auditions.

His most recent performance was in the musical comedy *Truffles: Jazz, Murder and Dinner Theater*, at The Cutting Room in Manhattan. He's appeared in movies (most recently the film *SubHysteria*, about 16 people trapped for days in a New York City subway car) and on television (as a court clerk in *The Good Wife*).

"When I was in fourth grade I auditioned and got the part of one of the royal children in *The King and I* with a local theater company," says Dr. Uyanik. "After that I never stopped acting. I did school plays and performed in theater as an undergraduate at NYU (in plays ranging from Shakespeare's *The Comedy of Errors* and Moliere's *Tartuffe*, to the musical *Spring Awakening*). I told my parents that I wanted to pursue being an actor and they said, 'Fine, but as a backup get a degree.' My father was a dentist so I figured I would go to dental school."

While in dental school he says he fell in love with treating patients with orofacial pain. "I didn't expect to find something I felt so passionately about in school," he says. After graduating, he spent two years in Los Angeles as a resident at the UCLA School of Dentistry. "The perfect place," he laments, "only I was too busy to do any acting."

Today, he normally devotes two days a week to acting, either performing or auditioning. The schedule can be grueling, but the pain specialist/actor has no plans to relinquish either passion.

"I aspire to keep doing what I love, as both a dentist and an actor," says Dr. Uyanik. "An actor having a second job is hardly unusual. But, often it's as a waiter. I'm fortunate [because of my job] that I can be choosy in accepting roles. I'm not stressed out if I don't get a part. I'll still be able to pay my rent, and I thank my parents for that."

He also keeps his two lives very separate. Virtually none of his patients knows about his acting, and very few actors he performs with have any idea about his "day job."

"I was in a car with several actors recently when I got a call from my answering service," he says. "I answered quietly, 'Yes, this is Dr. Uyanik,' and the heads of those in the front seat whipped around.' They were pretty surprised to say the least."

THE FANTASY FOOTBALL FANATIC

Do you select Arizona running back David Johnson or Jets' wide receiver Brandon Marshall in the first round? Do you grab the Giants' Eli Manning in the 8th round, or wait until round 11?

And, once you've drafted your team, do you sit your starting tight end in Week 10 because he never catches many balls against the Bears defense when playing on frigid days in Chicago? These are the kinds of dilemmas faced every football season by Dr. Gilbert Brovar, an endocrinologist at SBH Health System, and about 75 million other Americans devoted to fantasy football. Only Dr. Brovar is a little more serious about it than most, and much better at it. In addition to competing in several high stakes leagues – one has more than 2,000 participants and pays out $300,000 to the first place team – he advises others who struggle with the same decisions. His counsel, like that of a swing coach in golf or a grand chess master, is in demand because of his sterling track record. Last year, his team – which he shares with a "co-owner" (who is so involved in fantasy football that it's now his full-time job) – won $10,000 by finishing 15th out of 2400 teams.

While fantasy football leagues have subtle differences, most work in the following way: leagues hold a "draft," where teams select NFL offensive position players (quarterbacks, receivers, running backs) and an NFL defense. Each team names a weekly starting lineup during the season from these players, with points awarded for players' rushing, receiving and passing yards; touchdowns; and receptions. Win-loss records – as teams face off head-to-head each week – and a system of allotted points comprise their overall standing. Like the general manager of an NFL team, Dr. Brovar spends hours studying prior to the draft. This includes perusing NFL team rosters and poring over online fantasy football charts which rank players' historical performances. This helps him decide on choosing player A over player B in the early rounds and uncovering sleepers for late round picks.

For his high-stakes league, the draft takes place before the start of the NFL season in a hotel ballroom in Las Vegas, with each team's selections placed on a big board. Strategy also goes into drawing up your weekly lineup. For example, you may choose to start a player because he has consistently done well against the team faced that particular week. So, if the Patriots are playing the Jets, explains Dr. Brovar, this may mean starting Julius Edelman as your wide receiver rather than, say, one with greater overall productivity because the Patriot has averaged about a dozen catches per game in recent years against New York. Obviously, luck is also involved. Injured players (or, as happens all-too-often in the NFL, those suspended for off-the-field activities) can put a fantasy team on life support.

Dr. Brovar, finds himself glued to the TV every Sunday (and Thursday and Monday nights) when NFL games are played.

"Fantasy football has been great for the NFL," he says. "Sunday night I'm watching a game between (doormats like) the Cleveland Browns and the Tampa Bay Buccaneers, and so are most fantasy players. How else would the NFL get people to watch a game like that?" ■

Left: Actor and orofacial pain specialist Dr. Uyanik; Right: Dr. Brovar, fantasy football and diabetes specialist.

Physician Burnout and Depression

Taboo? Stigma? Epidemic? How recognizing your limitations and weaknesses can reduce stress and save your life. **By Lizica Troneci, MD, Chair, Department of Psychiatry**

"As I think about the emotional well-being for our country, I am particularly interested in how to cultivate emotional well-being for healthcare providers. If healthcare providers aren't well, it's hard for them to heal the people for whom they are caring."

- Surgeon General Vivek Murthy, MD, MBA

As physicians, we are entrusted with healing people's minds and bodies. We hold ourselves to high standards of responsible and accountable behavior. In our profession we see pain, we feel pain and we try to heal pain. We are not always successful, we sometimes feel culpable for the outcome and the cycle starts again. Long hours, missing family and friends, sleep deprivation and psychological stress in caring for very sick patients have an impact on our own physical and psychological well-being.

Yet, years of medical school and residency training have taught us that we need to be strong. We are hesitant to seek mental health out of the same fear as our patients: STIGMA. We might be concerned about confidentiality and fear of recrimination from our colleagues and the institutions we work for. We may be required to disclose a mental health treatment history when applying for a medical license. Ultimately, we fear that acknowledging we need help translates into being weak.

In the end, we are HUMANS. Without being human, we cannot help our patients. Not recognizing our limitations and weaknesses turns us into machines. Not recognizing and accepting that one might experience burnout, anxiety or depression is unhealthy and dangerous to oneself and one's patients.

Threats to the well-being of physicians begin early in their career. Studies show that among medical students, more than 20% will suffer from depression within the first two years and up to 9% will have suicidal ideation before graduation.

"The rate of depression in the population of training physicians is remarkably higher than the general population," said senior author Dr. Srijan Sen, associate professor in the Department of Psychiatry at the University of Michigan, when discussing the results of a large systematic review and meta-analysis study.

Studies with information on the prevalence of depression or depressive symptoms among resident physicians published between January 1963 and September 2015 were reviewed. The summary of the review of 54 studies involving 17,560 resident physicians estimate the prevalence of depression or depressive symptoms at 28.8%, ranging from 20.9% to 43.2% depending on the instrument used.

Residency Well-Being Questionnaire

These numbers prompted the Internal Medicine Residency Program at SBH to administer the "SBH Resident Well-Being Questionnaire" in March 2016. The questionnaire, assigned to 81 residents from all three levels of PGY training, had an 84% completion rate (68 residents). On the question related to burnout, 22 residents (32.4%) reported no symptoms, 39 residents (57.4%) reported being occasionally under stress but not feeling burnout, and a total of 7 residents (10.4%) responded that they were experiencing few burnout symptoms to feeling complete burnout.

On the question related to feeling depressed in the past 7 days, 47 residents (69.1%) reported they never felt depressed, while 8 residents (11.8%) reported they sometimes or often felt depressed. While these results are not as alarming as the ones from the article mentioned above, they prompted the residency program's revision of available resources to address burnout and depression.

Experience does not make us immune to burnout and depression. Having completed residency training and, as we have assumed more professional and personal responsibilities, we remain at risk for developing depression comparable to that of the general population. A recent study revealed that nearly half of physicians report at least one symptom of burnout. Some of the contributors include: caring for difficult and complex patients, facing ethical dilemmas, coping with patient death (and suicide), meeting deadlines and regulatory requirements, using EMR systems, and balancing professional and personal responsibilities.

What is burnout? What is depression?

Burnout is a triad of emotional exhaustion (emotional overextension and exhaustion), depersonalization (negative, callous, and detached responses to others), and reduced personal accomplishment (feelings of competence and achievement in one's work) associated with:

- Decreased productivity and decreased job satisfaction
- Physical symptoms including insomnia, appetite changes, fatigue, colds or flu, headaches, and gastrointestinal distress
- Daydreaming while interacting with patients
- Excessive cancellations of appointments or commitments
- Increased alcohol or drug use

When these symptoms are not timely and appropriately addressed, burnout can ultimately lead to depression and suicidal ideation, plans and attempts.

In physicians, depression can manifest in different ways:

- Severe irritability resulting in interpersonal conflict
- Erratic behavior
- Inappropriate boundaries with patients, peers, staff
- Isolation and withdrawal
- Increased errors in or inattention to the medical record and patients' calls
- Inappropriate dress or change in hygiene
- Inconsistency in performance and absenteeism

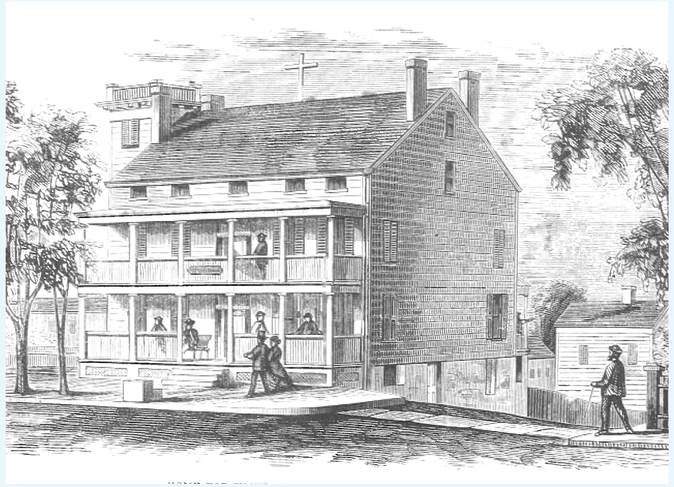
Burned out or depressed physicians limit their performance to focus on only the most necessary tasks. They may also have impaired attention, memory, and concentration that decrease their recall of information and consideration to detail. As burned out physicians become negatively detached from their work, they may develop negative attitudes toward patients, poor communication skills and ultimately an impaired capacity to deal with the dynamic and continuously evolving nature of the current health care system.

With greater recognition of the risks associated with increased rates of burnout and depression in medical students, residents, and physicians has also come a greater understanding that our profession needs to provide adequate care for its members. ■

SBH **Then** and **Now**

SBH Health System celebrates its 150th anniversary in 2016. Three physicians who lived through these changes, and were instrumental in the hospital's transformation, were **Dr. Scott Cooper**, the hospital's President and Chief Executive Officer from 2004 until his recent retirement; **Dr. Malcolm Phillips**, its long-time chair of medicine; and **Dr. Joel Sender**, director of the Geriatrics Division and medical director of the St. Barnabas Rehabilitation & Continuing Care Center. Together, the three have assumed leadership roles at the hospital for more than a combined 100 years. Here, the three physicians speak candidly about yesterday, today and tomorrow.

By Steven Clark



Beginning with the hospital's inception in 1866, it treated the chronically ill, and was known as: The Home for the Incurables. Few patients came from the Bronx and many stayed for years. In 1947, the name was changed to St. Barnabas Hospital for Chronic Diseases. It was not, however, until 1974, when the state ruled there would be only two types of healthcare institutions – acute care hospitals and nursing homes – that St. Barnabas Hospital became officially classified as an acute care facility. As could be expected, St. Barnabas Hospital underwent growing pains in those early years as an acute care facility.

How did you come to SBH and what are your memories of those early years?

Malcolm Phillips: I came in 1980 after I had finished my internship, residency, and cardiology fellowship at New York Hospital. I had every intention of staying there, but in those days they didn't promote private practice and didn't allow people to stay on at their own institution. They told me that I had to spend one year at St. Barnabas Hospital [which had an affiliation with New York Hospital] running their ICU and then would give me privileges at New York Hospital.

When I first went to visit St. Barnabas, I had no idea what to expect. I knew it was on Third Avenue, so I drove with a colleague straight up Third Avenue from Manhattan. It was July 1st and it was hot and the car overheated. There were no cell phones in those days and no pay phones along the way, but we found open hydrants and empty beer cans and filled the radiator. We got there an hour and a half late, but they were all waiting for us because we were there to help save the hospital with this Cornell affiliation.

After spending a year at St. Barnabas, the medical director at New York Hospital left and the new one said he had never made that promise. At the same time, I liked this place even though they were going through terrible turmoil, both financially and medically. The chairman had to personally go to Con Edison and beg them not to turn off the lights. There were quality problems all along. They made a change in the department of medicine and asked me at the age of 31 to take over and I couldn't refuse. I remember saying to the secretary, 'I'm the acting director. Now what do I do?' I quickly found that the most important thing was to have good doctors. I recruited many doctors and they stayed for years and, in fact, many are still here. I remember recruiting these two pulmonary doctors you may have heard of, Cooper and Sender. They had part-time jobs doing peer review quality insurance for the hospital. This was their moonlighting job. They came up to me one day and said, "You know, you have major problems with this hospital. And, I said, "No kidding." And they said, "How are you going to fix it?" And I said, "It's real easy. You're not just going to review charts, you're going to start treating patients." And I offered them the head of pulmonary, as I did other young doctors in their specialties, like Dr. (Rubin) Silverman, Dr. (James) Croll, and Dr. (Judith) Berger, and they've been with me forever. We had two rules in those days: you had to wear many hats and we didn't want high priced administrators telling us how to treat patients.

> "WE HAD TWO RULES IN THOSE DAYS: YOU HAD TO WEAR MANY HATS AND WE DIDN'T WANT HIGH PRICED ADMINISTRATORS TELLING US HOW TO TREAT PATIENTS."

Joel Sender: Both Scott Cooper and I were brand new pulmonologists at Lincoln Hospital in the summer of 1980, working on behalf of New York Medical College. I thought we were hired to go to the Westchester campus, but the director of the division changed his plans and brought us to Lincoln to be with him. In 1981, we came to SBH after a neurologist told us there was an opportunity to earn extra income reviewing charts after work – the pay at Lincoln was exceedingly poor – so we were both very interested. Once we met Dr. Phillips, Dr. [Richard] Daines, and the medical staff, we realized we could be of service in our specialty area. Dr. Cooper and I "officially" started our business association on December 10th, 1981 by sharing a beer at Ann & Tony's Restaurant (they had a bar back then) and did two pulmonary consults the very next day.

▲ Drs. Sender and Cooper at the 2016 employee dinner.

Scott Cooper: The quality of care was not good. Reviewing the cases, we were stunned at the negligence. Malcolm Phillips heard through the grapevine that we were holding people to real standards and called us in. He said, "You two recognize that we can make it into a good place, that there is potential. Would you be willing to apply for medical staff privileges?" He said the medical staff was ready to start a coup. Ronald Gade, a radiologist (who would become the hospital's CEO), was as appalled as we were and wanted to run for president of the medical staff. We hadn't met him, but knew Malcolm and we trusted that he felt like we did. Gade was successful and we got rid of the old guard and were able to bring good medicine and integrity and ethics into the institution, and built on that. We were all between the ages of 30 and 35, all just out of training and new to being on our own, and felt we had a chance to create the world the way we wanted to.

How was the hospital known in the community then?

MP: It was known as a place you went to die. It had never made the transition in the early '80s to an acute care institution. It ignored the community and the community was afraid of the hospital and rightfully so. When I came here the ER was four beds in what is now the cafeteria and it had contract physicians. I'll never forget getting called down as head of the ICU to see a patient who was rightfully concerned because the doctor had taken an EKG and was finding it very hard to interpret because he was holding it upside down.

JS: Many in the neighborhood were unaware that there was an acute care hospital in the community. Even local businesses didn't know we had an emergency department.

▲ Dr. Phillips (center) at a past hospital gala.

How did the hospital begin to evolve in those early years?

JS: On an average day in 1982 you could count the number of physicians' cars in the parking lot on your own 10 fingers. There were no residency programs; no OB/GYN, a tiny ED, and the medical director lived in a building called "the Cottage" surrounded by a glorious bank of azalea bushes. Nurses lived in the Braker Building. A special chef prepared pizza in the cafeteria daily.

SC: This place was just medicine and surgery for adults then. The next move was the development of the residency program. There was a residency program that was floundering in New Jersey and Gade heard about it and had it transferred to St. Barnabas.

MP: We heard about this residency program at Englewood Hospital, where the head of medical education was very unhappy in the way he was treated and wanted to move it. We said fantastic. We had 35 new interns and residents who came in with great fanfare, and sent a letter off to the ACGME that said "The residents are here, do you want to review the program?" We got back more expletives than a marine drill sergeant on a bad day. They said, "You don't have a program. You can't just move it. We're shutting you down." There was fire coming out of their mouths. The only thing that saved it was that they didn't want to punish the students and they put us on double, triple probation for four or five years and drove us crazy, but we got an accredited program. We started bringing in sub-section chiefs and these were very high quality people and most of them stayed.

SC: We added clinics for the residency program in the employee building, where it was 120 degrees in the summer and there was no air conditioning, but we loved it. The next iteration was when the state health commissioner at the time went to Gade and said Union Hospital is failing and asked if we would take them over. Since Union was a full-service hospital, we now had OB/GYN and peds. It was decided we needed some professionalism in the ED and did a deal with NYCOM to create an ED osteopathic program in the late 1980s. Gade knew I was taking classes at NYU (a graduate degree program for physicians) and said he would pay me an extra salary to create a Medicaid managed care program here. It became a real success financially and in terms of the quality of care, and it grew and mushroomed.

MP: Ambulances used to pass us by. I became part of the Matrix Committee for 911 and as a result got us to be a 911-receiving hospital. We developed a full-time hospitalist program in the '90s. The ICU got much better. We became a medicine-driven hospital as the medicine practiced here became pretty strong. We had a long-standing

"WE'VE HAD GREAT DIVERSITY HERE OVER THE YEARS, WHICH HAS BEEN VERY EXCITING. NEW PEOPLE BRING DIVERSITY AND CHANGE."

affiliation with Cornell, but because they refused to accept patients in our Medicaid HMO (Partners in Health), we changed affiliations to Einstein.

JS: Our real changes began with the core of physicians and physician-administrators in the 1980s, who forged better financial plans, encouraged departmental growth, established highly respected medical training programs, affiliated with teaching institutions, and expanded emergency and specialty services. For about a 12-year period we were one of the most financially stable facilities in the city – saving enough money to construct an addition to the hospital building on our own – without the massive endowments of the larger hospitals. Later the addition of OB/GYN services, our affiliation with New York Hospital, the growth of the outpatient department, the nursing home, regional AIDS Center, and development of trauma services thrust us into the mainstream traffic of healthcare in the region.

SC: In 1996, Gade decided to diversify the institution in two ways simultaneously: he bid on new services available at Rikers Island and on an affiliation contract at Lincoln that New York Medical College was giving up on. To his surprise, we won both bids. He and Daines now had a lot on their hands, which left a vacuum [which I filled]. There was no hierarchy here and I was loud and had plenty of opinions. So people would ask questions and I would give answers and no one second guessed me. So I became a de facto COO. In 2004, Gade called me up and said "I'm retiring." Shortly thereafter, the Board asked me to be his successor.

My job on day one was to figure out what my job was. I was still in full-time practice with Joel and I said to the board I would take the job as long as I could still see patients every day. They said if you want to work 15 hours a day, that's your deal. My dad sold furniture for a living and I said to him, "You know, I don't know if I should be doing this. My mission in life is taking care of patients." He said "It's not a bad idea. You have to look at it like you're moving from the retail to the wholesale side. You have to look at the

Dr. Cooper and Dr. Sender in the mid-1980s. ▶

> "THE HEALTHCARE SYSTEM NEEDS TO EVOLVE TOWARDS BEING AN ACCESS POINT FOR WELL PEOPLE."

opportunity you'll have to affect lives on a broader scale." I liked that. And Joel said, "Go for it. I have your back."

What do you see as SBH's biggest challenges moving forward and where do you see the hospital in the next five, 10 years?

MP: It's unclear, but the community will always have a need for excellent service and excellent doctors. We've had great diversity here over the years, which has been very exciting. New people bring diversity and change.

SC: The hospital needs to evolve in conjunction with medical care, meaning inpatient care can no longer be the center of the universe. The center of gravity has to shift across the street [the new health and wellness center to be built] on Third Avenue. The healthcare system needs to evolve towards being an access point for well people. In five or 10 years from now, it will be about what's across the street, where you'll be able to get preventive care, nutrition, a fitness program and treatment for your diabetes. And if, God forbid, you get sick, we have a hospital we can put you in.

JS: We are at a watershed moment when we truly need to flex our collective muscles to actively manage the health of a large numbers of people in our community. For many years our hospital excelled at value, and now the payment systems are re-aligning in such a way that our strengths might be put to the test. Theoretically, we've always outperformed the larger players – our weaknesses have always been our demographics and the payment sources that accompany our community. Surviving the transition to value care is the order of the day.

SBH will need to partner well and focus on excellent healthcare management. We may even need a new physical hospital building with better allocations of space. Most of all we will need to expand into our community and work with more of the groups in our region. If value care proves to be our strength, then it remains essential that the ACO's and insurers recognize that as well. There is promise in our association with the CUNY School of Medicine, and the hope that we become more academic over time.

What would you say to young doctors coming to work here?

SC: Embrace change. Don't get stuck in tradition, be willing and anxious to look at change and mold it in a way that benefits your mission.

MP: I tell young doctors that this is a hospital with a heart. We don't have many layers of bureaucracy and everyone is committed to taking care of people. The nicest thing about taking care of underprivileged people is if you show them any kind of caring, they respond tenfold. They are very grateful.

JS: With all our growing pains there is likely no better place to make an impact. I've been in contact with young physicians in my "new" field of geriatrics and find that they often have great difficulty in feeling appreciated and in creating and carrying out new and stimulating projects. We are still a place where creativity and innovation are possible.

Would you make the decision to come here if you had to do it all over again?

MP: Of course I would do it over again. It's been a heck of a ride. At 31, I was given the chance to mold the department over many years. I'm proud of the people we've brought in and have stayed. We've grown old together and made the place what it is today. This kind of continuity in a department of medicine is almost unheard of. The fact that we're a community, city, and private hospital all in one is unusual. My criteria was to take people who were incredibly well trained, who were dedicated to doing community hospital service, and recruit them, treat them nicely, and have a collegial atmosphere, and that's why they stayed.

I never would have had this opportunity at New York Hospital. When I first came here, we didn't have approval to see heart attack patients. It's been fun to see the development of cardiology, a cath lab, a full-time electrophysiologist, a congestive heart failure group. It's been a nice evolution.

JS: Looking back is always tricky, and the grass is always greener on someone else's lawn, yet I feel great personal satisfaction for having been a part of the progress, having witnessed enormous change, and having practiced in two fields with a sense of purpose. I suppose that's what a career is supposed to offer and I'm proud to say I've been a part of the journey.

SC: I would do it again in a minute. ■

The Impact of Generic Drug Costs

By Curvin Jolly, CPT, BS, MBA, Senior Buyer, Pharmacy Department

Over the past two years, SBH Health System's inpatient pharmacy, like most other hospital pharmacies, has seen unprecedented increases in the prices of generic drugs, causing unexpected cost increases.

This situation has made pharmacy operation managers, buyers and clinical pharmacists zero in on alternative measures to help pharmacy departments stay on budget and, at the same time, to continue excellent care to patients. Although generic drug price increases in the third quarter of 2015 did not incur substantial increases, the price of those generic drugs, which increased in range from 100-1,000%, never went back to their original prices.

An analysis was done for the time period of January 1st to June 30th, 2016. The analysis intended to explain SBH's pharmacy budget performance (YTD 2016) versus the comparable period of 2015. The method used to evaluate current budget performance was evaluation and analysis of inflationary contribution to generic and branded prescription (Rx) drugs leveraged on the drug cost in 2016. Table 1.0 below is broken down into three categories:

The first category consists of all Rx purchases that were rationalized (combination of generic and branded purchases), including contract and off-contract purchases. The data indicate that by comparing 2016 to 2015 for the same period overall acquisition cost deflated by 0.21%, while pharmacy utilization decreased by 5.49%, leading to an overall decrease in Rx drug spending by 5.70%. This overall decrease in SBH pharmacy drug spending contributed a favorable YTD 2016 budget variance of -$162,000.

The second category includes branded Rx purchases that were evaluated and rationalized for their impact on the overall contribution to cost inflation. The numbers were not what we expected. From the table, all three circumstances that were evaluated show the price deflation of 0.96%, 4.12%, and 6.51%. Also, the clinical and operational divisions of pharmacy as well as the group purchasing organization (GPO) were able to implement processes to initiate a decrease in the overall utilization of branded drugs.

The final section of Table 1.0 includes rationalized SBH generic drug inflationary factors. The numbers indicate that generic contract and off-contract purchases inflated 6.72% overall in 2016, 5.02% of which was contributed by utilization increases, while price contribution was 1.70%. We also evaluated only contracted generic drug purchases and noticed that even contracted generic drugs continued their price increase in the first two quarters of 2016 by 5.90%, which indicated that the GPO could not hold the price inflation to the projected 4.5% for 2016.

All in all, this research evaluated utilization and price inflation factors of brand and generic drugs for the period of 2015 - 2016, and, out of the analysis, it can be deduced that the driving force behind the overall drug price increases was heavily impacted by the increase of generic drug prices. It gives the opportunity to see a tendency of overall inflation changes in this sphere.

ALL (BRANDED + GENERIC)							
Overall Inflation Factor	Utilization Inflation Factor	Price Inflation Factor	Rx	Generic	Brand	Contract	Off-Contract
-5.70%	-5.49%	-0.21%	√	√	√	√	√
BRANDED DRUGS RATIONALIZATION							
Overall Inflation Factor	Utilization Inflation Factor	Price Inflation Factor	Rx	Generic	Brand	Contract	Off-Contract
-10.14%	-9.19%	-0.96%	√		√	√	√
-1.40%	2.72%	-4.12%	√		√	√	
-6.88%	-0.37%	-6.51%	√		√		√
GENERIC DRUGS RATIONALIZATION							
Overall Inflation Factor	Utilization Inflation Factor	Price Inflation Factor	Rx	Generic	Brand	Contract	Off-Contract
6.72%	5.02%	1.70%	√	√		√	√
5.90%	2.48%	3.42%	√	√		√	
21.84%	148.99%	-127.14%	√	√			√

Apendix A - Index Factor Formulas

Price Factor (%) = (Sum of Total Inflation / YTD_2015 Total Purchases)*100
Overall Utilization Factor (%) = [(Sum of Unit difference*Sum of YTD_2015 Price) / YTD_2015 Total Purchases]*100
Utilization Inflation Factor (%) = Total Purchase Difference / YTD_2015 Total Purchases)*100
Overall Inflation Factor (%) = Utilization Inflation Factor + Price Factor

Hospitalist Program Uses Population Health Approach

Based on an interview with Dr. Raj Gurunathan, Director, Division of General Internal Medicine, Department of Medicine

Since their introduction to the medical landscape in the 1990s, hospitalists continue to be a growing presence in healthcare institutions around the country. With a specialized professional focus on delivering high-quality inpatient care, through roles as direct care providers, medical educators, and quality improvement champions, they are an integral part of hospital-based care services, and have increased in number to over 25,000 providers nationwide.

The Hospitalist Program at SBH is similarly focused on the care of hospitalized patients, and driven by an over-arching mission aimed at supporting the overall health and welfare of patients in the South/Central Bronx community. Together with the Section of Ambulatory Care, also housed within the division, the program strives to be innovative, collaborative, and outcomes-based in its approach to patient care delivery, and seeks to foster the development of an integrated system, which provides comprehensive patient care that encompasses the transition from the hospital setting to the home. In this vein, hospitalists serve as liaisons for community physicians, communicating with primary care doctors, coordinating with sub-specialists, and developing comprehensive care plans for patients and families, helping them return to the practice they came from so their primary physicians can continue in their care.

What makes the SBH hospitalist program truly unique is that its doctors have been asked to focus on a population health-approach to patient care, a nuance that is rarely found elsewhere. As the healthcare world continues to be challenged to change the way care is delivered, with an emerging emphasis on value and quality over volume, it is critical that doctors are engaged with patients and their families, adept at evaluating social determinants of health and identifying high-risk patients, and appropriately using both care management and community resources at SBH and through the New York State DSRIP program.

Part of this delivery system transformation includes a mandate to identify patients who don't have access to appropriate medical care, or whose care is fragmented, and to promote a culture of safety, wellness, and disease prevention. Fragmented care and poor health literacy are common occurrences in this community, and the responsibility is to link these patients with appropriate physician practices and community resources that engage patients and their families in understanding and managing their disease burden moving forward. Hospitalists serve as in-patient bridges to these "medical homes," promoting integrated, coordinated care rather than maintaining "old world" healthcare siloes that have historically separated the roles of ambulatory physicians and hospitalists and hindered patient care. Construction of the new Third Avenue development, to include affordable housing and on-site programs that focus on preventative care and wellness, will serve to further this model, in hopes of stemming physical and mental health issues that have plagued communities in the Bronx for generations, such as lung disease, asthma, heart disease, stroke, and diabetes.

Just as important as the focus on prevention and wellness, is the focus on safety within the hospital setting and improving the patient experience. SBH hospitalists are key participants in numerous multi-disciplinary workgroups aimed at reducing central line and urinary catheter related infections, as well as reducing 30-day hospital readmissions following discharge. They are also part of a widespread hospital initiative to elevate the patient experience, with special focus on communication and engagement of patients and their families. By providing timely, evidence-based care, in an empathetic, compassionate and communicative manner, the hospitalist program hopes to help patients cope with the challenges and frustrations that can come both with acute illness as well as chronic disease, and provide them with a sense of well-being, knowing that the hospital does indeed "hear their voices" and is respectful of their needs.

As SBH embarks on this transformative journey in healthcare, it is paramount that these concepts of safety, wellness, disease prevention, and high-quality care be brought forth to the next generation of physicians, and that hospitalists serve as core faculty responsible for the training and supervision of the hospital's large Internal Medicine residency program, as well as medical students from the newly anointed CUNY School of Medicine and the Albert Einstein College of Medicine. The hospital takes great pride in these endeavors, and looks forward to continuing to learn and teach together. Note that in recent years over 80% of its graduating residents have gone on to become hospitalists at SBH and at hospitals throughout the country.

SBH is very excited for the future of healthcare in this community. While its vision and development plan are clearly long-term, there are many building blocks in place – a dedicated group of core hospitalist faculty, growing infrastructural support and opportunity for collaboration within the network and with Bronx Partners for Healthy Communities within the DSRIP program, strong academic partners, and an institutional commitment to population health and service to the community – that enable SBH to look with great anticipation towards the future.

Organ Procurement Program Supports Growing Demand

By Steven Clark

The demand for organs in the United States has never been greater, with more than 120,000 patients presently on the United Network for Organ Sharing (UNOS) list waiting for kidney, liver, heart, lung and pancreas transplants. Transplants, after all, give people a chance to resume full, productive lives.

At the same time, the numbers of deceased donors and deceased donor organ transplants have remained virtually static since 2003 (a little over 20,000). Due to various reasons, lack of identification, lack of consent (the primary reason), and various systems issues, only 42 percent of potential donors actually donate. If that sounds low, the percent of potential donors in New York State who donate is far worse – about half the national average.

As a result, the waiting list has increased to more than two years for half of the patients listed on the transplant registrar. About 10 percent of adult patients die awaiting transplantation. At a time when transplantation is the standard of care for patients with end-organ failure who fail medical therapy, the shortage of organ transplants has reached crisis proportions.

SBH Health System, as a donor hospital partnering with LiveOn New York – the area's designated organ procurement organization (OPO) that works with 10 transplant centers and more than 90 hospitals – is trying to improve the odds.

"We start as early as possible working with patients and their families," says Dr. Raghu Loganathan, director of Division of ICU/Pulmonary Medicine, and the physician responsible for the organ procurement program at SBH. "The public needs to be better educated, as do physicians. We now have established policies and procedures in place."

This includes efforts in the five phases of organ procurement: referral, declaration of brain death, donor management, consenting, donor evaluation and recovery.

When a deceased organ donor is identified, UNOS' computer system generates a ranked list of transplant candidates, or "matches," based on blood type, tissue type, medical urgency, waiting time, expected benefit, geography and other medical criteria.

Early efforts at SBH have been positive. In 2015, 11 lives were saved through organ replacement.

Donor Evaluation

Potential organ donors are declared either brain-dead (with cessation of certain neurological functions) or have suffered cardiac death after withdrawal of life support. Unlike in the past, there are now fewer medical contraindications – all well-established – to organ procurement. Donors are no longer ruled out based on chronic diseases or older age. In fact, HIV positive donors

Organ Donation Facts*

- One organ donor can save up to eight lives. The same donor can also save or improve the lives of up to 50 people by donating tissues and eyes.
- More than 120,000 people in the United States are waiting for organ transplants. Of these, more than 10,000 live right here, in the greater New York metropolitan area.
- On average, 18 people die every day while waiting for organ transplants in the U.S., and every 10 minutes another name is added to the waiting list. In New York State, someone dies every 15 hours waiting for an organ transplant.
- Each year, more than one million people need lifesaving and life-improving tissues, and eyes. (This includes heart valves, cardiovascular tissue, bone and soft musculoskeletal tissue, and skin.)
- 22% of New Yorkers age 18 and over have enrolled in the New York State Donate Life Registry as organ, tissue and eye donors. Nationwide, the average is 47%.
- Donation only occurs after the death of a patient is declared by physicians who are legally not affiliated with donation.
- The factors that determine who receives an organ include severity of illness, time spent on the waiting list, and blood type. Financial or celebrity status has no bearing on determining who receives a transplant.
- Donation takes place under the same sterile conditions as any medical procedure. A donor's body is never disfigured and donation does not interfere with funeral arrangements. Open casket services are possible.
- If you're a donor, the family does not pay any bills related to donation.
- All major religions support donation.
- The success rate for organ transplants is between 80 and 90 percent.

*According to LiveOn New York

"Although aggressive, the timetable for organ procurement can extend up to 72 to 96 hours to match the appropriate donor and recipient."

are now considered for procurement in selected instances.

According to Dr. Loganathan, a significant percentage of lost donor organs from brain-dead patients have resulted in hospitals demonstrating inadequate medical care prior to organ procurement. As the prognosis of the "potential donors" is often dismal for survival, clinical staff often develops inertia as they feel hopeless in instituting aggressive interventions.

However, sustaining the same intensity of care prior to declaration of brain death and consenting is appropriate to prevent somatic death and keep the option of organ donation open for families.

"At some point, we end life-sustaining treatment and transition to the goal of maintaining the organs for donation," he says. "At this time, we may be continuing to perform invasive procedures and manage the patient as any other critically ill patient in the intensive care unit. Subsequent to consenting, other procedures may include liver biopsies, bronchoscopy, dialysis, and cardiac catheterizations, and giving medication and performing blood investigations to keep the patient's organs functioning until procurement."

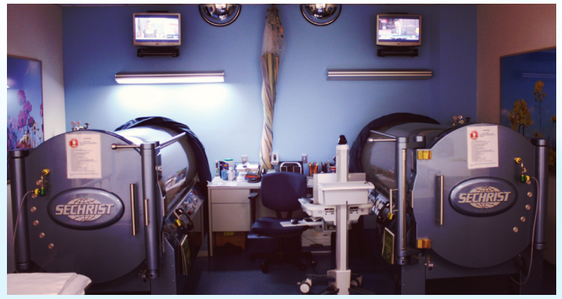
SBH Health System has been a leader in this area among various city and local hospitals, as intensive care physicians have a focused and aggressive approach in the ICU to better manage potential donors, including hemodynamic monitoring and treatment.

Although aggressive, the timetable for organ procurement can extend up to 72 to 96 hours to match the appropriate donor and recipient. LiveOn New York coordinates with transplant surgeons who remove organs locally in the operating rooms at SBH that are then rushed to local hospitals or to facilities in different parts of the country. In addition, specialized counseling services through LiveOn NY work closely with families to help them better understand the process. This includes provision of anticipatory guidance and social services assistance to family members before and after donation. This allows for grieving during this process, which includes permitting family members to be present in the operating room when their loved one has been declared with cardiac death, up until the transplant surgeons enter the room.

Mechanisms have also been put in place to increase the consent rates of available donors. Many state motor vehicle departments provide opportunities for individuals to register for organ procurement at the time of application or renewal of drivers' licenses. More information can be found at local DMV offices or online at donatelife.net.

HBOT Offers Help To Patients With Diabetic Ulcers

While talking on the telephone, Hyacinth Carr, a 63-year-old Bronx woman with type 2 diabetes, absent-mindedly picked at a slight cut on the big toe of her left foot. Within a short time, the area became infected. When the infection did not heal, she went to see her podiatrist, Dr. Andrew Campbell, at the Center for Wound Healing & Hyperbaric Medicine at SBH Health System.



The hyperbaric chambers at the SBH Center for Wound Healing and Hyperbaric Medicine.

"She had an abscess, was hospitalized for a couple of weeks and treated with antibiotics," says Dr. Campbell. "We then did some studies and consulted with infectious diseases [at the hospital] and it was determined that she had early OM."

Dr. Judith Berger, Director of Infectious Diseases, and her team will typically review the pathology, x-rays and/or MRI, and physically examine the patient's foot, collaborating with podiatry to recommend treatment for a patient with an unhealed wound. "The healing process for patients with diabetic ulcers has to do with three things: local care, systemic antibiotics and making sure the antibiotics get down there [to the infection]," says Dr. Berger. "If the blood supply is poor, the wound won't heal." This is where a vascular surgeon might get involved to improve the patient's circulation and/or, in the case of Mrs. Carr, there may be the decision to treat the non-healing wound with hyperbaric oxygen therapy (HBOT).

Without such treatment, patients like Mrs. Carr face the very real possibility of amputation.

Diabetes and Amputation

Studies show that every year 1.9 percent of diabetics develop a foot ulcer (as many as 25 percent of diabetics will have one at some time in their lifetime). Of these, 15 – 20 percent will undergo an amputation within five years of ulcer onset. Diabetic foot ulcers are precursors to 85 percent of major leg amputations, which lead to increased morbidity and mortality rates.

They often appear very suddenly and can grow progressively worse within 24 to 48 hours, says Noel Davila, a certified hyperbaric oxygen technician and safety director/HBOT coordinator for the center.

"As diabetics often lose sensation in their feet due to poor circulation, they may not even notice the injury," he says. "A seemingly insignificant wound can go south quickly and result in amputation within a matter of weeks. They need to remain hypervigilant."

For many of these patients, HBOT, which involves the intermittent administration of 100 percent oxygen inhaled at a pressure greater than sea level, is prescribed along with normal wound care (e.g., debridements, IV and/or oral antibiotics, and offloading, which may include the use of contact casting to take pressure off the ulcer). For Mrs. Carr, this meant 30 "dives" in the hyperbaric oxygen chamber, 90 minutes per session.

The Effects of HBOT

Studies have consistently showed the benefits of HBOT as an adjunctive treatment for diabetic ulcers. According to one study, diabetics suffering with foot ulcers avoid amputation 61 percent of the time while undergoing traditional wound treatment. That number jumps to 89 percent when HBOT is added.

The center at SBH can accommodate eight patients a day in its two monoplace chambers, with diabetic ulcers accounting for about 90 percent of their patients (with such other acute conditions as crush injuries, acute traumatic peripheral arterial insufficiency, compromised skin grafts and flaps, and soft tissue radionecrosis). Diabetic wound patients are typically treated in chambers pressurized at 2 ATA (atmospheric pressure absolute, which is equivalent to the pressure 33 to 48 feet below sea level).

HBOT works by increasing the saturation of oxygen in the blood by "force feeding" it through the lungs to the rest of the body. Increased oxygen – more than 10 times the normal amount in the bloodstream – can promote white blood cell activity, encourage tissue development and promote capillary growth.

According to an article in the journal *Podiatry Today,* "Oxygen under hyperbaric conditions 'behaves as drugs' and hyper-oxygenation causes a decrease in leg edema and excessive inflammation, an increase in the growth factors and receptors (VEGF and PDGF), doubled flexibility of red blood cells, increase in bacteriocidal capacity, and mobilization of the stem cell within the bone marrow to increase the circulating progenitor cells within the blood stream eightfold. These effects triggered by HBOT specifically counteract the facts known to impair wound healing, especially in patients with diabetes."

Since 2003, the Center for Medicare and Medicaid Services (CMS) has authorized reimbursement of HBOT for diabetic foot wounds – Wagner grade III or IV – as does virtually every private payor. A Wagner grade III diabetic ulcer is defined as a deep wound with abscess, osteomyelitis or tendonitis extending to those structures (whereas Grade I represents a superficial wound and grade IV indicates gangrenous toes and forefoot).

Although he offers the caveat that "every ulcer has a story," Dr. Campbell says he has seen a high rate of success with HBOT for those with diabetic ulcers. And, whereas in the past, the compliance rate among diabetic ulcer patients at the center was very low – estimated at 30 percent – the wound team has increased it today to well over 90 percent.

"HBOT works by increasing the saturation of oxygen in the blood by 'force feeding' it through the lungs to the rest of the body."

"It's been multifactorial," says Dr. Campbell, in explaining the reason for the improvement. "We've been a little more aggressive in tracking down patients and trying to remove some of the barriers, as well as educating them on how important treatment is. We juggle schedules and we're flexible."

As with a majority of diabetic ulcer patients seen by the center, Mrs. Carr is a recurrent patient. Three years ago, she lost the big toe on her right foot. She had a second ulcer that healed about a year ago. She credits HBOT and daily wound healing treatments (which included having a nurse treat her at home) for saving her other toes from a similar fate.

"When I came back [for the third time], Dr. Campbell asked me if I would be willing to do hyperbaric oxygen treatments again," says Mrs. Carr, who started treatment in late May. "I said, 'Yes, if it works.' After surgery, the foot was still infected. I could see and feel the difference within a week [of HBOT]. Before I started with the treatment, the foot was swollen, discolored and there was a discharge. This all went away, and the pain diminished within a week."

On a scale of 1 to 10, she said her foot pain was sometimes as high as a 10 and usually an 8.

The risks of HBOT are minimal. Most patients, says Dr. Campbell, even those with compromised health, are able to tolerate it. Mrs. Carr is a cancer survivor, having been treated with chemotherapy and radiation.

Mrs. Carr says her ears sometimes "popped" when she exited from the chamber, similar to the feel of traveling on an airplane. This is not uncommon.

Claustrophobia is one contraindication to HBOT. "I'm somewhat claustrophobic," she says. "I can't do a closed MRI, but I've never had a problem with the hyperbaric oxygen." This might have something to do with the fact that the casket-like chamber, made of acrylic, is clear on all sides.

Using Suboxone as an alternative addiction treatment

Maria is a 63-year-old woman with a history of polysubstance abuse.

"I used to do heroin every day for 32 years," she says. While heroin was her drug of choice, she also dabbled in cocaine, alcohol, pain killers, and other drugs. She battled Hepatitis C, a result of her drug habit. Yet, for 10 years, until about a year ago, she says she was clean until a variety of personal issues caused her to relapse.

Motivated by her daughter and her grandchildren, Maria got help. After undergoing inpatient detox, she started an outpatient treatment program with the Addiction Medicine department at SBH Health System that includes the use of suboxone and individual and group counseling.

"She's done extraordinarily well. She's a star," says Dr. Jonathan Samuels, medical director of Addiction Medicine. "She takes her medication, has had clean urine [screenings] and attends group therapy. It also helps that she has a stable family."

Maria is one of about 50 patients in SBH's suboxone treatment program, which is offered as an alternative to its long-standing methadone maintenance treatment program (MMTP). Approved by the FDA in 2002 and offered by SBH since 2014, suboxone – a drug produced through the combination of buprenorphine and naloxone and administered in sublingual strips – offers certain benefits over methadone.

With methadone, some patients complain of feeling sedated. It can cause dry mouth and has a high sugar content, both of which contribute to a high rate of dental caries and periodontal disease. Overdose is a real possibility. As such, methadone patients require more frequent monitoring and may often need to be seen on a daily basis to receive their medication.

Patients like Maria who use suboxone can be given a month-long supply of the drug. "It's virtually impossible to overdose on suboxone alone – although when combined with alcohol or benzodiazepines it does remain a risk," says Dr. Samuels.

Patients beginning the suboxone regimen typically undergo an initial period of close observation and dosage adjustment with frequent urine toxicology screens before receiving monthly home supplies.

Dr. Samuels speaks positively about the use of suboxone, but is candid about the uphill battle faced by addicts who, as a rule, often relapse. Not every suboxone patient, he says, has been as successful as Maria.

"It works for me," says Maria. "I feel beautiful and I don't feel like using."

Medical Futility

By Steven Reichert, MD, Director, Palliative Care

A 50-year-old man with a history of prior coronary artery disease, hypertension, prior myocardial infarction and congestive heart failure suffers cardiac arrest at home. CPR is not started at home by the family; EMS arrives eight minutes after the call and begins CPR.

After 30 minutes of CPR, circulation is restored. However, the patient suffers two more episodes of cardiac arrest in the ER with a combined 40 minutes loss of circulation. He is stabilized and transferred to the MICU where he is sustained on life support. After five days, the patient remains in a comatose state with only diffuse myoclonic movements and occasional seizures. CT scan and EEG demonstrate severe anoxic encephalopathy and neurology opines that the patient's long-term potential for neurological function is essentially zero. The wife is informed that the patient will remain in a vegetative state. She is a devout Catholic and states that God will provide a miracle and that her husband will wake up. She declines removal of artificial life support and requests prolonged artificial life support.

Discussion

Medical futility refers to interventions that are unlikely to produce any significant benefit for the patient or the family. Whether referring to the likelihood an intervention will benefit the patient or where the quality of the benefit may be very poor, the determination of value can vary greatly depending on the perceptions of clinicians, patients or families. Physicians are not obliged to offer treatments that do not benefit patients, prolong suffering or give false hope; however, patients or surrogates may see an intervention as beneficial where a clinician may not. As physicians we must respect the autonomy of patients and their families in medical decision making even though the degree of benefit is dubious.

In New York State, a medical therapy is deemed futile only if the patient's death is imminent even if the therapy is provided. Therefore, although at the time of the patient's initial cardiac arrest and comatose state he is deemed vegetative, the provision of artificial life support provides the opportunity for continued life in a nursing home. Although many would consider this care futile, medically inappropriate or even prolongation of life without quality, the patient's family has the right to continue this care as his life may be prolonged with the ventilator. Life support may give family time to pray or proceed through the stages of grieving (Denial, Anger, Bargaining, Depression, and Acceptance) or may simply be the way they wish for their loved one to live. From a sociological perspective one might question the cost and value to society for providing this care; however, rationing of health care, while important, does not supersede patient autonomy.

Case Continued

The patient is sent to a nursing home and six months later returns after suffering another cardiac arrest. Although resuscitation is successful, subsequent testing confirms that the patient is brain dead. His family remains steadfast at the bedside and refuses to allow for the ventilator to be removed.

While patients and families have the right to autonomous choice, a physician is not obliged to provide care that they feel is unethical or illegal. Families cannot demand surgical procedures where the surgical risk is deemed too high or the procedure will provide no benefit. Patients who are brain dead are legally dead and continued life support, supportive care or CPR cannot be demanded by family.

In resolving cases where physicians differ in judgment with patients or families, it is most helpful to explore the values and preferences of our patients. Spiritual and religious beliefs must be respected as long as the treatment remains within the legal statutes of the state and the ethical values of the treating physician. At times, families and patients lack the insight or education and fail to understand the diagnosis, prognosis or limitations in treatments available.

Resolution

A family meeting is held where the ICU staff, hospital palliative care team and chaplain meet with the patient's family. The legal aspects of brain death are explained in appropriate terms and at the family's request a second opinion regarding the diagnosis of brain death is provided. They are also given time to pray with a priest. After the second opinion confirms brain death, the family agrees to removal of the ventilator and the patient dies.

Dr. Ernest Patti, senior emergency medicine physician and president of the SBH medical staff, poses with students at Sophie Davis School of Biomedical Education after receiving its Faculty Appreciation Award at the school's commencement.

Presentations

Lacey Elwyn, DO, OGME-III; Cindy Hoffman, DO; Charles Gropper, MD; Damian DiCostanzo, MD

Pseudomonas-induced cutaneous polyarteritis nodosa

Annual American Academy of Dermatology Gross and Microscopic Symposium
June 8, 2016, Washington, DC

Lacey Elwyn, DO, OGME-III; Cindy Hoffman, DO; Charles Gropper, MD

Alternative treatments for hormonal acne, topic spironolactone and osteopathic manipulative therapy

NYCOMEC Resident Research Poster Competition
May 18, 2016, New York, NY

Raid Sadda, DDS

Top lesions of the oral cavity and appropriate brief treatment

Mandaean Medical Professionals Conference
July 29, 2016, Scheveningen, The Netherlands

Berry Stahl, DMD

Understanding sedation in dentistry

Indian Dental Association
February 21, 2016, Floral Park, NY

Marisa Wolff, DO, OGME-IV; Cindy Hoffman, DO

A novel case of osteoma cutis following tyrosine kinase inhibitor therapy with a dramatic response to intralesional sodium thiosulfate injections

New York Academy of Medicine Dermatology Resident Research Night
June 6, 2016, New York, NY

Awards

Trisha Arno, DO
Osteopathic Principles & Practice Award,
SBH Emergency Department

Amr Badawy, DO
Resident Teaching Award,
SBH Emergency Department

Feliciano Emralino, MD
Faculty Teaching Award,
SBH Pediatrics Department

Howard Greller, MD
Outstanding Faculty Award,
SBH Emergency Department

Charles Gropper, MD
Super Doctors,
The New York Times Magazine

Ana V. Gutierrez, MD
Compassionate Physician Award,
SBH Pediatrics Department

Leeva Mathew, DO
Compassionate Resident Award,
SBH Emergency Department

Shiori Nariai, MD
Physician Scientist Research Award,
SBH Pediatrics Department

Ernest Patti, DO
Faculty Appreciation Award, Sophie Davis School of Bioeducation Class of 2016

Jeffrey Whitener, DO
Outstanding Performance in Emergency Medicine, SBH Emergency Department

Marisa Wolff, DO, OGME-IV
American Osteopathic College of Dermatology A.P. Ulbrich Resident Research Award and American Osteopathic College of Dermatology Daniel Koprince Award

Aparna Yadatore, MD
Resident Teaching Award,
SBH Pediatrics Department

iMedicine

The Rise of Mobile Apps in Healthcare

In 2015, mobile app usage increased by 58 percent.

As mobile technology continues to assert its dominance, it's also making a noticeable impact in the healthcare sector. With the emergence of wearable fitness trackers like FitBit and Apple Watch, it's no surprise that doctors are also benefiting from the digital boom. We asked our doctors to tell us about their favorite apps.

72% of physicians access drug information from smartphones.

63% of physicians access medical research from tablets.

62% of smartphone owners have used their phone in the past year to look up information about a health condition.

Mina Attaalla, DO
Director, Simulation Education and Informatics, Emergency Medicine

Twitter

"It provides you with real-time information on technological innovations and procedures. Check out #FOAMed."

Jakub Bartnik, DO
Chief Resident, Emergency Medicine

Bugs & Drugs

"Real-time antibiogram and gives data on how to treat specific infections."

Dhaval Desai, MD
Chief Resident, Internal Medicine

Medscape

"Great reference tool for looking up information about drug dosing and interactions."

Lacey Elwyn, DO
Chief Resident, Dermatology

Epocrates

"Quick access to information about drugs, disease and differential diagnoses."

2016 Graduates – Congratulations!

Emergency Medicine

Trisha Arno, DO
United States Air Force
Hampton, VA

Mina Attaalla, DO
ED Director of Simulation Education and Informatics, SBH Health System
Bronx, NY

Amr Badawy, DO
Fellowship,
Maimonides Medical Center
Brooklyn, NY

Brittney Di Bella, DO
South Nassau Communities Hospital
Oceanside, NY

Atif Farooqi, DO
Fellowship, Stony Brook University Hospital
Stony Brook, NY

Annie Lau, DO
Halifax Health Medical Center
Daytona Beach, FL

Ali Shabestari, DO
Howard University Hospital
Washington DC

William Trinh, DO
EMPROS
Ormond Beach, FL

Shawn Weber, DO
North Colorado Medical Center
Greeley, CO

Jeff Whitener, DO
Mobile Infirmary
Mobile, AL

Internal Medicine

Shradha Ahuja, MD
Assistant Professor of Medicine, University of Mississippi Medical Center
Jackson, MS

Sumera Andleeb, MD
Wake Forest University
Winston-Salem, NC

Blerim Arifi, MD
New York, NY

Vikram Arya, MD
Penns Highland Healthcare
Du Bois, PA

Saba Bekele, MD
Mercy Hospital
Long Island, NY

Desai Dhaval, MD
Chief Medical Resident,
SBH Health System
Bronx, NY

Supreet Dhaliwal, MD
Jacobi Medical Center
Bronx, NY

Karina Diaz, MD
South Miami Hospital
South Miami, FL

Swapna Garrepalli, MD
JPS Health Network
Fort Worth, TX

Muralidhar Idamakanti, MD
Chief Medical Resident,
SBH Health System
Bronx, NY

Manan Jhaveri, MD
General & Transplant Hepatology Fellowship, Swedish Medical Center
Seattle, WA

Lavanya Manimaran, MD
JPS Health Network
Fort Worth, TX

Lourdes Martinez, MD
Heart of Florida Regional Medical Center
Davenport, FL

Laxmitejaswi Mittapalli, MD
Baystate Medical Center
Springfield, MA

Niju Baby Narakathu, MD
Marietta Memorial Hospital
Marietta, OH

Madhusudhan Ponnala, MD
Montefiore Medical Center
Bronx, NY

Moises Salcie, MD
St. Claire Regional Medical Center
Morehead, KY

Arash Samarghandi, MD
Virginia Commonwealth University
Richmond, VA

Praveena Satti, MD
Florida Hospital Memorial Medical Center
Daytona Beach, FL

Jacob Scutaru, MD
Infectious Disease Fellowship, Strong Memorial Hospital
Rochester, NY

Khairi Smina, MD
Mount Carmel Hospital
Columbus, OH

Yu Sun, MD
Medexplus Medical Center
Queens, NY

Ricardo Velasquez, MD
Pulmonary & Critical Care Fellowship, Westchester Medical Center University
Valhalla, NY

Prashanthi Veludandi, MD
Geriatric Fellowship,
Montefiore Medical Center
Bronx, NY

Zhigang Zhou, MD
Chinatown Medical Physician PC
New York, NY

Na Zhu, MD
IU Health Arnett Hospital
Lafayette, IN

Anil Kumar Nalla, MD
Montefiore Medical Center
Bronx, NY

Emergency Medicine/Internal Medicine

Karan Parmar, DO
Memorial Hermann
Houston, TX

Ambica Sandhir, DO
TeamHealth
Knoxville, TN

Surgery

Parker Bassett
Private Practice
Midland, TX

Jungwoo Han, DPM
Private Practice

Quynh Lee, DPM
Private Practice
Long Island, NY

Sean Lee
Fellowship, Lutheran Medical Center
Brooklyn, NY

Ravinder Reddy, DPM
Private Practice
Dallas, TX

Anthony Zizzamia
Private Practice

Pediatrics

Jarreau Chen, MD
Children's Hospital at Montefiore
Bronx, NY

Ana Hernandez, MD
Private Practice
Laconia, NH

Conalu Liwag, MD
Private Practice
Modesto, CA

Katarzyna Maryniak, MD
Private Practice
Riverside, CA

Shiori Nariai, MD
Private Practice
Oxnard, CA

Aparna Yadatore, MD
Chief Resident, SBH Health System
Bronx, NY

We like to stay in touch with all SBH alumni. Please send updates to webmaster@sbhny.org.

SBH Residency Program Highlights:

- Impressive 10-acre landscaped campus with 461 hospital beds
- Affiliated with the Albert Einstein College of Medicine and NYIT College of Osteopathic Medicine
- Training programs for 250 physicians in 9 different specialties
- 31 IM residents each year (PGY-1/2/3)
- New York State-designated Level 1 Regional Trauma Center
- New York State-designated AIDS Center
- Three ambulatory care sites
- Medical library with internet access
- Simulation lab access
- Centers for sleep medicine, wound healing and hyperbaric medicine, and infusion services
- Primary teaching hospital of the newly approved CUNY School of Medicine
- Major location for medicine clerkships for students from the Albert Einstein College of Medicine and NYIT College of Osteopathic Medicine
- Increase outpatient exposure for those residents interested in primary care
- Senior house consultation services

For more information, please visit www.sbhny.org or call 718-960-6202.

SBH Health System BRONX

Bronx Project Sees Health in Affordable Housing

Complex is designed to address many of the hurdles facing low-income residents. **By Keiko Morris**

A 150-year-old health-care institution in the Bronx has a new prescription for wellness that starts with affordable housing.

SBH Health System, which includes St. Barnabas Hospital, has joined with developers L+M Development Partners and Hornig Capital Partners LLC to create a 450,000-square-foot complex designed to address many of the hurdles to healthy living facing low-income residents in the Bronx.

St. Barnabas Hospital, above, in the Bronx and, at right, renderings if the exterior and interior designs for the 450,000 square-foot complex being planned nearby. (Renderings by Dattner Architects.)

The project, located on two parcels across the street from SBH's medical center, will have 314 units, all of them affordable apartments for low-income or formerly homeless households with services such as an ambulatory-care center and a kitchen for teaching healthful recipes.

"If you have a safe place to live, if you have good food, then you can start to think about all those other things that relate to wellness," said David Perlstein, chief executive of SBH Health System.

The $156 million development reflects the broader push in health care to focus on preventive strategies, integrate the way services are delivered as well as cut down on expensive and unnecessary hospitalizations or emergency-room visits.

New York state has set an ambitious agenda to revamp its Medicaid system and encourage providers to come up with ways to cut costs and boost the health of its low-income residents. This complex, on Third Avenue between East 181st and East 182nd streets, embraces those same goals.

"It's not simply that St. Barnabas is trying to design a hospital wing in a patient-friendly way," said Michael Sparer, chair of the health policy and management department at Columbia University's Mailman School of Public Health. "They are building prevention into the housing design, which is impressive."

Financing from New York state's Homes and Community Renewal includes $71.7 million in fixed-rate, tax-exempt bonds and a mortgage loan, low-income-housing tax credits and $7.5 million in Medicaid Redesign Team funds. New York City's Housing Preservation and Development Department is providing $36.8 million in a low-interest, 30-year loan. The Bronx Borough President's office has given the project a $1 million loan.

The developers and SBH plan to pack the project with features that address illnesses such as asthma, heart disease and diabetes. Interior green walls with living plants, trees and other plantings will serve as natural filters, in addition to the buildings' air filtration systems, said Spencer Orkus, a development director at L+M. The developers plan to use paint that breaks down chemical pollutants, Mr. Orkus said.

SBH's 57,000-square-foot medical space in the two-tower building on the north site will house ambulatory care, pediatric and women's health centers.

The complex will provide 95 apartments for formerly homeless families and individuals. Fifty of those units will be part of a supportive-housing component managed by BronxWorks, providing services, including case management, employment training and counseling.

The project offers an effective model with a setting for both social and medical services for formerly homeless residents, who often have many special needs, said James Rubin, commissioner of the state's Homes and Community Renewal agency.

Retail tenants, who won't be allowed to sell tobacco or alcohol, also play a role in the project's mission. Developers are in talks with James Izzo, the former owner of a family-run market on Arthur Avenue, to create a cafe with healthful, affordable food. They plan to bring in a child-care center offering extended hours.

Whether the project can deliver on all of its goals remains to be seen, but Dr. Perlstein is hopeful the project can transform the area.

"People are waiting to see what happens," he said.

Article courtesy of *The Wall Street Journal*
Published: July 10, 2016

Caring for the Bronx *for over* 150 years

Over the years, our doors have opened wider and wider to our diverse community, providing compassionate and comprehensive care.

We want to thank you for being our partner in making our patients feel like they are at the heart of the Bronx.

SBH
1866
Health System
2016
BRONX
CELEBRATING 150 YEARS