SBH-PHYSICIAN

THE MAGAZINE OF SBH HEALTH SYSTEM MEDICAL STAFF **SUMMER 2017**

A PHYSICIAN'S LIFE:
NO REST FOR THE WEARY

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Dear Colleagues,

I'm very proud to introduce the summer 2017 edition of the "SBH Physician Magazine." There are no lazy summer days around SBH this year as you will read about some very exciting work being done by our medical staff. Additionally, we said a fond farewell to our graduating residents and welcomed a wonderful group of new physicians. Take a moment to review all the great accomplishments of our resident staff and read about their exciting plans as they embark on the next steps in their career.

We recently have introduced some amazing new technologies at SBH, including 3-D Mammography, and new pharmacy software to help eliminate medication errors. These tools enhance our ability to provide the highest quality of care to our Bronx community. Speaking of quality, have a look at the update on our terrific achievement, scoring first in the HealthFirst Quality program for 2016. Also, read about the first-ever Bronx Emergency Medicine Simulation Competition pitting SBH EM residents in a patient care simulation battle against other local EM residency programs.

Finally, we celebrated National Doctor's Day recognizing the outstanding contributions of several SBH physicians. The celebration was highlighted by Dr. Judy Berger receiving the 2017 Ronald L. Ciubotaru Physician-to-Physician Award. It was truly a moving ceremony as Dr. Berger's colleagues celebrated her amazing accomplishments during her career at SBH. It reminded all of us what it means to be an SBH physician.

Sincerely,

Eric C. Appelbaum D.O.

Eric Appelbaum, DO, FACOI
Chief Medical Officer

Hospital Collaborative Explores Maternal Depression

By Steven Clark

Last year, Dr. David Perlstein, then working as a pediatric attending, was concerned about the health of an infant who was being seen repeatedly in the hospital's clinic and emergency department. Dr. Perlstein, now SBH's president and chief executive officer, and his team surmised that the condition of the mother's mental health was behind the infant's failure to thrive.

This led in spring 2016 to the hospital's formation of a Maternal Depression Collaborative to study and find answers to this issue. The collaborative brought together clinicians from different hospital departments that had previously worked, for the most part, in siloes when it came to maternal depression – OB, pediatrics, behavioral health and nursing – to explore the problem and create a standardized maternal depression screening and referral process. Coincidentally, at the same time, the Greater New York Hospital Association (GNYHA) started a similar collaborative. By becoming one of GNYHA's participating hospitals in the project, the hospital assured itself of additional resources and support from the citywide effort.

"It started a conversation [within the hospital] of 'what can we do better?'" says Dr. Kathleen Asas, a pediatrician who serves as the project leader. "Before this, while some of our doctors were screening for maternal depression in their clinics, we had no standardized screening process in place and there were challenges with consistent communication between departments regarding patients referred. We wanted to document the data and, when necessary, connect patients to behavioral health as part of the referral process. We still have a long way to go, but we're moving in the right direction."

While celebrities like Chrissy Teigen, Hayden Panettiere, Drew Barrymore and Gwyneth Paltrow have candidly discussed their own bouts with maternal depression, the problem is particularly pervasive in areas like the south Bronx, where socioeconomic, health and educational factors compound the severity of the problem and its occurrence (with as many as 1 in 5 patients reportedly affected here). New York, like most states, does not require maternal depression screening.

Pilot sites at SBH outpatient clinics have since been introduced, with a self-screening tool, the Edinburgh Postnatal Depression Scale, used to monitor mothers during their initial prenatal visit and later during their child's 1-week, 2-month and either 4-month or 6-month pediatric visits. Results of the 10-question test are evaluated at each stage and patients referred to behavioral health when necessary.

The use of technology and EMR has enabled doctors to more effectively gather and track data between departments, says Dr. Asas. This allows for more timely handoffs between OBs, nurses and pediatricians, and referrals to behavioral health specialists.

The challenges, however, remain significant. Due to myriad factors – language, education, fear of losing their children, fear of being deported – many mothers at SBH are still either hesitant to complete the surveys or answer the questions candidly. Others refuse a referral to behavioral health should they score over a certain point total on the screening. Still, the percentage of patients in compliance with the program has increased in recent months.

And, patients have benefitted. The mother who appeared in Dr. Perlstein's clinic a year ago, for example, was found during the screening to have depression. The team connected her with behavioral health services and the city's Administration for Children's Services (ACS). She received treatment and resources that provided her with additional care. In recent checkups, her pediatrician reported being pleased that the child had gained weight and is now meeting his developmental marks. Both mother and child are now connected to additional support services to assist with their health and well-being as a family.

Seeing Health Care Through Our Patients' Eyes

By Luci de Haan

Nationally, 13 percent of Americans are foreign born and 20% speak a language other than English at home. In the Bronx, almost one-third of residents are foreign born and more than half (55.7%) speak non-English languages at home.

Patients who come through our hospital doors may not meet with employees who share the same culture, communication styles and experiences with the health care system. Questions that may seem essential to a health professional might feel confrontational to a patient. Fear of seeming disrespectful or calling into question a provider's language expertise can keep a patient or family member from asking for an interpreter. Some patients may not feel comfortable providing certain information about their health, family history or housing status.

Last November, Bronx Partners for Healthy Communities (BPHC) began offering cultural competency training to the frontline workers of its 230-member organizations. It has quickly become the most popular training program the organization offers to employees.

"The word has spread and classes fill up immediately after we announce a new training," says Mary Morris, BPHC's director of Workforce Innovations.

The one-day, in-person training gives workers the skills and insights to listen, understand and provide care and services through the lens of a patient's or client's own culture, beliefs, language and experiences with the health care system. The training addresses issues of race, ethnicity, religion, disability and sexual identity in the context of how people access care and other services.

Participants learn to take the perspective of the client and see how overwhelming it can be to try to access health care or other community services. They can better understand the external factors that might be guiding a patient's decisions, the lack of control a patient may have over their health care and how that might make them feel.

More than 500 staff members, including nurses, community health workers, registrars, housing specialists and SBH leadership, have been trained. The curriculum was developed and administered by The Jewish Board. For physicians, related training will be offered through BPHC starting in the fall through a program being developed and presented by the Immigrant Health and Cancer Disparities Service at Memorial Sloan Kettering Cancer Center.

A highlight of the training is a historical look of the Bronx starting in the 1890s, when it was considered a "wonder borough," through today, including the immigration wave of the early 20th century, the Depression and the impact of urban renewal in the 1960s and 1970s.

"A light bulb goes off for people," says Morris. "They see the structural and environmental factors that contribute to the many health disparities in the borough like high rates of asthma, cardiovascular disease and diabetes. They understand the framework through which many patients and clients view their world."

Self-awareness is another key element of the training. Participants become more aware of their own beliefs, values, cultural influences and the way they communicate including their body language, tone of voice and attitude. From there, they learn effective ways to ask open-ended questions, provide explanations, and guide patients and clients to advocate for themselves.

"There is value across the board [to the training]," says Arlene Ortiz-Allende, Senior Vice President, Community and Government Affairs/Chief Diversity Officer at SBH Health System. "When we meet people where they are, doctors can provide patients with the quality care they deserve and truly engage them in their own health and wellness. That's how we achieve patient-centered care."

LEGAL DRUGS
The Impact Of Prescription Pain Pill Addiction

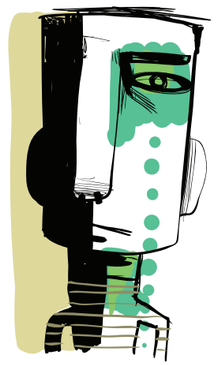
Jonathan Samuels, MD, director of addiction medicine at SBH, wrote the following article in response to a story that appeared on NPR's Morning Edition about Max, a young man who had kicked an addiction to prescription pain pills before breaking his hand in an automobile accident.

During surgery, Max was given medication that included opioids and then a small amount of Vicodin to relieve his post-surgical pain. Less than a month later, he was dead from a heroin overdose.

There is no guarantee that this story would have ended well no matter what was done, but there are some interventions that might have improved the chances for a better outcome.

Max had been treated for his opiate addiction with buprenorphine/naloxone (Suboxone) and tapered off the drug after a year. Buprenorphine, in addition to methadone, are opiate agonists that suppress drug cravings in opioid addicted individuals. Max had been using prescription opiates as a teenager and later moved on to heroin. In young people, the brain's executive function, i.e., the ability to make good decisions, is not fully developed until the mid- to late-20's. The effects of opiate addiction on the developing brain can be more profound and long-lasting. In such a case it may have been desirable to keep him on the buprenorphine for a longer period of time, possibly for many years, along with intensive psychosocial support. This support can be provided through 12-step programs such as Narcotics Anonymous, individual therapy, or both.

There is a stigma attached to treatment with opioid agonists and patients are often eager to get off as soon as possible. This is often not a good idea. Sometimes

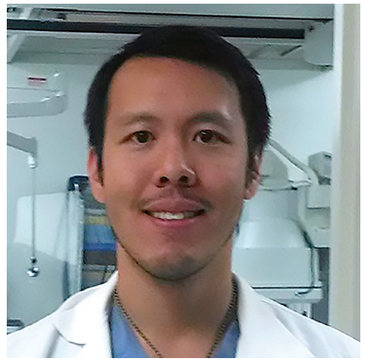


it is better to stay on agonist therapy for longer periods of time, combined with the intensive psychosocial support, so that the brain can be retrained to cope with triggers, stress, and pain in ways that do not include abusing opiates. The psychosocial interventions can be continued indefinitely, as addiction is a lifelong condition and relapses can occur after decades of abstinence.

When Max had his car accident, he undoubtedly was in real pain that required treatment. It would have been ideal if he could have been treated with non-opioid analgesics or non-pharmacologic measures. In his case, opioids were deemed necessary and the physician stated that he gave him a "small amount of Vicodin." Individuals with opiate addiction often have a lower tolerance to pain and may need higher, not lower doses of opioids to control their pain. Max may have sought out illicit opioids, including heroin (cheaper than prescription opioids and very effective as an analgesic) and begun habitual use as a result of his pre-existing addiction. Consultation with an addiction medicine specialist would have been appropriate. Max could have been evaluated for: 1) slow taper of his opioids under close supervision; 2) reinstitution of buprenorphine or methadone therapy and/or 3) psychosocial support. Families should seek out help as well, as they are key factors in helping individuals with addiction to achieve and sustain recovery. Hindsight, of course, is always 20/20.

Pelvic Congestion Syndrome (PCS): Underdiagnosed and Undertreated

By B. Bobby Chiong, MD, Chair, Department of Radiology



Often during the course of my day as an interventional radiologist, I'll take the time to explain arteries and veins at their most basic level. Arteries are blood vessels, carrying blood away from the heart to various tissues. In arteries the blood is propelled by the pumping of the heart.

Veins are a bit less intuitive to understand. For the most part, pressure and movement of blood in the veins is not subject to the pumping of the heart. Blood travels through the veins primarily by local pressure changes around the vein (e.g., muscles contracting around veins of arms and legs during movement). This action works in combination with valves in the veins allowing flow only towards the heart and blocking flow in the opposite direction.

Disruption in the normal flow of blood through the veins and the subsequent build-up of static blood in veins can lead to varicose veins, varicoceles in men, and pelvic venous congestion syndrome in women. Pelvic pain is a very common complaint with estimates of up to a third of women experiencing it at some point in their lives. Pelvic congestion syndrome (PCS) is an underdiagnosed and undertreated cause of female pelvic pain.

The classic presentation of PCS is that of a multiparous woman complaining of dull aching pelvic pain persisting for more than six months. Exacerbating factors include prolonged standing, menstruation, and sexual activity. Given that the pain of PCS is due to engorgement of pelvic veins, it should make sense that activities leading to increased blood flow to the pelvis would exacerbate the symptoms. Patients are usually parous since pregnancy increases pelvic vein capacity by 60 percent during which time the venous distension might leave pelvic veins incompetent. There may be associated varicose veins of the vulva, perineum, and lower extremities.

After history and physical exam (ovarian point tenderness and a history of postcoital pain is 94 percent sensitive and 77 percent specific for PCS), ultrasound should be the first line imaging study for PCS. Ultrasound may identify enlarged pelvic veins and reflux with Valsalva maneuver. CT and/or MRI may also be of benefit if coexisting pathology such as compressive tumors are suspected.

Historically, PCS was treated medically with limited effect using medroxyprogesterone acetate (Provera) or the GnRH agonist Goserelin. More recently, transcatheter therapy has increasingly become the first line of treatment. Typically the treatment involves embolization of the ovarian veins with coils and/or sclerosant medication. Occasionally, the internal iliac vein branches of the pelvis are also embolized. By embolizing the enlarged and incompetent veins responsible for pelvic pain, alternative collateral veins with competent valves take over and pain is relieved as the pelvic blood can return to the heart more easily from the pelvis following embolization.

The few studies published regarding response to treatment of PCS by transcatheter embolization have reported anywhere from 60 to 100 percent of patients reporting clinical benefit from the procedure.

The procedure is generally done with IV moderate sedation and patients generally go home the day of the procedure. Depending on the anatomy of the patient, the procedure can be done with access at either the neck or groin. The procedure will then usually take one to two hours.

There may be crampy pelvic pain following the procedure for a few days with most women recovering in one week or so. Reduction in pelvic pain typically occurs after two to three weeks.

Meditation, Mindfulness Can Reduce Physician Burnout

Studies support benefits of mediation and mindfulness for physician well-being

By Steven Clark

As a psychiatrist, department chair, spouse and parent, SBH's Dr. Lizica Troneci has become increasingly mindful of the effects of stress and burnout. Dr. Troneci started to raise the issue and discuss interventions at her departmental meetings, at times by suggesting that participants take a few minutes of quiet time to meditate or take in their surroundings.

"Some enjoy it, and yet some are clearly uncomfortable, sitting on the edge of their seat waiting for those minutes to end," says Dr. Troneci, chair of SBH's Department of Psychiatry. "It's as if they're saying, 'I don't have time for this.'"

At a time when fatigue, burnout and lack of self-satisfaction are growing concerns within the physician community, research into meditation and mindfulness has shown important physical and mental benefits. What is mindfulness? UCLA Mindful Awareness Research Center defines mindful awareness as "paying attention to present moment experiences with openness, curiosity, and a willingness to be with what is . . . It invites us to stop, breathe, observe, and connect with one's inner experience."

Leading advocates of the mindfulness technique argue that by learning to pay attention to each moment, physicians can ease burnout, reduce stress, enhance attention and concentration, grow self-awareness and emotional regulation skills, and improve both the quality and quantity of the attention clinicians give to their patients. According to a narrative review in the Journal of Clinical Medicine, "Mindful efforts to improve the healthcare culture and develop personal support systems can help physicians become more resilient and provide higher quality patient care."

Recognizing the increased personal and professional demands and expectations of its employees, SBH started offering hospital clinicians and staff free, weekly 30-minute meditation sessions. The goal is two-fold: to offer staff additional skills to cope with stress and pressure and, by experiencing the benefits, have them help promote meditation and mindfulness to patients once the hospital's Bronx Center for Healthy Communities opens in 2019.

"The rate of physician burnout continues to increase as the demands continue to increase," says Dr. Troneci. "While the electronic medical record, for example, has made sharing information readily and efficiently available, it also has contributed to burnout by further isolating us and restricting human interaction. Everything is so rushed today, and pressure from insurance companies, regulatory and licensing agencies, all adds to a busier, more stressful day.

"Researchers found that long-time meditators have an increased amount of gray matter in the auditory and sensory cortex and the frontal cortex, which is associated with working memory and executive decision making."

"Mindfulness meditation helps us become more centered, caring and empathic by teaching us to become more conscious of the present moment. We can only give as much as we have. In addition, how can we promote these techniques to our patients if we have not experienced their benefits?"

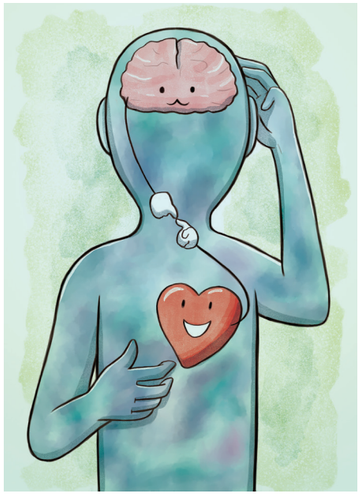
A new book, "Attending: Medicine, Mindfulness and Humanity" examines the problem of physician burnout and champions the benefits of meditation and mindfulness. "Even the most compassionate doctors are being pressured to see more patients, do more paperwork, and juggle more responsibilities every single day," writes the author, Dr. Ronald Epstein, professor of Family Medicine, Psychiatry, Oncology and Medicine at the University of Rochester School of Medicine and Dentistry. "Not only are those requirements exhausting, but they are also socially isolating."

He goes on to write, "Burned-out physicians are more likely to take shortcuts, make diagnostic errors, and prescribe recklessly. They order too many tests and refer more, just because it takes too much effort to think through problems themselves."

While in agreement with Dr. Epstein's findings, Dr. Troneci appreciates the challenges of teaching and practicing meditation and mindfulness to physicians while not making it yet another task. This is why she strongly believes that rather than feel pressure to incorporate meditation mindfulness per se, physicians could adopt the techniques that work for them. For example: "pay attention to your breath, the sky, the trees, and the smell of freshly trimmed grass as you walk through the campus; decide not to play the radio while driving and simply be with yourself; at the end of the workday, try to remember the day's activities and congratulate yourself for the accomplishments."

Physical Brain Changes

A recent study by Massachusetts General Hospital and Harvard Medical School found that meditation can physically change the brain. Researchers found that long-time meditators have an increased amount of gray matter in the auditory and sensory cortex and the frontal cortex, which is associated with working memory and executive decision making. While it has been well-documented that the cortex shrinks in size as one ages, they discovered that 50-year-old meditators had the same amount of gray matter as healthy 25-year-olds. Additionally, researchers found thickening in five regions of the brain among those in the group who had completed eight weeks of meditation. This included the posterior cingulate, which is involved in mind wandering and self-reliance; the left hippocampus, which assists in learning, cognition, memory, and emotional regulation; the temporo-parietal junction, which



is associated with perspective taking, empathy and compassion; the brain stem called the Pons, where many regulatory neurotransmitters are produced; and the amygdala, which is important for anxiety, fear and stress.

Dr. Troneci says she's personally noticed changes in physicians who are long-time meditators. One colleague, for example, who often exhibited impulsive, angry and irritable behavior, had become almost unrecognizable as one who was now "chill and collected."

There also is ample research that shows that meditation and mindfulness are beneficial to another group – those affected by psychiatric illnesses. This includes those suffering from bipolar disorder, borderline personality disorder, attention deficit, and substance abuse.

Dr. Jeffrey Lazar, vice chairman of the Department of Emergency Medicine at SBH, is another proponent and practitioner of meditation. He sees it as a potential tool towards achieving the hospital's Quadruple Aim – specifically, targeting the fourth tenet promoting health care provider satisfaction and wellness. "What I appreciate about meditation is that it trains one to block out noise, and focus on the moment," he says. "We have so much noise, both literal and metaphorical, in medicine. The skills called upon to focus and be present during meditation can assist providers in focusing on and being present with their patients despite the abundant distractions."

He says he first became intrigued by meditation after watching a TEDx talk by Matthieu Ricard, a French molecular biologist turned Buddhist monk, as well as via a friend, a successful corporate executive who incorporates meditation into her life and who became a mentor of sorts. This led him to taking regular meditation classes near his home, and developing his own practice.

"The more I do it, the more resilient I feel," he says. While he keeps a meditation pillow – one filled with buckwheat hulls – in his office, he admits that a hectic administrative schedule has limited him to meditating at the hospital only a handful of times over the past six months. This is why he tries to devote 20 minutes every morning to it before he leaves for work.

He introduced the idea of meditation to his Emergency Medicine interns during their orientation week, in what he characterized as a particularly intense period for them. Meditation, he says, can play an important role in a specialty like emergency medicine that has a high rate of burnout. Meditation programs, he says, have been used by the U.S. military for some Special Forces soldiers. "While they may have different aims, there are some similarities in the stresses shared by working in an ER and going into battle," he says.

So, considering the extensive research supporting and promoting meditation and mindfulness as techniques to lessen stress and burnout, why are physicians resistant to embracing them? That's a question that is not easily answered.

"Why is it so hard to find a few minutes to be with ourselves? To appreciate the moment, to be mindful of our feelings, to be empathic towards our tired and stressed self?" asks Dr. Troneci. "Could it be the invincibility we were trained to develop? Just as the times have changed, we must change. We need to change and embrace our humane, vulnerable and mindful I." ■

Change in Diet Benefits Children with ADHD

Paulo Pina, MD, SBH's director of ambulatory pediatrics, recommends diet as part of therapy for children with ADHD.

The Centers for Disease Control and Prevention (CDC) estimates that as many as 11 percent of American children between the ages of four and 17 suffer from Attention Deficit Hyperactivity Disorder (ADHD). It's a condition that can be perplexing to parents whose children typically show signs of inattention, hyperactivity, and impulsivity. This may manifest itself in a range of behaviors, including difficulty listening, having trouble playing quietly, talking excessively, aggression, lack of restraint, being easily distracted and/or not finishing tasks.

Guidelines from the American Academy of Pediatrics (AAP) recommend behavior therapy or medication as the first line treatment for ADHD in young children. While Dr. Paulo Pina, director of ambulatory pediatrics at SBH Health System, points to these as the only two evidence-based therapies available for children with ADHD, both of which options he presents to parents, he recommends that they also consider a change in diet for their children.

"While changes in diet have not been proven in any major studies, in a subset of kids, sugar and processed foods can make the condition worse," says Dr. Pina. "Studies have shown that some children with ADHD have low levels of omega-3 fatty acids and iron, which is why we recommend those nutrients."

He acknowledges that changing a child's diet can be difficult, but believes these foods can support better health for children with ADHD as well as other childhood conditions, like obesity.

He and the hospital's other pediatricians routinely distribute dietary information to parents of young children who have been diagnosed with ADHD. Recommended are two to three servings per week of foods that are good sources of omega-3 fish oils, such as tuna, salmon and cod. Omega-3 oils are also found in flaxseed, cod liver oil, walnuts, and spinach. Studies have found that omega-3 may also help fight heart disease, diabetes and breast cancer. Dr. Pina also suggests serving foods heavy in iron, which is commonly found in beef, pork, chicken and eggs; beans and lentils; dark leafy greens; and dried fruits (such as raisins and apricots).

Finding healthy foods in the Bronx, he says, can be a challenge. While he prefers that parents serve these nutrients in their natural form, he recommends the use of supplements, especially if a child won't eat the recommended foods or if they aren't available. If a child can't or won't swallow the supplements in pill or capsule form, parents can buy gel capsules and squeeze the contents of the capsules into food. In addition to avoiding processed foods and sugars, he encourages parents to have their children avoid foods with artificial colors and flavors and preservatives. "If it's a bright orange potato chip or a drink that is bright blue or purple, you can assume it's not natural, and so you should try to avoid it," he says.

Many parents are receptive to dietary changes for their children, he says, because they are motivated to do whatever they can to avoid treating with medications that can have such side effects as reduced appetite, sleep issues and abdominal pain.

"We go over the options with parents, discussing the science behind medication and behavior therapy, and talk about diet, in making a shared decision," Dr. Pina states, adding that doctors need to do a better job in teaching parents how to read nutritional labels. "Having a strong support system with patients who are very engaged also plays a role in helping these kids succeed."

SBH and the CUNY School of Medicine – Two Institutions with a Common Mission

A focus on progressive, primary care in New York. **By Edward Telzak, MD, Chair, Medicine**

"A new medical school run by the City University of New York will open with its first class in fall 2016 after receiving preliminary accreditation...The school, the CUNY School of Medicine… will begin with 70 students and have a partnership with the St. Barnabas Health System in the South Bronx."

So began an article on July 14, 2015 in "The New York Times." With a similar philosophical and operational mission, it seemed logical that the City University of New York School of Medicine (CUNY SOM) and SBH Health System would come together. Following initial discussions that began more than five years ago between the Dean of the Sophie Davis School of Biomedical Education, Dr. Maurizio Trevisan, and former SBH President/CEO Dr. Scott Cooper, the two institutions embarked on a long-term project with the goal of establishing a high quality Liaison Committee on Medical Education (LCME)-approved medical school that emphasizes the principles of primary care medicine and the training of physicians from racial and ethnic groups historically underrepresented in medicine.

The CUNY School of Medicine is an outgrowth of the success of the Sophie Davis School of Biomedical Education. Founded in 1973, the Sophie Davis School operated under a Cooperative School Model. Talented students recruited from high school completed the requirements for a Bachelor of Science degree and the traditional curriculum of the first two years of medical school within five years on the City College campus in West Harlem.

These students subsequently transferred to one of six cooperating medical schools to complete their clinical clerkship years and, if successful, were awarded an MD degree from the school in which they completed their clinical education. However, changes in medical education, including the shortage of clerkship availability due to the expansion of existing medical school class size and preference for offshore medical schools because of financial pressures, resulted in reduced opportunities for clinical training for Sophie Davis students. Over time, the Cooperative Medical Schools model became unsustainable. To continue its commitment to train students from economically disadvantaged backgrounds and racial and ethnic minorities, and to provide a large cadre of primary care practitioners committed to serving poor communities in New York City and elsewhere, Sophie Davis embarked on a process to become a full MD-degree granting institution accredited by the LCME. Critical to this effort was finding a strong and committed health care clinical partner with similar goals.

Established in 1866, SBH is a not-for-profit "safety-net" health care provider that plays an essential role in delivering health care in the South and Central Bronx medically underserved minority communities which rank among the poorest urban areas in the United States. In addition, SBH's network provides the breadth and depth in clinical services that CUNY SOM required with robust inpatient, outpatient and emergency medical, mental health and dental services. It operates a 422-bed acute care community hospital and Level II Trauma Center authorized to treat the most critically ill and severely injured patients. SBH's New York State-designated Stroke Center and AIDS Center ensure access to much-needed quality services in the South/Central Bronx. Most importantly, to support the CUNY SOM mission, SBH is also a major provider of ambulatory care services, with more than 250,000 outpatient visits annually. Its primary care physicians, specialists and subspecialists offer the necessary expertise to meet patients' challenging and evolving healthcare needs and students' educational needs. Mental health services are provided by SBH Behavioral Health (formerly Fordham-Tremont Community Mental Health Center), which operates six programs that meet the mental health needs of adults, teenagers and children. SBH Behavioral Health handles more than 93,000 visits annually, underscoring the crucial need for these services in the Bronx and the important role of this facility in the network.

Critically important to a new medical school, SBH has a long history of dedication to both undergraduate and graduate medical education. SBH sponsors ACGME-accredited residency programs in Internal Medicine, Pediatrics, Emergency Medicine and Psychiatry and non-ACGME residency and fellowships that are accredited by the American Osteopathic Association (AOA) in Dermatology, Internal Medicine, Family Practice, Surgery, Plastic and Reconstructive Surgery, Surgical Critical Care, Osteopathic and Manipulative Medicine, as well as other residency programs in Pediatric Dental Medicine and Podiatry. During the course of the academic year, there are approximately 250 resident physicians and well over 100 medical students from the Albert Einstein College of Medicine, New York

"To continue its commitment to train students from economically disadvantaged backgrounds and racial and ethnic minorities, and to provide a large cadre of primary care practitioners committed to serving poor communities in New York City and elsewhere, Sophie Davis embarked on a process to become a full MD-degree granting institution accredited by the LCME."

"For the 2016 - 2017 academic year it is estimated that over 100 SBH faculty have spent more than 1800 hours dedicated to the pre-clinical education of CUNY SOM students."

College of Osteopathic Medicine, and the CUNY SOM learning and working at SBHHS.

Since 2015, SBH's clinical faculty has participated as members of the core teaching faculty of the LCME provisionally-approved medical school curriculum. For the 2016 - 2017 academic year it is estimated that over 100 SBH faculty have spent more than 1800 hours dedicated to the pre-clinical education of CUNY SOM students. This includes the Organ Systems Course, Practice of Medicine, Introduction to Clinical Medicine and Physical Diagnosis courses. SBH clinical faculty has worked alongside CUNY SOM faculty in jointly developing, evaluating and revising these courses and other components of the pre-clinical course curricula. SBH is now deeply involved with CUNY faculty in developing the entire range of high quality clinical clerkships (scheduled to begin in July 2018) for the 6th and 7th year students who will do the majority of their clinical training at SBH.

Much remains to be accomplished and these are uncertain times, especially when it comes to medical training and caring for the poor. Funding remains a challenge for both the CUNY SOM and SBH. Federal funding for Medicaid, the major insurer for SBH patients, and the nature of the current health care system is under significant threat and may look quite different over the next five to 10 years. And yet, the two institutions remain fully committed to caring for the poor and training the next generation of physicians who will deliver comprehensive, compassionate and evidence-based care to populations such as those that reside in the south and central Bronx. It's a mission that is too important not to succeed. ■

SBH Receives 4-Star Rating, Ranks as #1 Hospital for HealthFirst Medicaid Patients

SBH Health System has been an active participant in the HealthFirst Quality Incentive Program (HQIP) program since it began in 2012, and has demonstrated continued improvement in its performance.

That level of performance reached its pinnacle in 2016, when SBH recently received a 4-star rating and was ranked as the #1 hospital for HealthFirst Medicaid patients, and among the top five hospitals for HealthFirst Medicare, when compared with all participating hospitals. This includes such large academic medical centers such as New York - Presbyterian, Montefiore, and the Mount Sinai Health System.

SBH reached a collective score of 4.0 out of 5.0 for the 33 measures focused on access, preventive care, acute and chronic disease management, medication adherence and patient satisfaction, and achieved a 4 or 5 star rating on 21 other measures. In meeting these metrics, as well as showing significant improvement on 11 additional measures compared to 2015 performance levels, SBH not only continued to demonstrate a commitment to high-quality care, but also earned over $4.5 million in incentive payments related to the program for the year.

The HQIP program measures the quality of care provided to patients in HealthFirst Medicaid and Medicare-managed care programs, and covers roughly 30,000 patients who have been assigned to SBH-associated physicians and practices across the South/Central Bronx. Patients receive care across a variety of clinical service lines, including internal medicine, pediatrics, family medicine, dental, ob/gyn, and behavioral health departments, and the program utilizes standardized metrics that allow for comparison across the 40 HealthFirst-member hospitals and serves as a barometer of the care provided to patients within the program.

Through use of national standards as defined by both the National Committee on Quality Assurance (NCQA) and the New York State Department of Health Quality Assurance Reporting Requirements (QARR), care is measured across multiple domains, including timeliness of access, patient satisfaction, quality of clinical care, and ER and inpatient utilization. Special emphasis is placed on measures within the well-known Healthcare Effectiveness Data and Information Set (HEDIS) tool, which covers specific metrics related to screening and disease prevention; comprehensive care for chronic disease such as diabetes, hypertension, and asthma; medication adherence for chronic disease; and behavioral health care services for depression and other mental health issues.

"Accomplishments of this magnitude are unattainable without a strong, committed and accountable team," says Dr. Raj Gurunathan, director, Division of General Internal Medicine, Department of Medicine. "SBH has been successful in assembling a winning interdisciplinary team of physicians, nurses, patient care navigators, managers and front line staff, who have developed and implemented sustainable workflows and processes to support compliance with the measures."

Added Irene Borgen, vice president, Ambulatory Care Innovation and Transformation, "Through numerous efforts aimed at patient outreach and engagement; improvements in decision support for clinical providers through use of the EMR; and the leveraging of information technology resources, many in the SBH community have contributed to this incredible achievement and in accomplishing these results, and we look forward to 2017 and beyond with much anticipation."

RESIDENCY IS NO VACATION AT THE BEACH

The life of a resident is a grind, a torturous path that any physician can attest to. It's a three-, four-, or five-year odyssey marked by backbreaking hours, little sleep and the need to make life-and-death decisions often without the prerequisite experience or knowledge. The goal is the same – to provide young doctors with the hands-on, intensive training that will allow them to become the best medical professionals they can be.

SBH is proud to have a diverse group of residents, who come from different countries, who speak different languages and and bring with them varied backgrounds. Here is a look at several all stars from the graduating class of 2017.

Dr. Jimmy Truong, a recent graduate of SBH's five-year combined emergency medicine/family medicine residency program, credits hard work and what he learned at Starbucks for his success.

Jimmy was on the fast track at Starbucks, advancing from barista to shift supervisor to manager of its Rockefeller Center store, while simultaneously earning a Master's degree in chemistry and later working as an EMT. In addition to the highlight of once serving a mocha to Jimmy Fallon and reaping the many benefits Starbucks provides its employees, he says the experience made him more confident and outgoing, and a better communicator and team player. It ultimately convinced him to pursue his dream of attending medical school and becoming a doctor.

During his residency at SBH, Jimmy scored a number of both personal and group achievements. He participated as part of a team that brought SBH victory in the maiden Bronx Sim Wars (see page 24) and finished in the top 16 in this year's SonoGames (a national ultrasound competition). He published in an emergency medicine journal, wrote grant applications, and won a national competition run by EMRA (Emergency Medicine Resident Association) and HippoEM for an entry he submitted for resident appreciation day on "why my residency program is the best program."

He is one of a number of outstanding residents – from as far away as India and as nearby as Brooklyn, in Jimmy's case – who comprise SBH's 2017 graduating classes. Some like Dhaval Desai, chief resident, Medicine, was admittedly "a little scared" coming to the Bronx. He quickly got over his fears, eventually starting a cricket club that includes hospital residents and attendings and plays throughout the metropolitan area. This year, after accepting a job at SBH, he even bought a house here. Meanwhile, his co-chief, Muralidhar Idamakanti, liked the experience so much that this summer his wife started at SBH as a 1st year PGY. The graduating residents featured, as well as the other 200-plus residents who finished this spring, now move on to the next chapter in their professional careers.

LACEY BETH ELWYN, DO

RESIDENCY PROGRAM
Chief Resident, Dermatology

HOMETOWN
Chester, Illinois

NEXT STEP
Dermatopathology fellowship, Larkin Community Hospital, Miami, FL

LONG TERM PLAN
Private practice (splitting time between reading slides and general dermatology patient care)

ABOUT THE RESIDENCY
"It was a well-rounded education and I really enjoyed it. New York City is at the heart of dermatology, the population is very challenging. The pathology you see here you won't see anywhere else. And the patients are so grateful for your care. SBH is like a family."

ALBERT PAVALONIS, DO

RESIDENCY PROGRAM
Chief Resident, Surgery

HOMETOWN
Powhatan, VA

NEXT STEP
Vascular surgery fellowship, NYU Lutheran Hospital, Brooklyn, NY

LONG TERM PLAN
Return to Virginia as a vascular surgeon

ABOUT THE RESIDENCY
"It was full of challenges, good challenges, that I think have helped make me a better surgeon in the long run. It's taught me to be able to think outside the box, to be able to deliver effective and safe patient care."

MICHAEL SMITH, DO

RESIDENCY PROGRAM
Chief Resident, Surgery

HOMETOWN
Scranton, PA

NEXT STEP
Surgical Critical Care, Westchester Medical Center, Valhalla, NY

LONG TERM PLAN
Don't have any

ABOUT THE RESIDENCY
"I had been in the Bronx for rotations [during medical school) and the chiefs and third and fourth years I saw were just so smart and talented and I said I wanted to one day be those guys. It's helped me develop a tool chest for good patient care."

DHAVAL DESAI, MD

RESIDENCY PROGRAM
Chief Resident, Medicine

HOMETOWN
Surat, India

NEXT STEP
Critical Care Hospitalist, SBH Health System, Bronx, NY

LONG TERM PLAN
Possibly do a critical care fellowship

ABOUT THE RESIDENCY
"All my fears [of the Bronx] were gone within a few months. It's been a very good experience where you see many different kinds of patients. I made a lot of friends here and feel well prepared to take the next step."

MURALIDHAR IDAMAKANTI, MD

RESIDENCY PROGRAM
Chief Resident, Medicine

HOMETOWN
Yallur, India

NEXT STEP
Hospitalist, SBH Health System, Bronx, NY

LONG TERM PLAN
Continue in an academic program

ABOUT THE RESIDENCY
"Was here multiple times [having done several clinical rotations here] and was very eager to join [following his cousin, Dr. Sharatkumar R. Rokkam, who works as an attending after completing a residency program here]. It's been a very good experience."

JIMMY TRUONG, MD

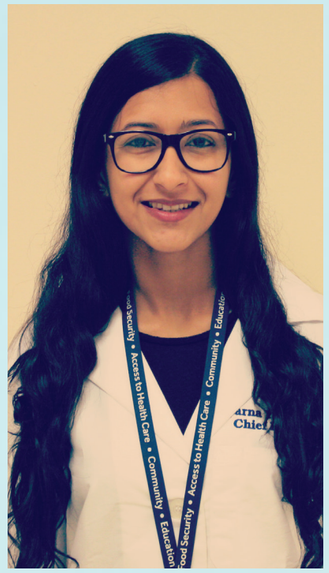
RESIDENCY PROGRAM
Chief Resident, Emergency Medicine/Family Practice

HOMETOWN
Brooklyn, NY

NEXT STEP
Emergency Medicine attending, New York Presbyterian Medical Center, NYC

LONG TERM PLAN
Teaching and working with residents

ABOUT THE RESIDENCY
"The training was very intense here. I loved it. It was a great experience working as part of a team in the ED and in the family medicine clinic, to work in both an acute and chronic setting. The teamwork and camaraderie have been memorable. When someone needs help, everyone pitches in. The training has provided me with so many opportunities."



APARNA YADATORE, MD

RESIDENCY PROGRAM
Chief Resident, Pediatrics

HOMETOWN
Bangalore, India

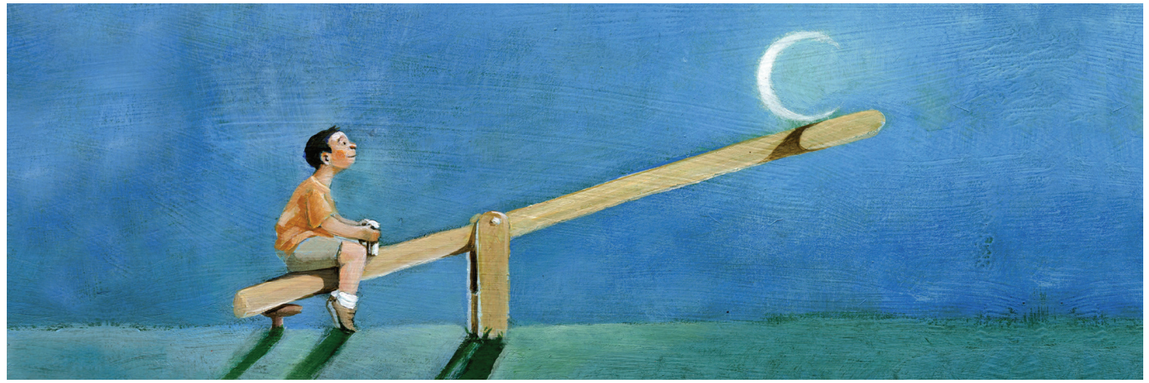
NEXT STEP
Pediatrician, federally-qualified health center

LONG TERM PLAN
Interested in working in private practice in areas of asthma and preventive care, and teaching

ABOUT THE RESIDENCY
"Small and beautiful. You get to know everyone and the faculty is very supportive. From the beginning, it felt like a perfect fit."

Is It ADHD or a Sleep Disorder?

By Steven Clark



Could those childhood symptoms consistent with Attention Deficit Hyperactive Disorder (ADHD), actually be suggestive of a sleep disorder?

"The symptoms of ADHD and sleep deprivation due to obstructive sleep apnea (OSA) are often very similar," says Dr. Mediha Ibrahim, a fellowship-trained sleep expert and director of the Center for Sleep Medicine at SBH. "A child who is sleep-deprived can display problems like inattentiveness, hyperactivity, mood problems and disruptive behavior that can be mistaken for ADHD."

It is estimated that two to four percent of American children between the ages of two and eight years old have OSA – and as many as 25 percent of children diagnosed with ADHD may actually have symptoms of OSA (with learning and behavior problems a consequence of their sleep disorder). OSA occurs when the child's airways are blocked for seconds or even minutes due to any one of a number of different reasons (most often enlarged adenoids, tonsillitis, allergic reactions, asthma, infection or injury). Snoring, waking up multiple times, gasping for air, difficulty waking up are all common signs.

Dr. Ibrahim encourages pediatricians to ask parents about their child's sleeping habits before diagnosing a child with ADHD. At SBH, this is done routinely. Should a sleep problem be discerned, a polysomnography (sleep study) with the Sleep Center is recommended before exploring medication or behavior therapy.

A recent study conducted by the Department of Pediatrics at SBH found a significant association between inattention and hyperactivity as measured by the Conners' score and sleep latency (the length of time it takes to accomplish the transition from full wakefulness to sleep), sleep efficiency, and percent of sleep time spent in REM even when adjusted for age and BMI.

A polysomnography performed in a sleep center is the only tool for a definitive diagnosis and assessment of the severity of pediatric OSA. Conducted during an overnight stay at the hospital, with the child accompanied by a parent or guardian, the study provides a detailed look at the child's sleep problem, examining the patient's brainwaves, eye movement and respiratory pattern while asleep.

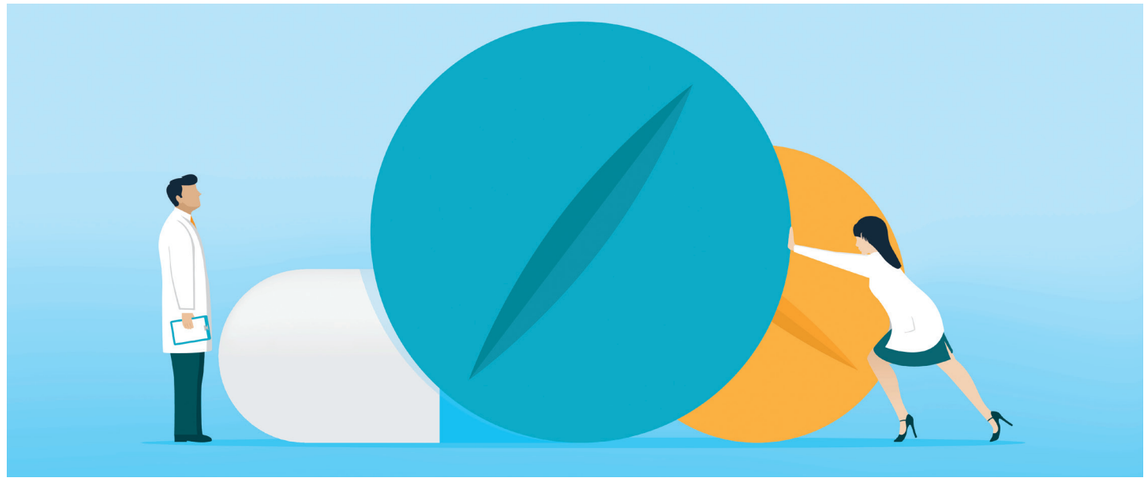
The first line of treatment for OSA is removal of the child's tonsils and adenoids. This will resolve symptoms in an estimated 85 percent of cases. If this is not effective, then a CPAP mask (continuous positive airway pressure therapy) may be recommended.

According to Dr. Ibrahim, the right diagnosis is important, as medication taken for ADHD can exacerbate OSA. Lack of sleep can also have health and development implications that can adversely affect a child's development. This can include memory problems, lack of cognitive growth, decreased ability to learn, and lower IQ.

While ADHD symptoms persist for some children, improvement in the child's OSA may allow for treatment of ADHA with reduced medication.

Making Community Pharmacists Part of the Provider Team

Community pharmacists have become an increasingly essential part of the healthcare team at hospitals like SBH. **By Steven Clark**



Roger Paganelli, owner of the Mt. Carmel Pharmacy in the Bronx, remembers the difficulties he faced when juggling the six prescriptions he took following knee replacement surgery.

"I'm only 52, this (being a pharmacist) is the only job I've ever had, and I found myself saying, 'Did I take that one?'" says the third-generation pharmacist. "I can certainly empathize with patients who are elderly and take 20 to 25 prescriptions, two-thirds of which are in tablet form."

Patients on multiple medications comprise a significant percentage of the clientele seen by Paganelli and other community pharmacists in the Bronx. To support these patients in managing their medications and their overall health, the Bronx Partners for Healthy Communities (BPHC), the SBH-led Performance Provider System, introduced a Community Pharmacy Workgroup in February 2016. This collaboration has led to several patient-centered projects – the latest being the evaluation of the use of antidepressants and its effect on patients' hemoglobin A1C levels (which is indicative of a three-month average of their blood glucose level).

Additionally, this past May, a panel discussion was held at SBH Health System between members of BPHC's Program Advisory Committee (PAC) and Bronx community practice pharmacists. The focus was on how these pharmacists can help improve medication adherence.

"When patients get discharged and are handed a bunch of prescriptions, the fill rate is about 50 percent, and the chances they will be readmitted are great."

"Patients often return to the hospital or come to the Emergency Department due to undesirable events linked to medication non-adherence, or their inability to fill prescriptions at the pharmacy," says Ruth Cassidy, senior vice president and chief pharmacy officer at SBH. "Community pharmacists can play a key role in helping to manage these patients and need to be a component of the provider equation."

It was highlighted during the panel discussion that there are myriad reasons why many patients are not compliant with their medications. These include a lack of understanding why they need a particular medication, confusion over how to take it, an inability to pay for it, a concern over side effects, or simply a failure to get refills from the pharmacy.

Tony Sementilli, owner of Total Care Pharmacy and a member of the workgroup, says that patients can also be afraid to ask their doctors questions, not understand the answers, or only think of questions once they leave their doctor's office. This is a role the community practice pharmacist can play. "After all, we are the last ones they see before they go home and take their medications," Sementilli says.

Prior to this relationship with BPHC, SBH and select community practice pharmacies have been collaborating on the "Meds to Beds" program. This is where contracted pharmacies fill medications to patients at the time of hospital discharge. The program started with a few nursing units in the hospital and has been expanding due to its success.

"When patients get discharged and are handed a bunch of prescriptions, the fill rate is about 50 percent, and the chances they will be readmitted are great," says Sementilli. "There is a lot of potential for error. With Meds to Beds, they get 100 percent of what the physician wants them to take once they leave the hospital."

Community pharmacists also help simplify the process for the patient and health care worker in various ways, such as by creating blister packs and synchronizing medications (neither of which they are reimbursed for). They conduct medication reviews, don't require appointments and are available virtually every day. "Those patients who understand this, take advantage of it," says Paganelli.

Part of the transformation in health care, say the community practice pharmacists, will hopefully change the long-standing perception of patients and providers who view them merely as medication dispensers. Not giving community practice pharmacists access to patients' electronic medical records – hospital pharmacists have access to this information – only furthers that perception. To fully understand what's going on with the patient, having such access is imperative, say the community pharmacists.

"When you go to a pharmacy, your question is often, 'Why does it take so long to fill 30 pills?' or 'Why am I spending so much money for an inhaler?" says Cassidy. "In New York and other states, patients, providers and insurers have to look at community practice pharmacists as part of the medical team." ■

First Bronx Sim Wars Offers Educational Opportunity For Emergency Medicine Residents

By Steven Clark

Returning home with his girlfriend from a trip to Cambodia, a young man arrives in the ED in heart and respiratory distress after vomiting continuously for hours. Within minutes, he begins to have seizures.

Over the next 20 minutes, the medical team requests a battery of tests, consults with supporting clinicians, dispenses medication, and extrapolates pertinent information from a highly agitated patient and his less than forthcoming girlfriend. (It was later discovered that the patient had ingested a large amount of cocaine.) This is all done so the team of emergency medicine doctors, fighting against the clock, can quickly piece together the clues in hopes of determining the patient's diagnosis – and saving his life.

Just another day in the life of a busy city emergency room – or so it would seem. Only this time, it's the Bronx Sim Wars, a battle between emergency medicine resident teams from three Bronx hospitals, SBH, Jacobi/Montefiore, and Lincoln.

The competition was created as a collaborative effort between sim leaders at Jacobi and SBH, and conceived as a fun and educational exercise for residents, says Dr. Mina Attaalla, SBH's director of simulation education and informatics.

According to Dr. Marianne Haughey, director of the emergency medicine residency program at SBH, "I am thrilled to have this opportunity to bring the three emergency medicine residencies from our borough together to jointly enhance education. The good natured competition allows for a spirit of excitement as we work to improve care for our Bronx patient population. I think this reflects the unity of the baseline motivation of emergency medicine – the goal to give our patients the best possible care despite whatever challenges exist. As we work together we only get smarter and better at what matters – providing world class emergency care."

Held in the auditorium at SBH before a packed audience, the event was at times both dramatic and comedic. Each five-member team worked on a patient who transformed from an actor to a state-of-the-art mannequin. "Hal" is an advanced multipurpose patient simulator that features physical and physiological features capable of simulating lifelike cases in an ED setting. This includes airway and lung compliance that allows for ventilation and sensors for drug recognition and real life monitoring.

A panel of judges, comprised of emergency medicine physicians who serve as medical directors of simulation labs at New Jersey Medical School, St. John's Riverside Hospital and Elmhurst Medical Center, scored the three teams on their clinical actions, teamwork and communications.

The SBH team, comprised of Drs. Natalie Hubbard, Christina Hajicharalambous, Jimmy Truong, Maisah Shaikh and Yash Chavda, emerged victorious. As a result, the Bronx Sim Wars cup will reside at SBH for the time being, or at least until the next winner is crowned.

Taking a Closer Look at End-of-Life Wishes

By Steven Reichert, MD, Division Director, Palliative Care

Mr. B. is a 58-year-old man with COPD who presents to the ER with increasing swelling and pain in his legs associated with shortness of breath. In the emergency room he is noted to have increasing shortness of breath and restlessness. Treatments for COPD and CHF are administered, but his respiratory status deteriorates rapidly. The patient, who is fully alert and oriented, tells the doctors that he is DNR and does not want to be on a machine. He becomes increasingly combative and hostile requiring physical restraints. He is told he will die without intubation; he does not change his advanced directive. His sister, contacted via telephone, states that she does not know her brother's end of life wishes, but requests that everything be done to keep him alive. He is sedated, intubated and sent to the ICU.

Later that shift, Mrs. G., a 98-year-old woman with profound dementia, severe cachexia, and frailty presents via ambulance from a nursing home. She is laboring to breathe, is frail and cachectic. Records from the nursing home reflect that she is bed bound, nonverbal and fed via PEG tube. A chest x-ray shows a large lung mass with diffuse metastatic illness throughout all lung fields. The nursing home transfer form identifies the patient as full code and lists a health care proxy; however, the nursing home cannot be reached via telephone. The ER physician debates not intubating the patient given her dismal baseline functional status and newly diagnosed metastatic lung cancer.

Discussion:

Perhaps no conversation is more difficult than the discussion regarding end-of-life wishes. Patients and families are often reluctant to discuss death and are often unaware of the need to appoint a health care proxy. Although recent changes in Medicare reimbursement now allow physicians to bill for end-of-life discussions, doctors are challenged finding the time and lack the ability to facilitate these difficult conversations. In the Bronx, where social support and family structure is often fractured, it is not uncommon to find a patient who not only has no advanced directive, but has no family or friends who could serve as a proxy or surrogate decision maker. Unfortunately, many end-of-life decisions are made in times of crisis where emotions are high, time is short and discussion is not possible.

These cases illustrate the conflicts between patients' rights – upholding patient autonomy, right to self-determination and the need to preserve life – and doctors' decisions – the role of paternalism and the directive to first do no harm.

In the first case, it would seem apparent that intubation of this patient would be inappropriate as he states "he is DNR." However, he is a relatively young man who would more likely than not have his life saved with temporary invasive ventilation. He is noted to be fully alert and oriented, but how much does he really understand about being DNR? His family, unaware of his wishes, caught off guard and unable to speak with their brother, understandably requests "everything be done." Intubation would appear to be a violation of the patient's right to self-determination. However, this violation of his autonomy is certainly influenced by the opinion of the physician who feels that intubation would be only a temporary sacrifice and would be lifesaving with only temporary discomfort for the patient.

How do we handle the second case? An advanced directive is clearly noted on the nursing home transfer sheet and the health care proxy cannot be reached. However, given the patient's condition and horrific x-ray, intubation will prolong life, but will likely result in no clinical improvement and, in the opinion of many, will only prolong suffering. Is there a role for paternalism in this case? Can the ED staff act with paternalism here and "do no harm" by not intubating and allowing a natural death? Is it appropriate to violate the patient's right to life under the principles of beneficence (first do no harm)?

"THESE CASES ILLUSTRATE THE CONFLICTS BETWEEN PATIENTS' RIGHTS ... AND DOCTOR'S DECISIONS."

Epilogue:

Mr. B is successfully extubated after 36 hours of ventilator support. He vividly recalls the events in the ED and remains angry at being intubated against his will even though he is alive. He does not feel that intubation was necessary to save his life. A family meeting is held with his sister who is appointed his health care proxy. The patient clarifies his wishes stating that he is no longer DNR, and would allow intubation, but would not want prolonged artificial life support if there was no hope he could live without a machine. Surprisingly, he does not express gratitude towards the ED doctor.

Mrs. G is intubated and sent to the MICU. Her health care proxy is reached the next day and after discussion regarding the patient's prognosis, the decision is made to transfer the patient to the hospice unit the following day. Family gathers and the ventilator is stopped the next day. She peacefully dies two days later in the presence of family. The family is grateful they had the time to be with the patient when she dies.

Routine Exam Results in *Far-From-Routine* Brain Surgery

By Steven Clark

A routine eye exam may have saved Oina Aquino's life.

It was during Holy Week in April that the 33-year-old mother of two had gone to visit an eye doctor as part of the physical required for a job as a home health aide. During the eye exam, it soon became apparent to the optometrist that something was wrong. While Oina had lived with blurred vision for about 15 years – because, she thought, she was no longer wearing glasses – the doctor became alarmed by the abnormal pressure she discovered in the back of Oina's eyes. She immediately put her into a cab, directing the driver to take her to the emergency department at SBH and handing the Spanish-speaking woman a note telling the triage nurse that she needed to be seen immediately.

Within minutes of her arrival at the hospital, she was taken for an MRI. The news soon got worse when the picture revealed a large mass on her brain. Shell shocked, and repeating to her older sister, LoAna, "I feel fine, I feel fine," she was transferred to the ICU, where she met neurosurgeon Dr. William Wirchansky the next morning.
"I explained to her and her family that this was something we'd have to remove right away," says Dr. Wirchansky. "I told them this would be complicated surgery because of the location of the tumor [on the left side of the brain, abutting the corpus callosum, the white matter that connects the brain's two hemispheres], and there was a risk from the surgery of weakness and other neurological deficits, even paralysis."

The diagnosis and the need for risky surgery hit Oina hard. Although she had recently been experiencing increased pressure on her head – "it felt like a vise" – it was all happening too fast. She needed time to think. So, she left the hospital that day to consider her options, returning to the home her sister and brother-in-law had generously opened to Oina and her children a year earlier when they had migrated from the Dominican Republic.

Two weeks later, on April 25th, she returned to SBH, for brain surgery. The next morning, she was prepped for an operation that Dr. Wirchansky told the family could last for six or more hours. Using a sophisticated device called stereotactic image guidance, which enabled him to visualize the anatomy of Oina's brain during the surgery and precisely track the location of their surgical instruments in relation to the anatomy, Dr. Wirchansky made a track through her brain, right in front of the motor cortex. This is the region of the cerebral cortex involved in the planning, control and execution of voluntary movements. With the navigation system, accompanied by a device called CUSA (cavitronic ultrasonic surgical aspirator) and an operating microscope that provides for enhanced magnification, the neurosurgeon was able to avoid any collateral damage as he entered the ventricles of the brain and started resecting the tumor. The ultrasound waves emitted by CUSA emulsified the target tissues, causing the cells to disassociate from one another while the device irrigated the area with sterile saline. During the approximately eight-

SBH patient Oina Aquino (l.) with Dr. Wirchansky (r.)

hour-long surgery, he was able to remove virtually the entire mass.

Pathology found the four to five centimeter tumor – "the size of a small orange," says Dr. Wirchansky – to be a ganglioglioma. This is a rare tumor, representing about one percent of all brain tumors, that is almost always seen in a pediatric population (which is when it most likely began to invade Oina's brain). Although a ganglioglioma tends to be benign – Oina's tumor was revealed to be a WHO grade 1 – if left untreated it can cause worsening symptoms (such as seizures and other neurological problems, as well as permanent vision damage), and lead to death.

Oina woke up several hours after the surgery without any neurological affects, and with her vision no longer blurred. Weeks later, during a routine checkup with Dr. Wirchansky, her phone rang with a text message. She could be seen casually glancing at the words that came across the tiny screen of her cell phone – something she would have been unable to do before the surgery. Her plan is to begin working with elderly people in the very near future.

iMedicine

A Look at New Technologies

SBH Health System will be introducing a number of exciting state-of-the-art technologies in the upcoming months that offer strong benefits to patients in the community. Here is a brief look at two exciting modalities that have just become available.

BD Cato

Christopher Jerry started the Emily Jerry Foundation after his two-year-old daughter died in 2006 from a medication error at a Cleveland hospital. Emily Jerry was just one of 440,000 Americans who die annually from preventable medical errors – the third leading cause of death after heart disease and cancer.

Jerry recently spoke at SBH as part of a pharmacy grand rounds, one of the more than 30 hospitals he travels to each year in his mission to reduce medication errors. He believes that if BD Cato – an integrated software system designed to prevent errors during the compounding of intravenous medications – had been available at Rainbow Babies & Children Hospital in Cleveland when his daughter was being treated there for an abdominal tumor, it may have very well prevented the medication error that took her life. The pharmacy technician had used a 23 percent sodium chloride concentration rather than the less than 1 percent required to prepare the little girl's chemotherapy. Shortly after being infused, Emily fell into a coma and died the next day after being taken off life support.

BD Cato uses gravimetric and bar code verification to detect wrong product or wrong dose type or errors during IV compounding. It promotes medication safety by:

- Using real-time gravimetric verification that alerts the pharmacist of potential errors
- Featuring bar code technology designed to detect dosing errors related to incorrect selection of drug, diluent, and final container
- Calculating drug and diluent quantities needed to compound prescribed admixtures
- Providing immediate notification of errors and steps on how to correct a mistake
- Verifying that doses are prepared within institutional tolerances
- Enabling the pharmacist to verify admixture preparations remotely
- Not allowing print patient label until all steps are completed correctly
- Enabling the pharmacist to view final label and validate that admixture was prepared correctly

Jerry is a strong proponent of how certain technologies – like the BD Cato and the RIVA (Robotic IV Automation) system, instituted several years ago at SBH – can prevent medical errors when combined with a Just Culture environment, a practice followed by SBH and other progressive health systems around the country.

"Today's technology can prevent tomorrow's tragedies," said Jerry, speaking at the hospital's grand rounds. "Yes, it can, but not by itself. For technology to be effective, it has to be coupled with best practices. The good news is that when it comes to medication error we can fix it."

Low-Dose 3D Mammography

SBH will be the first hospital in the Bronx to offer 3D mammography. By examining breast tissue layer by layer, this new technology has been shown to provide far greater accuracy than conventional mammography (regardless of a women's age or breast density). Whereas existing technology provides doctors with a two-dimensional image of a three-dimensional breast – and so can result in unclear findings, false alarms and, most importantly, missed cancer – the new 3D mammography makes fine details more visible. Studies have shown that when compared to 2D technology, the new technology:

- Detects 41 percent more invasive breast cancers.
- Reduces false-positive recalls by up to 40 percent.
- Detects cancer an average of 15 months earlier.

"The Bronx has one of the worst, if not the worst, mortality rates for breast cancer anywhere in New York City," says Dr. Bert Petersen, director, Division of Breast Surgery at SBH Health System. "Despite all the advances in the fight against breast cancer, the thing that makes the biggest difference is early detection. Our rate at SBH of stage 1, or localized breast disease detection is much better than the national average (76 percent to 68 percent), and bringing in new technology like this only makes a bigger case of how a small hospital in the Bronx is winning the fight for women with breast cancer."

The new technology also uses very low x-ray energy during the exam, about the same as a film-screen mammogram. The exam itself is similar to the conventional 2D exam.

Some statistics regarding breast cancer: Studies show that one in eight women will develop breast cancer in her lifetime. Eight out of nine women diagnosed with breast cancer have no family history. With early detection, the five-year survival rate is almost 100 percent.

Resident Research Day

Dr. Francis Wadskier (right, center photo) and **Dr. Chad Lue** (left, center photo) pose with **Dr. Paulo Pina**, director of Pediatric Ambulatory Care and president of the SBH Medical Staff, and **Dr. Victoria Bengualid**, director of the Medicine Residency Program, after being selected as the top winners in SBH's 12th annual Resident Research Day. **Dr. Wadskier**, a Medicine resident, won overall best poster research for her poster "Antibiotic Course and Recurrence in Osteomyelitis." The study was initiated to determine the duration of antibiotics post resection of involved bones in chronic osteomyelitis patients. Dr. Lue, a resident in Family Practice, won for overall best poster – case report for his poster "Newborn Sheds Light on his Mother's Fevers: A Case of Vertical Transmission of HSV2." The researchers followed a young mother and baby with HSV2 infections. Here is a look at other award winners:

Diversity Award

Dr. Libardo Rueda Prada (Internal Medicine)
Assessment of Performance of Three Predictive Scoring Systems among Critically Ill Minorities at an Inner City Hospital.

Dental

Dr. Alexander Shau
Intraoral Adenosine-Triphosphate Activity and Salivary pH Levels in Caries-Free Versus Caries-Active Children

Emergency Medicine

Dr. Brian Fiore, Nicolay Hernandez
Motor Vehicle Accident Causing Traumatic Cataract

Internal Medicine

Dr. Libardo Rueda Prada
Pneumocystis Jirovecii Choroiditis in an AIDS patient

Medical Student Award

Autumn Hinds (CUNY School of Medicine)
Social Determinants of Sudden and Unexplained Infant Deaths

Osteopathic Manipulative Medicine

Dr. Ruba Katrajan
Osteopathic Considerations in the Ventilated Patient: a case study

Pediatrics

Dr. Vicky Gutierrez
Neurodevelopmental Outcomes and Prenatal Exposure to Marijuana

Psychiatry

Dr. Vanesa Disla
A Case of ADHD and Adverse Childhood Experiences (ACEs): An opportunity for intervention

Surgery

Dr. Danielle Vanderet, Dr. Kyle Hitscherich
The Utility of Zip Ties for Thoracostomy Tube Management

SBH Residency Program Highlights:

- Impressive 10-acre landscaped campus with 461 hospital beds
- Primary teaching hospital of the CUNY School of Medicine. Also affiliated with the Albert Einstein College of Medicine and NYIT College of Osteopathic Medicine
- Training programs for 250 physicians in 9 different specialties
- New York State-designated Level 2 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
- 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

SBH Health System BRONX

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

Congratulations to all SBH Graduates

Dental

Daniel Abramov
Chief Resident
Jewish General Hospital
Montreal, Canada

Yousef Behbehani

Talia Berg
Private Practice
New York/New Jersey

Ali Dabirrian
Private Practice
California

Vrutti Dave
Private Practice
New York

Rosa Estrada
Private Practice
California

Jeffrey Friedman
Private Practice
New York

Erin Gearity
Private Practice
New York

Phan Huynh
Private Practice
Texas

Boris Israilov
Private Practice
Queens, NY

Alina Karpova
Private Practice
Toronto, Canada

Israel Korobkin
Private Practice
Los Angeles, CA

Reshma Kumar
Private Practice
New York

Nimish Maniar
Associate Attending
Washington, DC

Matthew Meister
Private Practice
New York

Gabriella Nocerino
Private Practice
New York

Aleem Noormohamed
Private Practice
Canada

Atish Patel
Private Practice
New York

Dennis Ragoza
Private Practice
Connecticut

Gregory Rosenberg
Private Practice
New York

Shawheen Saffari
Chief Resident
Jacobi Medical Center
Bronx, NY

Purvy Shah
Private Practice
Pennsylvania

Alexander Shau
Private Practice
Texas

Deepak Singh
Private Practice
Virgina

Priyanka Srivastava
Private Practice
Pennsylvania

Alex Weidenfeld
Endodontic Fellow
Montefiore Medical Center
Bronx, NY

Elad Yossefi
Private Practice
New York

Emergency Medicine

Joel Abraham, DO
Attending Physician
Vassar Brothers Medical Center
Poughkeepsie, NY

Matthew Abad, DO
Attending Physician
Montefiore Medical Center
Bronx, NY

Rachel Augustine, DO
Attending Physician
St. David's HealthCare
Round Rock, TX

Jakub Bartnik, DO
Attending Physician
North Shore University Hospital
Manhasset, NY

Marcin Byra, DO
Attending Physician
Brooklyn Methodist Hospital
Brooklyn, NY

Joseph Ewy, DO
Attending Physician
Long Island Jewish Valley Stream
Valley Stream, NY

Brian Fiore, DO
Attending Physician
University of Miami Hospital
Miami, FL

Lindsey Gaddis, DO
Attending Physician
CoxHealth
Springfield, MO

Gayana Grigoryan, DO
Attending Physician
Valley Hospital
Ridgewood, NJ

Nicolay Hernandez, DO
Attending Physician
Westside Regional Medical Center
Plantation, FL

Natalie Hubbard, DO
Attending Physician
Saint Francis Hospital & Medical Center
Hartford, CT

Sean Krapf, DO
Attending Physician
South Nassau Communities Hospital
Oceanside, NY

Nancy Lievano, DO
Attending Physician
The Hospitals of Providence Sierra
El Paso, TX

Essa Ahmed Mehkkri, DO
Attending Physician
Flushing Hospital Medical Center
Queens, NY

Ann Price, DO
Attending Physician
Holy Cross Hospital
Silver Spring, MD

Lauren Pueschel, DO
Attending Physician
Montefiore Medical Center
Bronx, NY

Kristen Rada, DO
Attending Physician
Florida Hospital DeLand
DeLand, FL

Jimmy Truong, DO
Attending Physician
NewYork-Presbyterian Hospital
New York, NY

Family Medicine

Chad Lue
Primary Care Physician
Urban Health Plan
Bronx, NY

Kathryn Mazza

Internal Medicine

Abdur Rahman Fuzail Ahmad, MD
Cardiology Fellow
Aurora Health Care
Milwaukee, WI

Nora Ajdir, MD

Anas Al Hallak, MD
Hospitalist
John Peter Smith Hospital
Fort Worth, TX

Mehak Ali, MD
Hospitalist
Baystate Medical Center
Springfield, MA

Ragia M. Aly, MD
Hospitalist
Springfield Regional Medical Center
Springfield, OH

Ana Maria Bechara, MD
Hospitalist
St John's Regional Medical Center
Oxnard, CA

Shravana Bheemanathi, MD
Outpatient Physician
Jamaica Hospital
Queens, NY

Frank Bonpietro, MD
Hospitalist
Regional West Medical Center
Scottsbluff, NE

Lyna Campo, MD
Hepatology Fellowship
Rutgers New Jersey Medical School
Newark, NJ

Oscar Carazas, MD
Hospitalist
St John's Regional Medical Center
Oxnard, CA

Dhaval Desai, MD
Telemetry Hospitalist
SBH Health System
Bronx, NY

Sarwat Fatima, MD
Hospitalist
CHRISTUS St. Michael Health System
Texarkana, TX

Bessy Flores, MD
Hospitalist
SBH Health System
Bronx, NY

Alfiya Gabidullina, MD

Bhavita Gaglani, MD
Hospitalist
University of Alabama
Montgomery, AL

Kumait Jaroje, MD
Hospitalist and Assistant Professor
University of Central Florida
Orlando, FL

Nadyn M. Giralt, MD
Hospitalist
East Texas Medical Center
Jacksonville, TX

Sorab Gupta, MD
Hematology/Oncology Fellow
Einstein Medical Center
Philadelphia, PA

Muralidhar Idamakanti, MD
Hospitalist
SBH Health System
Bronx, NY

Nishitha Rao Kotla, MD
Attending Physician
Sutter Health
Sacramento, CA

Gabriel Lopez Vega, MD
Geriatric Fellow
Montefiore Medical Center
Bronx, NY

Cristian Madrid, MD
Hospitalist
Mayo Clinic Health System
Eau Claire, WI

Raul Madrid, MD
Associate Physician
Brigham and Women's Hospital
Boston, MA

Priyanka Makkar, MD
Pulmonary Medicine Fellow
Memorial Sloane Kettering Cancer Center
New York, NY

Alvaro Martin, MD
Pulmonary and Critical Care Medicine Fellow
Westchester Medical Center
Valhalla, NY

Nandini Menon, MD
Attending Physician
Bristol Hospital Multi-Specialty Group
Bristol, CT

Rishabh Mishra, MD
Chief Resident
SBH Health System
Bronx, NY

Rebecca Neril, MD
Endocrinology, Diabetes & Metabolism Fellow
NYU Winthrop Hospital
Mineola, NY

Swetha Parvataneni, MD
Hospitalist
Geisinger Health System
Danville, PA

Meenakshi Punj, MD
Geriatric Fellow
Aurora Sinai Medical Center
Milwaukee, WI

Maria Gabriela Quinteros, MD
Palliative Care Fellow
Hofstra Northwell School of Medicine
Garden City, NY

Jaime Verano, MD
Hospitalist
Essentia Health-St. Mary's Medical Center
Detroit Lakes, MN

Francis Wadskier, MD
Infectious Disease Fellow
Montefiore Medical Center
Bronx, NY

OMM

Ruba Katrajian, DO
Private Practice
West Virginia

Jeremy Shugar, DO
Faculty
Touro College of Osteopathic Medicine
New York, NY

Bethany Prater, DO
Faculty
NYITCOM
Private Practice
New York, NY

Anna Lobzova, DO
Private Practice
Oregon

Pediatrics

Mishuka Adhikary, MD
Hospitalist
NewYork-Presbyterian Hospital
New York, NY

Zobida Aligour, MD
Primary Care Physician
New Jersey

Sandra Flaishmakher, MD
NICU Fellow
Cincinnati Children's Hospital
Cincinnati, OH

Ana Gutierrez, MD
Pediatric Endoscopy Fellow
NYU Langone Medical Center
New York, NY

Analydia Gutierrez, MD
Primary Care Physician
Dallas, TX

Ana Landaverde, MD
Pediatric Chief Resident
SBH Health System
Bronx, NY

Surgery

Albert Pavalonis, DO
Vascular Fellow
NYU Lutheran Medical Center
Brooklyn, NY

Michael Smith, DO
Critical Care Fellow
Westchester Medical Center
Valhalla, NY

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

Doctors Day Celebration

Dr. Judith Berger, director of SBH's Division of Infectious Diseases, arrived at St. Barnabas Hospital in November 1986 during the height of the HIV/AIDS epidemic, caring for young people who were dying from what was then an incurable disease. Years later, she would be at the forefront in helping the hospital prepare for another killer – the Ebola virus.

Recognized for her role as an extraordinary teacher and mentor, compassionate and meticulous clinician, puzzle solver, and person of honor and integrity, Dr. Berger was recognized by her colleagues during the hospital's Doctor's Day Service and Recognition Awards with its highest honor, the **Ronald L. Ciubotaru Physician to Physician Award**. The award was established in 2014 in the memory of the beloved SBH physician who embodied the highest values and standards. The award acknowledges the recipient as "an exceptional clinician, dedicated mentor and valued colleague, characterized by integrity and humility and deeply committed to teaching and the delivery of compassionate care."

"I thought I'd stay a year or two and I have been here now for 30-plus years," said Dr. Berger in accepting the award. "It's the camaraderie that kept me here. It's a place I keep close to my heart." She was introduced by **Dr. Brian Delaney**, who called her "my teacher and mentor," and who added the comments of many of her long-time colleagues, who described her as "a person of honor and integrity…a mensch" (**Dr. Malcolm Phillips**), "a true scholar of medicine" (**Dr. Rubin Silverman**), "someone who will always do the right thing" (**Dr. James Croll**), and "an extraordinary teacher and role model" (**Dr. Victoria Bengualid**).

Dr. Ernest Patti, a senior emergency medicine physician, received the **Medical Staff Achievement Award**. Dr. Patti, who did his residency training at St. Barnabas Hospital in the early 1990s – first stepping foot at the hospital in 1987 when he was a medical student in the Caribbean – has long been "the face" of SBH, appearing frequently on local and national television to speak about health and medical issues. "When I was working on a skyscraper in Manhattan [with his father's construction company], I never in a million years thought I'd be in this position," he said in accepting the award.

Dr. Ilmana Fulger, division director of Hematology/Oncology, received the **Medical Staff Service Award**. In acknowledging her love for what she does in her acceptance speech, Dr. Fulger said she reminds her students to "love it with every fiber of your body."

Pediatrician **Dr. Kathleen Asa**s received the **Emerging Leader Award**. She was described by her presenter and colleague **Dr. Paulo Pina** as "someone you can always count on." In accepting her award, Dr. Asas quoted Mother Teresa: "None of us, including me, ever do great things. But we can all do small things, with great love, and together we can do something wonderful. Leadership," she added, "cannot be impactful without teamwork."

Service awards were presented as well. This included recognition of 35 years at SBH for **Drs. Phillips and Joel Sender**, 30 years **Dr. Abdurhman Ahmed**, and 25 years for **Dr. Nelson Eng**.

Can you guess which one got a 2017-18 flu shot?

Spread smiles, not the flu.

Flu shots will be available for physicians at this year's
Employee Appreciation Day on **Thursday, Sept. 14, 2017**.
Morning: 6:30am-8:30am
Day: 11:00am-2:00pm
Evening: 4:15pm-6:15pm

For information about SBH flu shot guidelines,
please visit the Flu Shot Central Group on Workplace.

#GetAFluVax

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