SBH-PHYSICIAN

THE MAGAZINE OF SBH HEALTH SYSTEM MEDICAL STAFF FALL 2018

THE COLLABORATION BETWEEN

PHARMACISTS AND PHYSICIANS

SBH Health System BRONX

SBH-PHYSICIAN

Fall 2018

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SBH Health System BRONX

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Dear Colleagues,

If the leaves are turning colors it must mean it's time for another edition of the SBH Physician magazine. These past months have been very exciting with several new initiatives reaching important milestones. Whether it's our first bariatric surgery being performed by Dr. Nahmias or the new neuro-interventional procedures by Dr. Rahme we continue to add much-needed services to our Bronx community.

Leading off this edition we learn about the introduction of the first-ever pharmacy residency at SBH. The program further enhances the collaboration between physicians and pharmacists and greatly improves our ability to care for our patients. Next read the very exciting article by our President and CEO, Dr. David Perlstein, outlining SBH's efforts to address the social determinants of health with our new mixed-use development on Third Avenue.

We then journey into very important issues surrounding physician wellness with articles by Dr. Troneci and Dr. Haughey and Dr. Abbott, addressing physician suicide and burnout, respectively. Dr. Lazar provides us with an interesting viewpoint on free tuition for medical school and Dr. Reichert once again delivers an ethics case review that will surely stimulate an interesting discussion. Finally, don't miss Dr. Smith's story on advanced treatments for asthma patients that are truly changing our patients' lives.

Keep reading as there are many more great articles in this issue that showcase all the great work our SBH team does every day.

Wishing everyone a Happy and Healthy 2018,

Eric C. Appelbaum D.O.
Eric Appelbaum, DO, MBA
Chief Medical Officer, Executive Vice President

Greetings to St. Barnabas Hospital (SBH) from the Medical Executive Committee. As the president of the medical staff I have the pleasure of welcoming our two newly elected members. Dr. Scott Leuchten, ED attending and president of the Bylaws committee, will be serving as second vice-president. Dr. Lizica Troneci, the current chair of psychiatry, will be serving as third vice-president. Additionally, we are welcoming Dr. Olga Argeros, an OB/gyn attending, as our interim secretary/treasurer. I am confident their experience and talent will help achieve the goals of the medical board going forward.

My vision for the medical board is to strengthen SBH and optimize delivery of the best patient care possible. Patient safety is a necessary component of that care. SBH has proven its ability to achieve quality outcomes and can still add to those achievements. I am optimistic we can set the bar high and continue improving.

The Quadruple Aim includes improving population health, enhancing patient experience, reducing cost and improving provider experience. These are all important, but strengthening provider experience is necessary to attract and retain physicians. Improving provider experience through various ways may improve job satisfaction while slowing attrition and burnout. This may be challenging, but surely not impossible. We should reach out to physicians and staff to identify areas which can be improved and act appropriately. The medical board is an experienced group that works hard to support the institution and is committed to achieving set goals.

As we increase our physician engagement activities we can collaboratively create new opportunities. The SBH staff is like a family that welcomes all and always has your back. I've worked here for over three decades and look forward to working with all of you on this continuous journey to strengthen our hospital.

All the Best,
Chris Grantham, MD
President, SBH Medical Board

Biologic Therapy Helps Asthma Patients

The lives of severe asthmatic adults and children are being dramatically helped by a new type of therapy.

By Steven Clark

Alannah Garcia, an eight-year-old girl with a sweet nature, curly dark hair and glasses, rushed into Dr. Alyson Smith's examination room bubbling over with a smile that stretched from ear to ear. She held aloft a small plastic trophy that represented an important milestone in her life.

"It was the first time she ever had perfect attendance in school," says Dr. Smith, a pediatric allergist at SBH Health System. "She was so proud of her award."

At two years old, Alannah was diagnosed with asthma. Medications prescribed by her pediatrician since then did little to relieve her symptoms (which included coughing, wheezing, shortness of breath, chest congestion, and chest pain).

"For years, we'd bring her to the emergency room or she would need to be hospitalized, especially during the winter when her asthma was worse," says her mother, Ashley. "Using the asthma pumps and giving her medication when her asthma flared up didn't work. She wasn't living a normal childhood."

It was about a year ago that Dr. Smith prescribed what is known as biologic therapy, a treatment SBH offers adults and children with persistent and severe asthma with conditions that are not controlled by inhaled corticosteroids alone or in combination with long-acting bronchodilators or leukotriene pathway inhibitors. In conjunction with traditional treatment, Alannah now receives an intramuscular injection every two or three weeks.

A Chronic Disease

Asthma, a chronic disease of the airways, affects an estimated 300 million children and adults worldwide. The rates of asthma in the communities surrounding the hospital are staggering – eight times the national average, affecting 8.3 percent of children. These patients are sensitive

therapy has been shown to dramatically decrease the number of asthma attacks in patients with severe and difficult to treat asthma (which constitutes up to 10 percent of all asthma patients according to a recent article in "The New England Journal of Medicine").

The use of the drug omalizumab (Xolair) works on children and adults who

manufacture too much of a protein called IgE antibody. This overproduction can result in the development of such allergic conditions as allergic rhinitis (hay fever), allergic asthma, or a food or drug allergy. Clinical studies have shown that the addition of a biologic agent that targets the IgE pathway can significantly reduce exacerbations and improve asthma control.

"It is very exciting that we now have something to offer these really sick asthma patients who don't respond to typical asthma treatment," says Dr. Smith. "Before, our patients were told to use daily inhalers and pills but we would continue to see our patients in the emergency room and hospital all the time. I would frequently have kids on adult dose medications and their asthma symptoms were still not controlled. Now, we can finally offer something that works for these patients and allows them to live a normal life."

Biologic therapy targets different molecules in the body that contribute to asthma. Other medications, in addition to Xolair, include the newer biologic therapies Nucala (mepolizumab) and Fasenra (benralizumab), which are medications for patients with eosinophilic asthma that work by reducing the number of eosinophils in the blood.

"It's about identifying which type of mediator the particular asthma patient may have and then trying to block these specific mediators," says Dr. Raghu Loganathan, director, Division of ICU/Pulmonology at SBH. "It leads to the concept of what we call personalized medicine in asthma."

"What has changed is recognizing that there are clinical phenotypes, meaning clinical characteristics of a particular patient, that when identified and treated with specific drugs can make a big difference in their outcomes."

Xolair, as an example, is subcutaneously injected every two to four weeks into the fat where it can be fully absorbed by patients as young as six years old. It works by binding to the IgE allergic antibody in the blood stream and blocking its actions.

"What has changed is recognizing that there are clinical phenotypes, meaning clinical characteristics of a particular patient, that when identified and treated with specific drugs can make a big difference in their outcomes," says Dr. Loganathan. "What we have found at SBH (among the approximately 100 patients who have to date received this therapy), which is very similar to other clinical studies, is a marked improvement in the asthma control of a number of patients to the point that they are no longer using or now use a very low dose of systemic steroid or steroid bursts when they have asthma exacerbations and so end up spending less time in the emergency room or being hospitalized."

Biological agents need to be administered subcutaneously in the asthma / allergy clinic (located in the CCC) every two to four weeks and patients need to be monitored for about 15 to 30 minutes. Patients are evaluated by the asthma or allergy specialist before each dose of the medication is given. This gives additional opportunities for the patient to review asthma control and use of inhalers, and ensure that asthma does not affect their work or school.

Side effects of the treatment are infrequent and minimal, he says. Medicaid and most insurance carriers cover the cost of the medication, which is expensive. The therapy must be done in a hospital setting.

While studies show that most asthmatics can be controlled by the gold standard of treatment, biologic therapy is changing the lives of patients like Alannah.

"Over the past year, she's been able to run and take swim classes," says her mom. "She has a life now. She's a normal kid."

Partnering with Community-Based Organization to Improve Patient Health

By Luci de Haan

A team of SBH residents has joined in a unique collaboration with a Bronx Community-Based Organization (CBO) to improve the health of patients living with uncontrolled diabetes.

The pilot project brings nutritious food and education to patients to help them adopt lifestyle changes that can alter the course of their disease.

Dr. Victoria Bengualid, Director of SBH's Internal Medicine Residency Program, says that partnerships between residency programs and CBOs give residents the skills to recognize health disparities and address social needs associated with poor patient health.

"The Bronx has a higher prevalence of diabetes than all other New York City boroughs," she says. "Access to nutritious food is a serious barrier to good health in our communities. This is a social determinant of health that we know we need to address."

The residents are working with Mary Mitchell Family and Youth Services, a CBO that serves families in the Crotona and Fordham areas of the Bronx.

The pilot is an Innovation Fund project through Bronx Partners for Healthy Communities, the DSRIP Performing Provider System led by SBH Health System. DSRIP is New York's five-year Medicaid transformation program that aims to reduce avoidable hospital admissions by building an integrated network of clinical and community-based care that is coordinated, patient focused and improves health outcomes.

"When we met with Mary Mitchell, we knew this was an opportunity to work together to pool our goals and resources and build on what community organizations are trying to achieve," says Dr. Evan Siau, Chief Resident for Internal Medicine at SBH.

Since February, when the pilot was launched, a group of 25 patients with uncontrolled diabetes (HgA1c greater than or equal to 7) has been enrolled in a newly-formed "Life Enhancement Clinic," which provides monthly programming of education, healthy activities, cooking demonstrations, and health coaching.

Since nutrition is a core component of the program, patients are provided with a weekly delivery of nutritious food, including fresh fruit and vegetables, and healthy recipes. The food is provided by La Canasta, a community food buying club of Mary Mitchell.

Dr. Siau and his colleagues developed the concept of the Lifestyle Enhancement Clinic (LEC) as a way to foster the doctor/patient relationship, improve patient well-being, and enhance their own work satisfaction. "Often patients need the guidance and tools to get on the right track," says Dr. Siau. "We wanted to move away from our desktops and engage with patients in a meaningful way."

Participating patients were identified and registered for the pilot through an intake survey designed jointly by SBH residents and Mary Mitchell. The two groups collaborated to design an interactive LEC program that informs and empowers patients to take charge of their health in four main areas: nutrition, weight management, physical activity, and medication management. LECs take place at SBH.

During LEC sessions, local nutritionists, smoking cessation counselors, and exercise instructors lead workshops and activities like walking, salsa dancing, yoga and live cooking demonstrations to learn how food from La Canasta can be prepared to make healthy meals.

Residents and patients also spend time discussing health concerns and challenges like eating healthy, staying on a medication regimen, being active and getting to medical appointments.

"It's not enough to tell a patient to exercise more," says Dr. Siau. "You need to listen and understand their responsibilities and constraints to find personalized solutions that enable them to do what is feasible and still productive."

At the pilot's conclusion, outcomes will be measured by looking at patients' HgA1c levels, lipid profiles, body mass index, medication adherence and frequency of emergency room visits. Results will also be compared to a patient control group that received weekly distributions of La Canasta food and recipes, but did not participate in the LECs.

According to Dr. Bengualid, patients have expressed positive feedback on the LECs. Residents have welcomed the experience of working closely with patients and partnering with Mary Mitchell. "SBH and Mary Mitchell could not have accomplished this alone," says Dr. Bengualid. "We needed to integrate the best of what we have to offer."

Physicians and the Importance of 'COMPASSIONATE COMMUNICATIONS'

By Steven Clark

The victim of trauma, suffering with several cracked ribs and numerous other injuries, cries out from her hospital bed for pain medication. She has experienced a troubled history with multiple prior hospitalizations for substance use disorder, including opiates and cocaine. Shrill and demanding, even hostile, she poses a challenge to the entire hospital staff.

The good news, however, is that she is not an actual patient. Instead, she's being played by a senior nurse who knows this type of patient only too well. It's part of a role-playing exercise in a recent Planetree training class at SBH on compassionate communications.

"How do you diffuse a very tense and hostile situation like this?" asks Dr. Edward Telzak, chair, department of medicine at SBH, and one of the hospital's Planetree leaders. "These types of interactions are very prone to escalating and turning into an explosive situation between providers and patient, and sometimes between doctor and nurse – the doctor saying the nurse never gave the medication she ordered because of a break, or the nurse claiming the doctor did not order the medication she wanted to give.

"Instead, the providers need to acknowledge the patient's suffering, but show a unified front by explaining to the patient what she can do and what she cannot do – what is acceptable behavior and what is abusive behavior. You acknowledge your experience and you propose some alternative interventions like OMM or physical therapy. It may not be exactly what the patient wants, but it leaves the family saying, 'These doctors understand what's going on. They recognize that addicts can have pain as well. They care. They're afraid to give her too much of that medicine, but they're not saying she's faking or an addict.' This legitimizes the patient's point of view and presents a uniformed front without pointing any fingers."

The Planetree journey at SBH officially began in August when training classes were held for staff working on 6 North. This included attendings, residents, social workers, CNAs, respiratory therapists, dietitians, physical therapists, transporters and housekeeping staff. Additional training will be held for other patient floors in the months ahead. SBH is one of 30 hospitals across New York State chosen by the Greater New York Hospital Association to work with Planetree.

Compassionate communications is defined as "a feeling of deep sympathy for another who is stricken by misfortune, accompanied by a strong desire to alleviate their suffering." This means, according to Dr. Angela Babaev, assistant vice president, education and nursing recruitment – who led the training classes with Dr. Telzak; Dr. Halana Finnie, director of nursing, behavioral health and addiction services at SBH; Mary Carmel, director, med/surg in nursing; and Maureen Eisner, vice-president, patient experience – "hearing what they (a patient, a fellow staffer) hear and seeing what they see, so you can learn to walk in someone else's shoes." Classes consist of lecture, video, and role-playing exercises, which followed completion by each participant of the 90-minute online program modules.

More than being nice

Compassionate communications is beyond being "nice." It is about creating a person-centered focus within the organization, assisting staff in seeing how to integrate compassion into practice, and creating a common language with patients, staff and families. It is about having mindfulness [or being mindful] of what the patient is experiencing while in the hospital. Research has shown that compassion is a quality imperative (patients have been found to experience better results under the care of empathic doctors), a business imperative (that helps drive consumer healthcare decisions), and a workplace benefit (leading to higher job satisfaction, less stress, greater sense of teamwork, and lower risk of burnout).

So, how do you sell this program to doctors who Dr. Telzak calls "instinctively skeptical" about training of this kind? "I try and speak from the perspective of the patient and their family, as well as the point of view of their own experiences as a doctor in this hospital," he says. "With respect to family, it's really about being in someone else's shoes."

He speaks from very recent personal experience of a close friend who was recently seen as a patient at a hospital in Brooklyn, with the man's wife feeling "beside herself" because she didn't fully understand what was going on with her husband and there was never a senior physician available to speak with her. To attempt to remedy that problem, Dr. Telzak reached out to an influential physician he knew at the hospital, who in turn contacted the hospitalist in charge of his friend's care.

"There are a lot of people in your life that you care about deeply who are very much affected by doctors who may do a very good job medically, but don't provide the information for either patients or more importantly their family to help them understand what is going on in a day-to-day, and hour-to-hour basis," says Dr. Telzak. "Every doctor at any level of training has had the experience where they have been called by a family member or friend to explain what's going on. You get involved and try to reach doctors who will speak to them. In terms of Planetree, that's how I personalize it to our doctors."

Dr. Telzak says he also encourages doctors to think about those patients in the hospital with whom they've formed good relationships and how that enhances their own life on a daily level. "This is where you not only have made the right diagnosis and provided the right treatment, but you feel the patient has a deep appreciation for what you and your team have done," he says. "It's a morale booster in contrast to the patient who is much more hostile, who has the attitude, 'I've got to get out of here, the doctors here don't know what they're doing.' You get a lot more of the former and a lot less of the latter by spending quality time with patients and their family, and that's true at any level of training."

Providing a skill set

Planetree, he believes, unlike other programs, gives doctors a skill set that can enable them to help patients understand their medical story a little bit better and feel better about their relationship with their doctors. This, in turn, enhances the doctor's and the entire hospital staff's experience.

Often, he says, it's about being sensitive to the little things. "For example, understanding that when you're entering a patient's room, it's really their space, not your space," says Dr. Telzak. "How do you act when you're entering someone else's space? For starters, you ask permission to come in and you certainly don't start removing blankets to examine them or rearranging their chairs. You wouldn't come into someone's living room and move things around because you don't like the way it looks. You narrate what you're doing and ask permission at each step of the way. You introduce the people you're with – your team. You make eye contact, speak softly with kindness and concern, and hold a hand when appropriate. And, when you're seeing a patient in a window bed, you need to acknowledge that patient by saying, 'I'm here to see your neighbor. Please excuse the interruption.'"

Compassionate communications, it has been proven, is a skill that can be learned. This means remaining sensitive to patients' less-than-demanding wish list: 10 seconds of eye contact, human touch when appropriate, correct use of their name – as well as incorporating such non-verbal tools as tone of voice, eye contact, facial expression, and body language, and "listening to hear, not to respond."

So, can Planetree even help senior physicians like Dr. Telzak? "It's reinforced the importance of really thinking about the patient interaction from the point of view of the patient," he says. "I would sit down with patients probably 50 percent of the time, and always when I was speaking to them about something that I believe is particularly substantive. But now, I find myself doing it more often – perhaps three-quarters of the time. It's made me think that even what I perceive as more superficial interactions can still have great importance for the patient. I now more fully appreciate that every interaction can be impactful for a patient and I cannot always accurately judge which will have the greatest impact on that particular patient. So I try to adhere to certain practices and principles as close to all the time as I can."

Suicide and Saving Patients

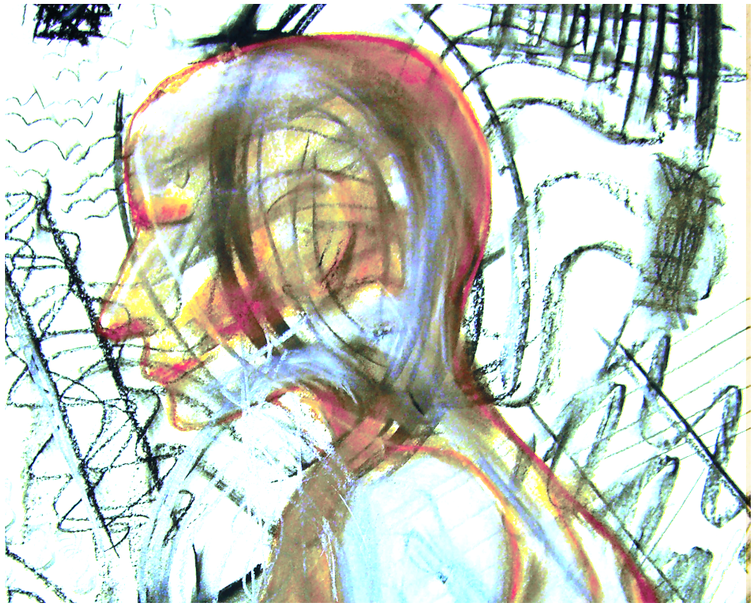
By Lizica Troneci, MD, Chair, Department of Psychiatry at SBH

Anthony Bourdain, American chef and TV personality; Kate Spade, fashion mogul; Robin Williams, actor and comedian; Ernest Hemingway, writer; Vincent Van Gogh, painter. **What did they have in common?** Fame and death by suicide.

Deelshad Joomun, attending nephrologist; Kathryn Stascavage, medical student; Dean Lorich, orthopedic surgeon; Gabriel Goodwin, anesthesiologist. **What did they have in common?** Health care providers and death by suicide.

Eight hundred thousand people in the world, from all countries, all backgrounds, all cultures. **What did they have in common?** Death by suicide.

Beyond statistics and numbers each suicide is a human being. Someone's mother, father, child, uncle, grandmother, friend, co-worker.



SUICIDE FACTS IN THE UNITED STATES:

- **2013 CDC report: suicide accounted for $50.8 billion (24%) of the fatal injury cost**
- **2016 CDC report: nearly 45,000 people age 10 or older died by suicide**
- **Suicide: the 10th leading cause of death overall**

What Makes Someone Take Their Life?

There is no single cause for suicide as it has a multidimensional basis. All health care professionals are expected to screen for suicidal thoughts, "Have you ever thought of ending your life?" And, if positive, they are expected to refer to mental health professionals who in turn are expected to assess the identified risk for suicide using these comprehensive assessments:

- Review risk factors (past suicidal attempts; psychiatric diagnoses; history of suicide in the family; substance abuse; history of abuse)
- Review protective factors (reasons for living; existence of children; cultural and religious beliefs related to suicide)
- Identify modifiable risk factors with interventions
- Make recommendations on managing the risk for suicide

When "famous" people commit suicide we ask ourselves: why HE who had money and fame? Why SHE who had admirers and followers? It is the seemingly "unexplained" suicide that captures the attention, raises questions and seeks to find answers.

We think we know these individuals and we imagine they have it ALL. We ignore they are human beings with their failings, sufferings, disappointments and heartaches. We fantasize glamour and money offer solutions to all problems, but we forget mental illness can affect ANYONE.

Fear of stigma makes people of any status hide the depression they experience, the abuse of drugs, the highs and lows they feel.

In an attempt to explain WHY, social media, journalists and investigators start searching for reasons. Many times, these searches bring speculation and pain to the surviving family and anxiety and more questions to the public. As laymen, we might think:

- Didn't it have to be severe depression that made this person hopeless and helpless?
- Did a borderline personality disorder make someone suicidal on the brink of the moment (as associated by low self-esteem and mood swings)?
- Did they overdose with drugs?
- Were there flashbacks/nightmares about the traumatic events they witnessed or suffered?
- Did they face a terminal illness? Or chronic, unrelenting pain?
- Was there a loss (of a close person, a job, social status, freedom)?

Physician Suicide

Most concerning, frightening and alarming is the suicide of medical professionals. Why do medical students, trainees, physicians kill themselves? Is it the intensity, the hardship of the work they do? Is it the suffering they witness every day?

When doctors kill themselves the question "why" becomes more intense. Why the people who are supposed to help and heal? Why the people who know about depression and anxiety and substance abuse? Why the ones who have the most well-informed access to resources?

In "What I've learned from my tally of 757 doctor suicides," an article that appeared earlier this year in "The Washington Post," Pamela Wible provides a list of potential reasons: burnout; patients' death and medical errors; malpractice suits; sleep deprivation; and loss of status or affiliation in addition to such personal factors as divorce, death, illness.

FACTS ABOUT PHYSICIAN SUICIDE IN THE UNITED STATES:

- **Annually 400 physician suicides translate to more than 1 million patients losing their doctors to suicide each year.**
- **The suicide rate among doctors is between 28 to 40 per 100,000 – more than twice than in the overall population.**
- **The suicide ratio for physicians compared with age-matched controls in the general population is 1.41 times higher for men and 2.27 times higher for women.**
- **The mean cost of replacing a physician is $500,000 to $1,000,000.**

Stigma is again the main obstacle in seeking treatment. Physicians worry their report of depressive symptoms or other mental health symptoms can impact licensure, employment or hospital privileges.

After reading this article and many more, we are left with more questions: Can it happen to the mother who feels depressed? Or to the spouse who drinks heavily to alleviate pain? Or the next-door neighbor who is always apparently happy?

Suicide can be preventable by raising awareness, improving and encouraging access to mental health care, mobilizing resources and fighting stigma. There are multiple venues:

- World Suicide Prevention Day, organized by the International Association for Suicide Prevention, is observed worldwide on September 10.
- National Physician Suicide Awareness Day, organized by the Council of Emergency Medicine Residency Directors (CORD), in collaboration with other agencies, is observed on the third Monday in September.
- On September 10, 2018, the World Health Organization released WHO's preventing suicide: a community engagement toolkit, a step-by-step guide for people who would like to initiate suicide prevention activities in their community.
- The CDC encourages everyone to learn the warning signs of suicide, to identify and to appropriately respond to people at risk by visiting the National Suicide Prevention Lifeline website and learning about #BeThe1To movement

5 ACTION STEPS FOR HELPING SOMEONE IN EMOTIONAL PAIN

1. **Ask them: "Are you thinking about killing yourself?"**
2. **Keep them safe: Reducing a suicidal person's access to highly lethal items or places is an important part of suicide prevention.**
3. **Be there: Listen carefully and learn what the individual is thinking and feeling.**
4. **Help them connect: Save the National Suicide Prevention Lifeline's number in your phone so it's there when you need it: 1-800-273-TALK (8255).**
5. **Stay Connected: Staying in touch after a crisis or after being discharged from care can make a difference.**

Coming Soon:
Health and Wellness Center at SBH

This is an excerpt from an article that appeared in www.aha.org/physicians.

By David Perlstein, MD, MBA, President/CEO, SBH Health System

Photo credit: Danttner Archiects

Why does a community hospital that cares for an underserved population – one with a challenging 95 percent government payer mix that results in significant annual net losses – choose to "break the mold" by reinvesting in its community and betting on social determinants to alter its destiny?

The answer is a simple one: because we must. The health and wellness of the community we serve depends on it.

SBH Health System serves a low income and ethnically diverse population, one which often changes as immigration changes. Most of our patients are covered by Medicaid. The average income for a family of four is under $13,000 per year, way below the poverty level. Unemployment is high and educational levels low, as are the measures of health and wellness. The prevalence of obesity, asthma, diabetes and heart disease are the highest in New York City, as is the prevalence of substance abuse, non-accidental trauma and behavioral health diagnoses.

Bronx County ranks 62nd out of 62 New York State counties in terms of health and wellness, according to the 2018 Robert Wood Johnson Foundation County Health Rankings Report. But a significant investment in addressing the social determinants of health (SDOH) has begun to move the needle for our county.

As an "anchor institution," SBH Health System is part of an urban microorganism. We know that by reinvesting in our community, as the community improves, so will our financials. Treat a wound on one part of the body, and the rest of the body heals with it. We view the chronic wounds associated with certain social determinants as an important part of the health care calculus. It is due to this knowledge that we decided to leap into the world of housing development, combined with programs aimed to address other unmet SDOH – food security, safe outdoor spaces, education, stress reduction, and health care coverage.

This commitment, we believe, will support the healing needed in our community and ultimately result in a healthier, happier and more productive population.

"BY ADDRESSING FOOD AND HOUSING INSECURITY, AND PERSONAL SAFETY CONCERNS, WE WILL BE BETTER ABLE TO ADDRESS THE BURDEN OF UNTREATED PREVENTABLE ILLNESS IN THE COMMUNITY, WHICH KEEPS PEOPLE FROM MAXIMAL PRODUCTIVITY AND CREATIVITY."

The Building Project

The project itself is a $156 million, mixed-use development that includes two affordable housing units with 314 apartments, managed by L&M Development Partners, and a 60,000 square-foot health and wellness space, managed by SBH.

Ninety-five units are being reserved for formerly homeless families and individuals, as well as those individuals identified as "high-utilizers" of the Medicaid system. Also planned is a daycare and early learning center, as well as other retail frontages dedicated to supporting a culture of wellness. The project also includes the creation of a multi-use community space, as well as an outdoor landscaped terrace with a walking track, a patient education center, and an integrative medicine space.

The project would never have gotten off the ground without the right partners, including L&M Development Partners and Hornig Capital Partners, community members, New York State, New York City, local and state elected officials, a receptive board of trustees and, of course, a visionary leader like my predecessor Dr. Scott Cooper, a pulmonologist, who had the courage and the vision to get the project started in the first place.

The Bronx Borough President's office has dedicated $1 million to the build out of a rooftop garden, which will be used for educational purposes, as well as supplying produce for a seasonal green market to be housed in the lobby. The health and wellness space will include clinical programs such as urgent care, women's and children's health, as well as a fitness area and a teaching kitchen that will be used as an educational tool for providers and the community.

Some of the funding of the project was possible through tax-exempt bonds, low-interest housing loans by New York City, Medicaid Redesign funding, and the "donation" of the land by SBH in exchange for a long-term, lower-rate lease for the clinical space. The housing units are due to open in early 2019, and the wellness space in early 2020.

This and other projects focusing on SDOH could not have gotten off the ground without New York State's Delivery System Reform Incentive Payment (DSRIP) program. DSRIP supports the state's commitment to addressing rising Medicaid costs and variable quality outcomes by funding a five-year program to decrease unnecessary hospitalizations and emergency department visits. The program functions by creating a value-based payment system, and by encouraging community engagement and broad-based partnerships.

For example, SBH runs Bronx Partners for Healthy Communities (BPHC), a Performing Provider System funded through the DSRIP program. New

Photo credit: Danttner Archiects

York State has also granted $22.6 million in capital through the Facility Transformation Program to support the build out of the "wellness space." These sorts of community partnerships have sometimes been overlooked by hospitals and health systems, but are vital to ensuring the success of our local transformation.

A Paradigm Shift

By addressing food and housing insecurity, and personal safety concerns, we will be better able to address the burden of untreated preventable illness in the community, which keeps people from maximal productivity and creativity. We recognize that through partnerships, we can begin to address the educational disparity and lack of career opportunities that pervade our area, with the ultimate goal of decreasing the intensity of those common urban stressors that inhibit personal growth and development. This creates the foundations for even more vibrant and resilient neighbors.

The challenge, of course, is that while value is an imperative in this new model, we still must maintain volume; after all, this is how we get paid. The fitness center needs to be able to pay for itself, and the teaching kitchen needs to be sustainable. But finding ways to pay for wellness services that current insurers do not automatically reimburse remain significant barriers. We are hopeful that as value-based care becomes the dominant model for reimbursement in New York State, both SBH and our community will be ahead of the curve and already on the road to improved health and wellness.

A project such as ours is not only the right thing to do, but it is a very good business to be in. We are in this for the long game. Our plan includes stewarding our community members towards independence and entrepreneurship, which will accrue to SBH for years to come.

Many urban health care organizations invest in their communities by purchasing homes and lots and building both residential and nonresidential units. However, the investments can sometimes have unintended consequences, such as gentrification and displacement. We believe that by giving our community the opportunity to address the social determinants often associated with lower education rates, worse health outcomes, and lower economic status, we will foster the growth of a revitalized community that is proud, productive, healthier and hopeful. We know our community deserves it, and we want to see this commitment and investment in other like-minded communities.

How will we determine success? We are looking at improving measures of wellness among our patients, including both qualitative and quantitative elements such as decreased hospital admissions, fewer unnecessary ED visits and of course, moving Bronx County out of that dreaded 62nd position in New York State. We are also hoping that we can decrease the necessity to "push" wellness on our community — and benefit from activist patients and community members who begin to "own" their health and wellness — so that a true partnership is created and the impact is not only sustained but continues to improve.

We believe that our project can be truly transformational. We won't know for sure of course for another five to 10 years, but vision requires looking forward and a willingness to take a leap.

Accurate Translations Can Avoid Litigation

Using a qualified translator can make millions of dollars' worth of difference.

By Cassandra Andrews-Jackson, Compliance & HIPAA Privacy Officer

If you take the time to use a qualified interpreter, you won't have to spend time to settle a lawsuit.

Misinterpretation of a single Spanish word (intoxicado misinterpreted in this case to mean "intoxicated" instead of its intended meaning of "feeling sick to the stomach") led to a $71 million-dollar malpractice settlement associated with a potentially preventable case of quadriplegia.

"Providing adequate translation is also a safety issue and a potential liability issue," says Dr. Glenn Flores, a nationally renowned pediatric researcher, noting a successful $71 million Florida lawsuit in the case of a teenager who was left a quadriplegic. The 18-year-old had gone to a sporting event at his high school, felt ill and walked over to his girlfriend's house. Just before he collapsed he said, "Me siento intoxicado." Neither the paramedics coming to his aid, his girlfriend or her mother spoke any Spanish and didn't understand what he said. Yet, the paramedics hearing the word "intoxicado" assumed he meant intoxicated. So, they rushed him to a local hospital emergency room.

Falling into a coma, the young man was taken to the ICU, where for 48 hours they worked him up for drug abuse. Finally, they did a CT scan that revealed that he had a brain aneurysm, and once it burst, resulted in a huge intracranial bleed. "Intoxicado," in fact, can mean nausea. "That is one example of why, if you spent $30 for an interpreter, you wouldn't have had to spend $71 million to settle a lawsuit," says Dr. Flores.

High-profile cases are accumulating because of medical errors due to language barriers. Lack of an interpreter for a three-year-old girl presenting to the emergency department with abdominal pain resulted in a several hour delay in diagnosing appendicitis, which later perforated, resulting in peritonitis, a 30-day hospitalization, and two wound site infections.

A resident's misinterpretation of two Spanish words ("se pegó" misinterpreted as "a girl was hit by someone else" instead of "the girl hit herself" when she fell off her tricycle) resulted in a two-year-old girl with a clavicular fracture and her sibling mistakenly being placed in child protective custody for suspected abuse for 48 hours.

A 2003 study in "The Journal of Pediatrics" said that translation errors are common and can be dangerous. Dr. Flores and colleagues at the Medical College of Wisconsin and Boston University examined the transcripts of 13 audiotaped visits of Spanish-speaking patients in a pediatrics clinic. Six encounters involved an official hospital interpreter; seven involved an "ad hoc" interpreter like a nurse, social worker, or, in one case, an 11-year-old sibling. The official interpreters made 231 errors, 53 percent of which were judged to have the potential to cause clinical problems. The ad hoc interpreters made 165 errors, and 77 percent of them were potentially dangerous. Some errors included the interpreters' omitting questions about

drug allergies; telling a parent to put a steroid cream on an infant's entire body (instead of just the face); telling a mother to give an antibiotic for two days instead of 10; telling a mother to put an oral antibiotic into her child's ears (instead of his mouth) for a middle-ear infection; and using a Puerto Rican slang word for mumps, which a Central American mother could not understand.

Is Google Translate considered a "qualified interpreter"? Not quite.

Consider the following: According to an article in the daily British newspaper "The Guardian," "Even though Google Translate has improved a lot over the years, there's still no real guarantee of accuracy. There's still a worry that, on [vacation] if you visited a doctor with a sore throat and used Google Translate to list your symptoms, he would end up amputating your leg."

An article published by the National Institute of Health reported that "Ten medical phrases were evaluated in 26 languages (eight Western European, five Eastern European, 11 Asian, and two African), giving 260 translated phrases. Of the total translations, 150 (57.7%) were correct while 110 (42.3%) were wrong."

"Scientific American" reported that "the news that 'your wife needs to be ventilated' often became 'your wife needs to be aired,' which just adds insult to injury."

Similarly, a typical error for "your husband had a heart attack" was to have it come out as "your husband's heart was attacked."

The use of mobile devices by health care professionals (HCPs) has transformed many aspects of clinical practice. Mobile devices have become commonplace in health care settings, leading to rapid growth in the development of medical software applications (apps) for these platforms. Numerous apps are now available to assist HCPs with many important tasks, such as: information and time management; health record maintenance and access; communications and consulting; reference and information gathering; patient management and monitoring; clinical decision-making; and medical education and training.

Several issues challenge the future integration of mobile devices and apps into health care practice. While the majority of HCPs have adopted the use of mobile devices, the use of these tools in clinical care has been debated since their introduction, with opinions ranging from overwhelming support to strong opposition. Among the concerns raised regarding mobile devices are: their reliability for making clinical decisions; protection of patient data with respect to privacy; impact on the doctor–patient relationship; and proper integration into the workplace. In addition, HCPs have expressed concerns about lack of oversight with respect to standards or content accuracy, especially for apps involved in patient management. Older HCPs, as well as those who are intimidated by or less inclined to use new technologies, may be at a disadvantage if the use of mobile devices becomes a requirement within the health care fields.

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

At SBH, we have Cyracom for language interpretation services. Cyracom provides 24/7 access to HIPAA-compliant interpretation services. Their staff utilizes medical terminology, anatomy and physiology, and other topics essential for healthcare interpreting. The Cyracom phone interpretation system is a diversified language service company which supports over 200 languages and dialects. Staff must consider the following when using this system:

Staff utilizing the Cyracom system to communicate with a patient must document in the appropriate sections of the patient's medical record that the Cyracom interpreter phone was used and document the Cyracom interpreter's ID number.

Cyracom telephones are available in all inpatient and outpatient care areas.

Instructions on the use of Cyracom telephones are attached to each Cyracom telephone. In addition, the Cyracom service can be accessed from office department phones and instructions on how to access Cyracom services via office department phones are affixed to the department phones.

Language interpreters assisting a patient/visitor should call Cyracom through the speed dial **777 and/or its toll-free number.

Staying Engaged Limits Physician Burnout

By Marianne Haughey, MD and Dr. Ethan Abbott, DO

WHAT IS BURNOUT?

Burnout, as defined in a 2017 discussion paper in the National Academy of Medicine, is "a syndrome characterized by emotional exhaustion, depersonalization (i.e. cynicism), and loss of work fulfillment." Burnout has become more common in the changing system of healthcare and the implications for our health care providers, society, and our healthcare system have become more apparent.

Although many physicians are challenged by the demands of their careers, a 2018 article in "The Journal of Internal Medicine" further describes it this way: "Burnout is distinct from conceivably related constructs such as job dissatisfaction, fatigue, occupational stress and depression. Although burnout correlates with these problems, it may be present in their absence or absent in their presence."

Implications of burnout include psychological stress for the healthcare provider, which can result in addiction issues, depression and/or suicide, poor family and personal connections, and isolation. Patient care can suffer with lower quality care, increased medical errors, and decreased patient satisfaction. The healthcare system as a whole will find decreased physician productivity and increased physician or provider turnover which can increase the cost of providing care.

Suggested reasons for increased burnout are more demands of the job. This includes non-clinical activities, the implications of the many keystrokes involved in using an EMR and increasing demands for rapid and less personal care.

One suggested way to avoid burnout is to find ways to stay engaged. Clearly, clinical care provides opportunities to re-engage on a daily basis, but academic medicine in addition to presenting more requirements and challenges also provides opportunities for the practitioner to engage on another plane. The strains of providing what the ACGME requires as "scholarly work" for the department presents additional challenges, but also new opportunities. Per the ACGME, requirements include that "faculty must establish and maintain an environment of inquiry and scholarship with an active research component." This includes such things as participation in conferences and

discussions, journal clubs, publishing, and scientific society meetings at the local, regional and national levels.

Satisfying the requirements of academic faculty can feel quite daunting, but we can argue that it allows for a level of creativity that permits the engagement needed to avoid burnout.

Below are our personal perspectives and suggestions on how to accomplish these goals:

DR. HAUGHEY

As a new attending, one frequently gets involved in many different projects. This allows the young attending to consider many possible interests and how they might be incorporated into their time. At some point, however, it becomes important to focus on a few interests that make the most sense to spend time pursuing. Prioritizing your focus areas can be the most challenging.

To begin the process, annually make a list of every task of non-clinical work you do. This is useful not just for you as you decide your priorities, but also as a tool to share with your Chair so that they can be aware of your contributions to the department. As you go through the list, consider the following:

1. Group things together that complement each other. For example: serving on a national medical student education committee for your specialty, running the medical student interest group at your institution, and getting a publication in process regarding medical student curriculum development while serving on a medical student curriculum committee. These can all complement each other more than working on disparate committees that don't align as well with a theme of your interest.

2. Allow your interests to bring you joy. Divest yourself of those non-clinical tasks that don't bring you joy. When I say "divest," I don't mean "dump back on your Chair." Remember, all doctors must contribute to the running of a department, but by seeking out others and discussing with them what brings them joy you may find someone who would be a natural fit to take on the extra work you would like to shift onto someone else's shoulders in order to better align your focus area.

3. Figuring out your personal mission statement can help you define where your focus might best lie. Why do you do what you do? Do you have a drive to care for the underserved? Does a particular method of surgery fascinate you? Think of what is important and make a list so that you can fit the pieces and phrases together into a personal mission statement that can help give you guidance when your motivation falters.

4. Make a list of your joys. For example, in my case: hanging out with friends; writing; making new friends; expressing written creativity; doing word puzzles.

FIND A FRIEND

Early in my career I found a friend, Dr. Yvette Calderon, who was a wonderful mentor as well. We complemented each other well as she had far more interest in evaluating the data that came with doing a study and I had more interest in writing the ideas down and editing a summary of our project for an abstract submission for the Society of Academic Emergency Medicine's annual meeting. I also loved editing and writing (and re-writing) the paper that came from that abstract into a journal submission. We had 10 abstracts accepted over five years.

MAKE THINGS COUNT MORE THAN ONCE

One of the easy ways to think of this is if you have an abstract done, do the extra work while it is fresh in your mind and get the first draft of the article done. You can then go on to present the abstract, and if important points are brought up by those who see or hear it when presented you can incorporate those points into the written piece. But if you wait until the abstract is presented to write the first draft you lose some of your momentum and it makes it more challenging to get that first draft out. By doing this you also develop the reputation of becoming an expert in the area of interest, which is significant for academic promotion.

Also, if you have an educational innovation you have developed, consider writing it up or presenting it at a meeting. If you have put the time into coming up with a creative solution to a conundrum, chances are others have the same conundrum and would love to see your thoughts on a solution.

Likewise, if you do a talk for the residents, it often involves a literature review and search for current practices. This is the basic background work for a summary article or textbook chapter. With a little more work and persistence, you can find a publication. Or, from the other side of the coin, if you have put together a chapter for a text it certainly makes sense to take that topic and make a grand-rounds level talk that you can do not just at your institution but at neighboring institutions, and possibly even a national talk.

FIND NEW FRIENDS WHO SHARE YOUR INTERESTS

Through national or regional academic societies, you can find other practitioners from different institutions, different states and even different areas of the world who share some of your interests. By joining forces with them they can share with you perspectives that widen your ability to look at the problem from new angles. It allows you the opportunity to consider new solutions and innovative approaches. This also provides you with new co-conspirators to develop new talks, papers, questions for explorations and projects to accomplish, now in a more focused area of interest shared by others. This will also help you create a reputation beyond your institution – a quality that is important in considering academic promotion.

AND DON'T FORGET PULLING UP THE NEXT GENERATION

There are many benefits in the mentor/mentee relationship. Although the benefits to the mentee are often described, there are many benefits to the mentor as well. By mentoring others who share your interests you achieve engagement and cross-pollination with new and fresh ideas. This helps re-ignite the energy of the mentor and allows the enthusiasm of the (often) younger mentee to allow the mentor to consider exploring new avenues in their work.

MAKE CHOICES

In order to allow your academic success to develop and focus, it is important to make choices that help support your goals. There may be a time and a place to take on new opportunities and it might not be just when the opportunity is presented for the first time. Know your timeline and your commitments outside of work – family, self-care, hobbies that are separate from your work, other obligations – and realize that some opportunities come with an additional time/cost factor that might best be taken on at some specified time in the future. Limiting the opportunities you are taking on at one time allows you to focus and develop areas of interest and expertise that have value over time.

DR. ABBOTT

START WITH TAKING A RISK

I think the key for building strength and longevity is to start with taking a risk, albeit calculated, that can potentially lead to reaching your personal and professional goals. This can include leaving a comfortable position at a program or hospital or possibly even taking a decrease in salary. For me, I found myself somewhat unsatisfied with my prior position as an attending. I was able to identify my passion for clinical teaching and working with residents and becoming a part of an academic program. I took the leap and left my prior position to join Dr. Haughey at SBH as the assistant program director for the residency.

GET ORGANIZED

I think one of the most challenging elements of academic medicine is finding a balance between clinical

and administrative duties. When I first started in my position as assistant program director for the residency, I found myself overwhelmed on my non-clinical days by e-mails, projects, meetings, and all the various residency-related tasks. For me, organization helps to insure productive days and streamlines the free time I have to be productive. I like to use platforms such as Basecamp, Slack, Evernote, and Google Docs to integrate research, writing, and residency-related tasks. On clinical days, I like to be able to quickly pull up recent journal articles or research for discussion with residents during a shift and these platforms assist with that process.

FIND YOUR NICHE

This is the perhaps the most difficult task, but I think using a more intuitive approach can lead to success. I found early on that I really enjoyed bedside and on-shift teaching of residents. I worked hard to develop more creative ways to teach on shift and integrated some electronic and paper resources that I think has led to a successful approach. For me, this has made my clinical shifts even more interesting and enjoyable as I look forward to engaging with the residents and medical students who are passionate about learning.

START WITH THE LOW HANGING FRUIT

I think one of the initial challenges in academic medicine is finding the time to write and publish. As a more junior faculty member I knew I needed to start to work on publishing as this is a requirement. Initially I set my ambitions on developing research projects and ideas that were unreasonable in size and scope. So I adjusted my focus and started with case reports and shorter pieces for other emergency medicine journals. While I have only begun to scratch the surface, I have gained valuable experience even with these smaller publications.

MERGE THE PERSONAL AND THE PROFESSIONAL

I found early on in my current position I was able to integrate my interest in photography and website development to help build the electronic learning center for the residency program. Since then, I have worked on the official website for our program and have been responsible for updating and adding new content. Being able to bring together your own personal interests or hobbies into your professional life can be incredibly fun and satisfying.

Resident Does Medical Mission in Peru

By Roger Baril, DO, PGY2, Emergency Medicine

This past summer, I spent two weeks in Peru on a medical mission coordinated by Michigan State University. The trip began in Iquitos, a small port city and gateway to the Amazon jungle that is only accessible by boat or plane.

We spent the first week at a military base where we set up clinic, seeing 300 or more patients a day. Each morning we took a bus from the hotel to the base, where patients were gathered in a line that extended around the block. The medical volunteers were composed of students, residents, and attendings, representing many specialties including Emergency Medicine, Family Medicine, Gynecology, Pediatrics, Radiology, and Osteopathic Medicine.

Iquitos is a poor but lively city, and an unassuming tourist spot. The streets are filled with rickshaws and stray dogs. We spent our evenings walking around the city square, shopping at the craft markets along the pier and enjoying the local cuisine. My favorite spots included a floating restaurant accessible by water taxi and a barbeque joint owned by an ex-patriot from Texas.

We spent our second week at the Ceiba Tops Lodge in the heart of the Amazon. When we arrived at the lodge, it was a welcome change of scenery. The moss-laden wooden paths that led us to our room, the hammocks, the sound of macaws – it was how I'd imagined traveling to the rainforest of Peru. A tapir, named Cynthia, wandered freely around the grounds of the lodge, and the nearby Isla de los Monos housed hundreds of orphaned monkeys who seemed eager to entertain a group of tourists.

Each day, we got onboard a three-story riverboat and took a trek down the Amazon River to nearby villages. As we approached the villages, we could see patients waiting eagerly along the edge of the mud bank. It is low water season from June through November, when the river water could ebb up to 45 feet. The patients climbed down steps carved into the mud on the side of the bank to reach our boat. My station was on the top deck of the boat, which served as a more favorable environment than the humid and crowded rooms in Iquitos.

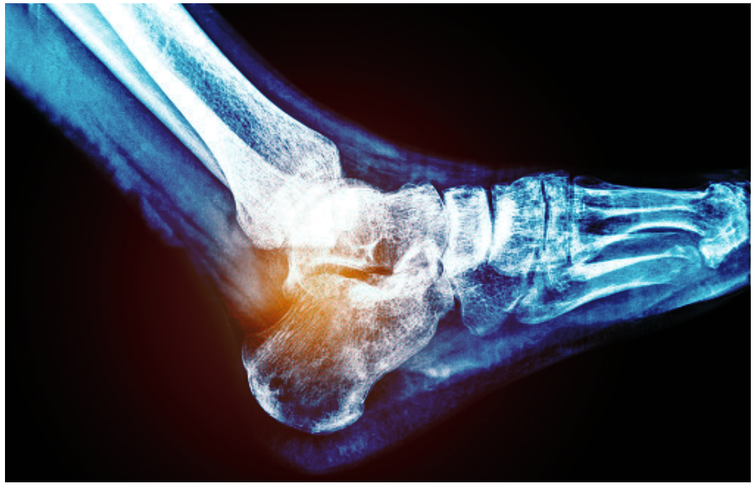
Due to the nature of our mission, most of our diagnostic studies and medications were geared towards treatment of acute conditions. Our makeshift pharmacy carried such things as antibiotics, steroids, nebulizers, and antipyretics. Our diagnostic tools were limited to x-ray, ultrasound, urine dipsticks, and a HemoCue. The practice of international and rural medicine relies heavily on your history, physical exam, and gut instincts to reach your diagnosis. I enjoyed practicing medicine this way, without the dependence on an abundance of labs and expensive imaging.

Altogether, we saw just over 2,200 patients, many of whom had not seen a physician for years. I believe that the pursuit of health is an unalienable right. However, to the underserved communities around the globe, it may often feel like a privilege. This trip served as a reminder that patients, both in Peru and back home in New York City, entrust me with their well-being and it is a position that I will never take for granted.

PODIATRISTS in the ER

By Steven Clark

An ambulance rushes a 29-year-old man to the SBH emergency department after a high-speed motorcycle accident. In addition to internal injuries, the patient is soon found to have suffered multiple fractures to his foot. Once he is stabilized, the surgeon begins a race against the clock to treat the patient's compartment syndrome, as excessive pressure builds inside the enclosed muscle space that has compromised the flow of blood to his foot. This causes severe pain and the threat of amputation. The doctor performs a fasciotomy, cutting into the band of connective tissue that attaches, stabilizes, encloses and separates muscles in the patient's foot to relieve pressure and restore circulation to the tissue and muscle. The patient's foot is saved.



In the middle of the night, a middle-aged woman leaps from her seventh story window. This causes, among other injuries, an open fracture of her heel. The surgeon washes out the injury, pieces together the tiny bones as if working on a jigsaw puzzle, and fixates it using pins that will stabilize the foot and allow the wound to heal.

A young man staggers into the emergency department with a low velocity gunshot wound to his foot. X-rays indicate that the bullet had caused several simple fractures of the metatarsal bone before exiting from a small hole in the foot. The surgeon places an external fixation across the area of the fracture (which will later be resected with a bone graft placed within the fracture fragments). His biggest concern now is infection, whether the wound becomes contaminated from metal fragments, a sock, or dirt from the ground. This involves performing local wound debridement, irrigation and antibiotic ointment.

PODIATRISTS ON CALL

In each case, the emergency room surgeon is an SBH podiatrist. Podiatrists are on emergency call at the hospital 24/7, with a podiatric resident stationed in the ER at all times. The podiatry department receives 3,000 ER calls annually, with an average of three trauma calls weekly that are serious enough to require calling in an attending podiatrist to treat the injury. This may raise the eyebrows of those who associate podiatry more with ingrown toenails and bunions than with limb-saving surgery.

Podiatrists at SBH often work closely with emergency medicine physicians and orthopedic, trauma, vascular and plastic surgeons in treating trauma victims. "We become involved whenever it involves an extremity, after vitals and internal organs have been checked to see that the patient's life is not in danger," says Dr. Emilio Goez, Chief of Podiatry at SBH. "The foot is often the last thing to be taken care of, and yet it may be the only thing requiring surgery."

The podiatry team includes Dr. Goez, Dr. Andrew Campbell, and Dr. Harold Goldstein, all with 25 or more years at SBH, and younger podiatrists, as well as 20 or so first to fourth year podiatry residents. In addition to trauma and sports injuries to the foot and ankle, ER cases often involve severe diabetic infections and other soft tissue injuries.

CHARCOT FOOT

This includes Charcot foot, or Charcot Neuroarthropathy, which is a severe joint disease that attacks the bones, joints and soft tissue of the foot. As the bones of the foot lose calcium and begin to weaken, they can break and shift out of place. While it's a condition commonly found among diabetics, it can also occur as a result of a skin infection, a spinal cord injury, Parkinson's disease, a sexually transmitted disease, post foot surgery, or other causes. As with any diabetic infection, it can hit with a vengeance with little if any warning. The patient can become septic and may arrive in the ER unconscious and/or with signs that may more closely resemble a head injury than a foot condition.

Without proper diagnosis and treatment, the foot may soon lose its shape, toes may curl, and the ankle may become twisted and unsteady. As the condition deteriorates, the foot may need to be removed. Surgical stabilization during early-stage Charcot foot is a consideration for those with complications of a foot deformity and difficulties should such conservative treatments as prolonged immobilization, custom shoes and bracing, and activity modification fail. Surgical procedures include ostectomy, which involves removal of abnormal bone growth and bone and cartilage fragments; midfoot realignment arthrodesis (permanent fusion of the joints between the bones), where bony overgrowths are removed and the collapsed arch is repaired; or hindfoot and ankle realignment arthrodesis, where screws and plates are inserted to stabilize the bones and cartilage is removed.

"Emergency foot surgery has seen a huge amount of progress in recent years," says Dr. Goez. "There are new technologies today, better materials and more treatment options for podiatrists, as well as for vascular surgeons and other doctors we work with in this environment of collaborative care. This means that only when the blood flow is not there, or the pain is so severe, are we likely today to consider amputation."

"PODIATRISTS AT SBH OFTEN WORK CLOSELY WITH EMERGENCY MEDICINE PHYSICIANS AND ORTHOPEDIC, TRAUMA, VASCULAR AND PLASTIC SURGEONS IN TREATING TRAUMA VICTIMS."

Fixing Flat Feet

Most children are born with flat feet (i.e. feet without arches), with the arch height of their feet gradually increasing over several years. Yet, when Eric celebrated his eighth birthday, he had feet that were flat in all positions – loaded (standing on the whole foot), unloaded (off the foot) and standing on his toes positions. This caused him increasing pain in the soles of his feet and ankles when walking or running.

"Surgery may be an option when flat feet are associated with pain or decreased function, and don't respond to such conservative treatment as braces, stretching, physical therapy or shoe orthotics," says Dr. Goez. "With pediatric patients we try to hold off on surgery until foot growth is complete (by around age 10)."

Children and adults with flat feet often over pronate, or roll their feet inwards too much, which can make them vulnerable to foot, ankle, knee, hip and back injuries over time. They may also complain, he says, about legs that feel tired (a response to their muscles working overtime).

During the patient evaluation, a full medical history is taken and a physical exam, clinical exam, radiographs and gait evaluation are performed (as well as a CAT-scan and/or MRI in certain cases). Once the type of flat foot deformity is determined, specific surgical procedures are selected to target the cause of the problem(s).

For patients like Eric, whose condition was not helped by conservative treatments, surgery was performed to lengthen his short Achilles tendon and combine it with a bone graft.

"The success rate for children like this is very high," says Dr. Goez. "By restoring the arch, we can prevent opposite knee and back pain from occurring years later. We also do this type of surgery with adults with flat feet, but it takes longer for them to heal and the rate of success is not as high. Our goal with children is that they do so well we never see them again."

Is This the Right Business Investment?

By Howard Hook, CPA, CFP

Howard Hook is a CFP and CPA with the wealth management firm of EKS Associates in Princeton, NJ. He has been named to Medical Economics' list of its top financial planners for doctors for nearly a decade.

If you have been practicing medicine long enough you probably have been approached at some point by someone with a business idea looking for investors. Some might even sound quite appealing. If it is a friend, family member or colleague asking, it can be quite difficult to say no. But saying no, more times than not, is probably the right decision to make.

Statistics back this up. According to the US Bureau of Labor statistics, about one half of small businesses make it at least five years, and only one third survive for 10 years. Here are some things to think about when deciding whether to invest in a business idea:

AFFORDABILITY

Before entertaining any offers to invest, you first need to evaluate whether you can afford to. Allocating funds that would otherwise be used for other purposes, such as college education for your children or for retirement, for example, is a risky proposition. Any good salesperson can make any business idea sound like the next Amazon or Google, but practically speaking most small businesses fail and even more never even get past the idea stage. So be sure to allocate only discretionary funds to a possible new business venture.

A good rule of thumb on how much money you would be willing to invest is to invest only an amount of money you can afford to lose without it affecting your ability to maintain your current lifestyle.

KNOWLEDGE ABOUT THE BUSINESS

Remember that someone looking for you to invest in a business with them is going to emphasize all the positive reasons why you should invest your money with them. They probably are not going to discuss or spend any meaningful time discussing with you the negatives of their business idea. Keep in mind that if something sounds too good to be true, it probably is. Also, evaluating the success of a new business all by yourself may be difficult to do. First, you may have an emotional attachment to the business idea which could keep you from making the right decision.

Second, not all good business ideas make for profitable businesses. An example of this is a business idea which sounds promising, but is not protectable by a trademark and can be knocked off by someone else. It is probably best to pass on an idea like that. Finally, the complexity of the business may preclude you from being able to evaluate the idea yourself. In that case, you should hire an advisor to help you evaluate the idea.

"Starting out as a 10% owner, after several rounds of additional capital contributions where you did not participate, may dilute you down to 1 percent or 2 percent, which may not make the investment worthwhile."

ADDITIONAL CAPITAL REQUIRED

New businesses often require additional capital contributions as the business grows and hopefully expands. This is partly due to the difficulty new businesses may have in securing financing from a bank because of an unproven track record. Therefore, it is important to inquire whether additional capital will be needed and how your ownership equity will be affected if you do not contribute additional capital as the business needs it. A review of projected cash flows also may uncover future cash needs. It is likely that your ownership interest would become diluted if you do not contribute more money when the other owners do. Starting out as a 10% owner, after several rounds of additional capital contributions where you did not participate, may dilute you down to 1 percent or 2 percent, which may not make the investment worthwhile.

RETURN ON INVESTMENT

It is not uncommon for many businesses to lose money the first few years. That, in itself, should not necessarily deter you from making an investment in the business. Clearly, a business should start to make money soon thereafter. But profitability alone should not be the yardstick. Instead, the potential return on your investment (ROI) should be evaluated to determine if it is high enough given the amount of risk you are taking by making the investment. If the ROI is not high enough, even though it is profitable, then you may want to pass on the investment. Keep in mind that until you receive all of your initial investment back, your ROI is negative. So, in evaluating the deal, you should inquire as to whether the cash flow projections allow for cash distributions to be made to the owners of the business. The longer it takes for this to happen the more risky the investment. Keep in mind that there is a tradeoff between making distributions to owners and retaining cash in the business to be used to grow the business.

The above are things you need to think about when deciding whether to invest in a new business idea someone brings to you. There are additional details which should be considered if after evaluating the above you decide to pursue it further (e.g. reputation of management, cash flow projections, viability of product or service being offered, legal constraints, and tax ramifications). While the excitement of investing in a new business may be enticing, a more unemotional review is necessary to help you make a more informed decision whether to invest or not.

PHYSICIAN/PHARMACIST COLLABORATION

at SBH Health System

by Steven Clark

Dr. Valery Chu, a clinical pharmacist in the SBH Center for Comprehensive Care (CCC), freely admits that when she started working five years ago in the CCC – a center that works with seniors as well as younger patients suffering from diabetes, asthma and other respiratory conditions – its providers "didn't know what to do with me." Adds Dr. Chu, "They had some idea of my background, but many of the physicians, nurse practitioners and PAs had never collaborated before with a pharmacist."

Harris Leitstein, a nurse practitioner who treats diabetic patients in the CCC, agrees. "I must admit early on my attitude was 'What do we need a pharmacist here for?'" says Leitstein. "But I have really been won over."

The model of having a clinical pharmacist collaborate with providers in an ambulatory care setting is rare. Perhaps the biggest reason for this is financial. Pharmacists in an outpatient setting can't bill independently and so are viewed by many hospitals as a luxury. Yet, as both a Certified Diabetes Educator and Certified Asthma Educator, as well as a smoking cessation instructor, Dr. Chu wears multiple hats. It's this versatility that has allowed her to play so many roles – troubleshooter, educator, mediator, detective and confessor (as patients tend to "let their guard down" with her, telling her things they might not tell their physician about their health and compliance – or lack thereof).

"Some diabetics, for example, have concerns about injecting. They will tell the doctor, 'Sure, I'll do it,'" says Dr. Chu. "Then they'll come to me and say they never started. I'll talk this through with them and if necessary find another option. Sometimes the doctor will prescribe medication they take twice a day or suggest they check their sugar levels at different times. The patient will confess to me that since they can never remember the second dose, or maybe only take it when a home attendant is present, they only get half of what's been prescribed. So, with this information, we can strategize on next steps, which may mean switching to a once-a-day formulation."

Much of her day is spent helping patients with medication access. Patients once discharged may find they can't get the medication they have been prescribed," she says. "Our population is such that they don't delve into the reasons why. When they come back to me for follow-up a month later, I'll say 'Did you start the new medication?' and they'll say 'No, my pharmacy told me my insurance won't cover it,' and it ends there. They will never pick up the phone and say, 'Hey, I couldn't get the medicine.'"

"In the centralized pharmacy model practiced at SBH, staff pharmacists in the main pharmacy team with clinical pharmacists who work on the floors, in the emergency department and ICU as part of the medical team."

Meanwhile, Leitstein, who once questioned Dr. Chu's role in the CCC, today calls her value "priceless."

"She has a really good feel for diabetic patients and the medications they take and how to make adjustments," he says. "This often means jumping through hoops because each insurance is different. I'll very often say to her, 'OK, Valery, I want this patient on a GLP-1. I don't know what her insurance will pay for, but this is what I'm thinking. Can you find out which one the insurance pays for and teach her how to use it?'

"This saves me a ton of time because looking up insurances takes forever and then teaching also takes a good amount of time. She's also really great with medication in knowing what you have to watch out for in terms of conflicts and doing medication reconciliation by going through all of the patient's meds. I can ask her, 'Hey, is drug x safe for somebody with limited kidney function?' and she can tell me right off. When you inject her into the mix, it just makes us so much more efficient and it's so much better for the patient."

According to Dr. Anthonia Ajao, associate director of pharmacy clinical services at SBH, transitions of care remain a critical issue at SBH. "Patients cry or get very emotional when they leave the hospital because they can't afford to get their medication," she says. "Relieving this fear removes a big burden. Valery is like a bridge for these patients between once they leave our institution and when they come to the clinic. It's important to find out what has transpired with the patient as soon as possible and to address any medication access issues. She's involved with this on a daily basis."

Centralized Pharmacy Model

Dr. Chu is only one of several clinical pharmacists embedded throughout the hospital. In the centralized pharmacy model practiced at SBH, staff pharmacists in the main pharmacy team with clinical pharmacists who work on the floors, in the emergency department and ICU as part of the medical team. Here, they round with physicians and work closely with them and other care providers in order to improve patient outcomes.

"We have strived to bring a well-rounded clinical pharmacy team to SBH, one comprised of clinical managers, clinical practice coordinators, and pharmacy residents in a number of key clinical departments: transitions of care/internal medicine, pediatrics, infectious diseases, critical care, emergency medicine and ambulatory care," says Dr. Ruth Cassidy, senior vice-president, clinical support services and chief pharmacy officer at SBH. "As a health system, we are fortunate to have a fantastic and incredibly talented group of clinical pharmacists who assist physicians, as well as all other disciplines of the medical team in clinical pharmacy and pharmacotherapeutics. This has brought clinical pharmacy to a completely new level at SBH, one that has proven repeatedly on both a clinical as well as a financial level to be a key component not only for the institution but also for the better health of our patients."

Transitions of Care and Patient Rounding

Most mornings will find clinical coordinator Dr. Amanda Rampersaud, clinical pharmacy residents like Dr. Ziyun Huang, and Milton Sandoval, an advanced pharmacy tech, at white board huddles with attendings, nurses and medical residents in advance of patient rounding.

"We handle all kinds of medication access issues on a daily basis," says Dr. Rampersaud. "We run the 'meds to beds' program where we try to get patients their medications before they are discharged so at least they are leaving with their first month's supply on hand. Many times the issue arises where patients don't have insurance. So we tell them about different programs here that will allow them a discount if they fill at a pharmacy we are contracted with. There are lots of moving parts to that process and Milton and I do this daily."

Like Dr. Chu, they also spend time troubleshooting and educating patients

"The clinical pharmacists also play a key role in reconciling patients' new medications with those they took before they were hospitalized."

admitted to the hospital with such conditions as asthma, diabetes, heart failure and uncontrolled hypertension. Sandoval also translates for Spanish-speaking inpatients.

"We try to flag those patients who are at a high risk for readmission," says Dr. Rampersaud. "For a patient being discharged on high-risk medications, this might mean explaining proper techniques to help increase adherence."

Transitions of care can influence readmission rates, which make this an institutional-wide concern for both reasons of quality patient care and reimbursement. "When patients are not transitioned appropriately with the correct medication, they are more likely to come back," says Dr. Manisha Kulshreshtha, vice president and associate medical director. "Amanda works with the physicians and the nurses to ensure that medications are appropriately dispensed to the patient, she teaches our patients how to use them, and makes sure they are sent home with the correct medications. Should there be issues with regard to dispensing medications, the clinical pharmacist knows exactly who to call and is very helpful in getting things accomplished. This is not only for discharge planning, but also in helping residents understand the depth and breadth of side effects, dosing, and preventing errors."

This makes a huge difference with SBH's high-risk patients, which includes a significant number of indigent and homeless patients. It may mean having medications picked up and delivered to patient's beds, explaining medication discounts and enrolling patients in the hospital's 340B program, where 80 percent of medication costs are covered. The clinical pharmacists also play a key role in reconciling patients' new medications with those they took before they were hospitalized.

This impacts patients regardless of age. "We are a pediatric unit in an adult hospital," says Dr. Kathleen Asas, division director, pediatric inpatients. "So, the intricacies of pediatric dosing of medications are extremely important for children, where there is a higher risk of medication errors because all medications are weight-based. What has been very important to us is to be able to work closely with the pharmacy team in making sure our pediatric patients are protected from medication errors by taking into account the nuances of their age and how they metabolize medications."

Emergency Department

Similarly, a clinical pharmacist, Dr. Robert O'Connell, and a clinical pharmacy resident, Dr. Myroslava Sharabun, are embedded in the ED with Dr. Andrew Smith, who oversees the SBH ED clinical pharmacy residency program as an assistant professor of pharmacy practice at Touro College of Pharmacy. Here, they work closely with emergency department physicians, residents, and nurses to oversee the safe and effective use of medications.

"A lot of our work is focused on acute resuscitation," says Dr. Smith. "A patient, say, comes in with septic shock or in respiratory arrest, and we're part of the team that treats them. We assist in the preparation and labeling of medications, which is then handed off to the nurse for administering. Once a patient is intubated, and the residents are getting their labs and putting in orders, we're thinking about the next step. Does this patient need antibiotics because she came in with pneumonia? What antibiotics will she need? What dose? A loading dose vs. a non-loading dose? Will she need sedation? This takes a lot of the bandwidth off the physicians, allowing them to focus more on diagnostic medicine."

According to Dr. Daniel Murphy, chair, emergency medicine at SBH, the clinical pharmacists in the ED give the department "bang for their buck."

"An emergency department by definition is unscheduled, occasionally hectic, and interruption driven, and having someone around to help with the often-complex calculations and orders of very crucial medications is amazingly important," says Dr. Murphy. "When it comes to the more critically ill, having them around is immeasurably beneficial. When it comes to the not-so-critically ill, having them around to watch our P's and Q's and to guide us on error avoidance is just as crucial. On a scale of 1 to 10, having a Pharm D in an inner city emergency department is an 11."

Intensive Care Unit and Antimicrobial Stewardship

Similarly, there can be little doubt of the benefits of having a clinical pharmacist in the ICU. "This has been shown to significantly improve patient outcomes," says Dr. Raghu Loganathan, director, division of ICU/pulmonary medicine at SBH. "You have high acuity patients with very small room for errors, and a number of events that occur in a critical care setting are related to medications. Having a critical care pharmacist significantly increases the level of care and provides very important staff support and guidance to the physician and nursing staff. We certainly feel the difference when they're not here."

One important factor is medication utilization. Having a critical care clinical pharmacist has been shown to decrease medication usage and costs. A steady decrease in terms of the total days of therapy for all ICU medications has been shown over the past year, as well as individually for such IV GI prophylaxis medications as pantoprazole and analgesic medications like fentanyl; albumin use; sedation medications like lorazepam, midazolam, propofol and precedex; and broad spectrum antibiotics such as vancomycin, cefepime and zosyn.

"The whole goal here is to discontinue unnecessary therapy and narrow therapy from acuity IV to PO stabilized when appropriate so patients can be transferred out of the ICU," says Dr. Frank Piacenti, the clinical pharmacy practice manager who works in the ICU and with patients treated by the infectious disease team. "An IV to PO medication conversion also decreases the risk of a systemic infection or an IV line/device related infection. In

"Having a critical care clinical pharmacist has been shown to decrease medication usage and costs."

addition, the quicker you get patients from IV to PO, the quicker you will shorten their ICU stay and, possibly, hospital stay."

This all fits in well with the Joint Commission's new criteria on antimicrobial stewardship. Such a program is a multi-disciplinary approach between pharmacy, medicine, infectious diseases, surgery, ED, infection control, and nursing in order to manage antibiotics appropriately. "We have policies, guidelines, and practices in place to manage broad spectrum antibiotics, which is part of what I do in the ICU and with infectious diseases," says Dr. Piacenti. "Our goal is to minimize antibiotic use, recommend the most appropriate dose and antibiotic based on disease state, review culture results and antibiotic sensitivity, decrease unnecessary therapy, switch IV to PO, and minimize multi-drug resistant organisms in the institution. As part of our antimicrobial stewardship program, we collect data on antibiotic usage, cost, pharmacy interventions, and collect data on positive antimicrobial cultures in order to trend antibiotic susceptibilities and prepare and distribute our most current antibiogram biannually."

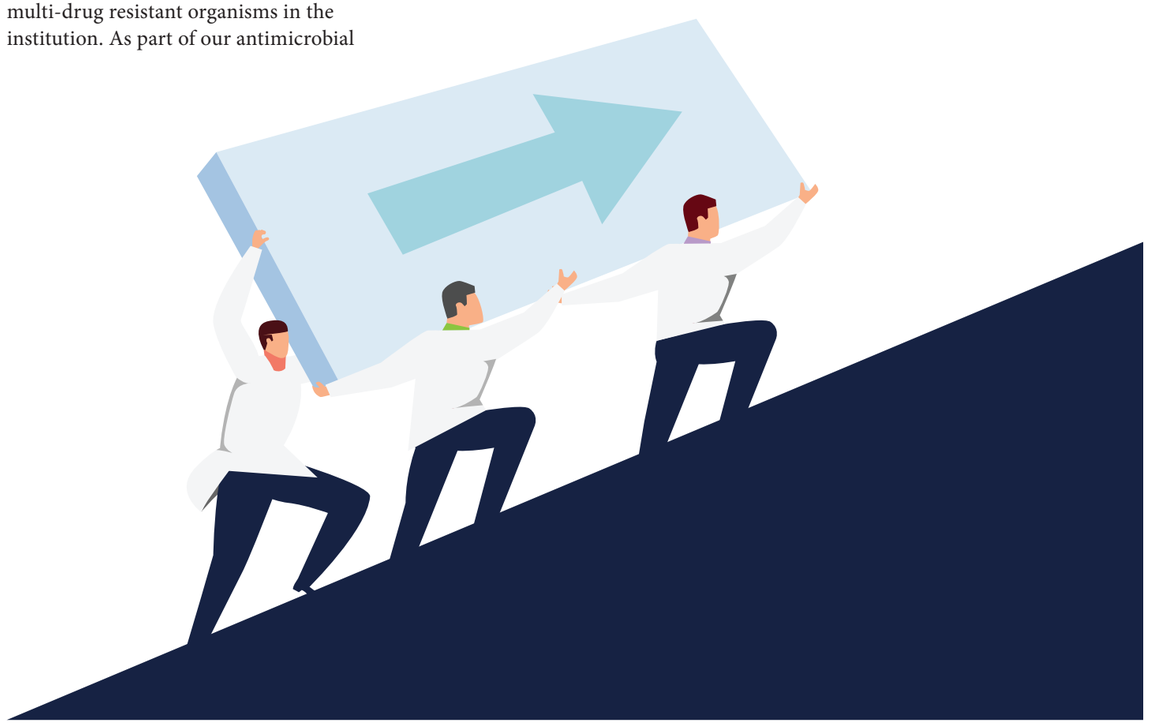
Future Plans

According to Dr. Piacenti, SBH physicians have been very receptive to working with the clinical pharmacists. "They want us everywhere," he says.

Aside from starting new clinical pharmacy initiatives with other departments, he hopes that in the future SBH will eventually bring staff pharmacists to patient floors as well. This will put additional pharmacists on the floors to accept orders and discuss treatment/preparation options alongside the medical teams.

"Moving order verification to the bedside improves accuracy and timeliness of medication preparation, delivery, and administration," he says. "For example, say a prescriber has a question in regards to the dose and preparation of a given medication. The pharmacist on the floor can assist immediately in dosing that medication.

"In a sense, the pharmacist is assuring prescribing accuracy before the order is entered. Once the order is entered, the pharmacist can immediately accept the order. Additional pharmacists on the floors can also prevent potential prescribing errors before they are ordered, which prevents medication errors. This, of course, is also part of the clinical pharmacist's role." ■



SBH Welcomes First Class of Pharmacy Residents

This past June, SBH welcomed two first-year general pharmacy residents and one second-year emergency medicine pharmacy resident to its inaugural clinical pharmacy post-graduate program.

The general program offers core rotations in critical care, infectious diseases, internal medicine, emergency medicine, ambulatory care and pediatrics. The ED program focuses six months on emergency medicine training – including resuscitation, trauma, adult and pediatric emergency medicine, urgent care, disaster management, public health, pre-hospital care, and experiences at the NYC Poison Control Center – in addition to two months of electives. Electives for both programs can be chosen from such growing areas in pharmacy practice as transitions of care, pharmacy informatics, acute surgical care, psychiatry, and oncology.

First-year residents, Dr. Towfiq Majumder and Dr. Ziyun Huang, previously worked in retail on opposite coasts. Dr. Majumder, a Touro College of Pharmacy graduate, spent six years as a technician and then a pharmacy manager at Walgreen's in Queens, while Dr. Huang spent time at CVS while a student at Western University of Health Sciences in San Francisco.

Both wanted to work clinically side-by-side with physicians, nurses, PAs, medical residents and medical students, which does not exist in the retail environment.

"I wasn't satisfied with my job as a retail pharmacist; I wanted something more rewarding," says Dr. Majumder. "I felt I could do more." Today, a typical day for him begins at 7 a.m. when he arrives at the hospital to work up patients before doing rounds (his shift officially begins at 8 a.m.) and making clinical interventions on patients in what this month is a critical care rotation.

Dr. Huang, who this month can be found most mornings huddled with medical residents in front of the patient white board on a med/surg floor, was also drawn to the hospital environment. "I really wanted to challenge myself to do something very different," she says. "I wanted that direct patient care, like rounding with a team. In retail, whenever the order comes in, you just verify it. You don't know what the labs are with the patient. You don't know if this is the accurate dose."

Last year at this time, Dr. Myroslava Sharabun was doing a seven-week emergency medicine rotation during her one-year general pharmacy residency at Mount Sinai Hospital – with thoughts of specializing in critical care – when she found herself drawn to the emergency department.

"With the ED staff often very busy, I found that I liked following up on the patient's care to make sure their drips were titrated and their medications were administered appropriately, and being available to answer any medication-related questions the nurses, attendings or residents may have," she says.

While clinical pharmacy residencies were first offered in the 1960s, beginning at the University of Michigan, the attraction has grown dramatically in recent years. The low match rate for pharmacy graduates today proves this – as only 60 to 65 percent of pharmacists match (compared to 94 percent for U.S. allopathic graduates and 81 percent for osteopathic students). The second tier "specialty" residencies like EM date back to the 1990s and are much less common (and so even more competitive). The SBH emergency medicine pharmacy residency program is only one of three in New York State.

While at SBH, it hasn't taken long for Dr. Sharabun to adapt to the pace of a big city trauma center and provide added value, as she and the clinical pharmacists on the floor provide a different skill set to an ED team composed of attendings, senior and junior residents, nurses, and medical students.

"We had just come back from a medical notification with our team when I saw a patient who was sitting up and vomiting blood," she says, recounting a recent day. She immediately announced this to the team, which responded quickly. "I helped them order drips and started the patient on therapy. We got the patient a GI consult and had an endoscopy done to determine the source of the bleeding. If I hadn't spoken up or if I wasn't comfortable with the team, that patient may have otherwise had a bad outcome."

Treating Children with Seizures and Headaches

Pediatric neurologist sees many children who have been misdiagnosed by physicians and educators for years. **By Steven Clark**

The mother had been telling her pediatrician for several years that her son, now eight, would often "zone out." He had a predilection for doing this countless times a day, she said, often for no more than a few seconds each time. It might happen while he was watching TV, or sitting at the dining room table, or doing his homework. "He acts like he's a million miles away," she told the doctor. "He seems to be there and then, suddenly, he's not. He drifts away. But, it doesn't seem like normal daydreaming."

"He'll outgrow it," said the pediatrician. The boy's teacher at school had also noticed it. "We see this all the time," she told the mother. "It's classic ADHD and you should consider medicating him."

Instead of taking the advice of either the doctor or educator, the woman chose to take her child to the office of Dr. Dina Kornblau, a pediatric neurologist at SBH Health System, for a more definitive explanation. After asking the mother several questions, Dr. Kornblau had a much different take.

"I asked her what happens if you stand between him and the TV when he's spacing out, or when you snap your fingers or clap your hands to get his attention," says Dr. Kornblau. "When she said he still doesn't respond, I had a good idea what we were dealing with."

Dr. Kornblau sat the child in a secure place in her exam room and got him to hyperventilate. The abnormally fast rate of breathing soon put him into a state his mother recognized all too well. "That's what he does," she said, as the boy stared into space for several seconds.

The child was diagnosed with absence seizure (or petit mal), which was later confirmed by an EEG. This is a common childhood malady caused by brief abnormal electrical activity in the brain. Most children will eventually outgrow it. Dr. Kornblau prescribed Ethosuximide (Zarontin) which soon controlled the seizure and eliminated his episodes of "zoning out."

SEIZURES

Many of the children referred to Dr. Kornblau suffer from seizures and headaches. "Seizures are very common," she says. "The most common in childhood are febrile seizures, which occur in as many as five percent of children. These are usually children between the ages of six months and six years, who are neurologically and developmentally normal, and have generalized convulsions that are associated with fever. They are normal before and after (the seizure)."

Epilepsy, which can start at any age, affects an estimated 450,000 American children under the age of 17. In some cases, it can be well controlled by medication and will be outgrown.

Dr. Kornblau typically becomes involved when the child is younger or older than this, or the seizures are recurring or longer in duration. These children are at greater risk of developing epilepsy.

Epilepsy, which can start at any age, affects an estimated 450,000 American children under the age of 17. In some cases, it can be well controlled by medication and will be outgrown. More severe cases of epilepsy may not respond well to medication and may require surgery (removing the area of the brain that is electrically abnormal and causes the seizures); vagal nerve stimulation, which involves implantation of a device that stimulates the vagus nerve with electrical impulses; or diet (e.g. the Ketogenic Diet, a severe, very low carb, high fat diet).

"The treatment depends on the child and the kind of seizures they have," says Dr. Kornblau. "If they have been through a few medications that don't work and their MRI is abnormal and it shows a specific lesion, then surgery is likely to be considered in order to remove the lesion. If the MRI is normal and there is no specific area of malformation, then diet might be considered. There are certain types of seizures that are more likely to be affected by diet."

Seizures, she says, are divided into two main categories: generalized (which affects both sides of the brain) and partial onset (or focal, affecting a certain part of the brain). "With generalized seizures, you have a loss of consciousness," she says. You may fall to the ground, get stiff, then convulse. This is what most people think of as a seizure." But generalized seizures include the more subtle absence seizure (when the child is not conscious but does not fall or convulse) as well as tonic-clonic (grand mal) seizures.

Partial seizures depend on the part of the brain affected. It may affect the child's vision or muscles in a certain part of the body and they may lose consciousness. There may or may not be a change in awareness. "The child may know his arm is shaking, but he can't stop it; or the child may be unaware what is happening," says Dr. Kornblau. "I have had patients who were previously diagnosed with psychiatric disease. But, no, they don't have psychiatric disease. They are having partial seizures with a change in their level of awareness."

Dr. Kornblau says it is particularly gratifying to explain to a parent that there is a reason for their child's behavior and that it can be successfully treated. "In many cases, these are signs that have been missed for so long," she says. "Parents are very relieved to hear there's a reason for what's happening and that we're going to be able to help them."

HEADACHES

In seeing a child with persistent headaches, Dr. Kornblau's first concern is dividing the condition into one of two main types: primary, where symptoms are consistent with migraines and muscle tension headaches; and secondary, where

"I send patients home with a headache diary so they can keep track of what is happening, how often they are having headaches, and what precipitated the headache, so we can then figure it out from there."

something else may be going on (e.g. a tumor, hydrocephalus, vasculitis, and idiopathic intracranial hypertension). "The vast majority of the time it's primary, most commonly among teenage girls," says Dr. Kornblau. Yet, migraines can start as young as five years old, and frequently occur within families.

"Certain things can often trigger headaches," she says. "It could be not sleeping enough or too much. Too much caffeine can be a trigger, as can being hungry. Stress can be a factor. I send patients home with a headache diary so they can keep track of what is happening, how often they are having headaches, and what precipitated the headache, so we can then figure it out from there."

For example, a headache that a child feels primarily on school days may be related to the stress they feel about going to school or because they are skipping breakfast or not sleeping enough, just as headaches that occur among children with a propensity for eating a lot of chocolate or cheese can be related to their diet.

"There is the mindfulness of being aware of your headache and what's triggering it that is so important," she says. "You need to figure out why you have a headache today and not yesterday. Did you sleep less? Eat differently? Experience certain stressors?"

High achievers, she says, are more prone to headaches. "The straight-A students get more headaches," she says. Treatments may include counseling, where patients learn techniques that will tamp down on stressors; changes in sleep patterns; or changes in diet (such as eliminating foods that are well-known triggers like peanut butter, processed meats, dairy, and foods with monosodium glutamate). Over-the-counter medicines such as ibuprofen and Excedrin (for those 12 and over) as well as prescription triptan medications are commonly used. If headaches remain frequent, then daily preventive medications such as Amitriptyline, Propranolol, Topiramate, and Valproic Acid are often used. Supplements, such as butterbur and magnesium can be helpful as well.

"The most common triggers are skipping breakfast and not drinking enough liquids," says Dr. Kornblau. "Sometimes just making small changes can make a big difference." ■

In addition to pediatric neurology, SBH Health System offers these pediatric specialties:

- Infectious diseases
- Neonatology
- Allergy/Immunology
- Endocrinology
- Genetics
- Gastroenterology
- Nephrology
- Cardiology
- Adolescent Medicine

To make an appointment with an SBH pediatric specialist, call 718-960-6430.

When Family Abdicates Its Role

By Steven Reichert, MD, Division Director, Palliative Care

Mrs. D is a 79-year-old very frail elderly woman with end-stage COPD, kyphoscoliosis and malnutrition who is admitted for recurrent respiratory failure requiring intubation. She has been hospitalized frequently in past years, including several intubations. She lives at home with her two unmarried sons who assist in her care; however, she has spent the majority of the past six months in either a hospital or a short-term rehab. Past discussions with her and her children have centered on end-of-life wishes and the role of hospice care. She consistently stated that she would want intubation if necessary, but would not want a tracheostomy. The family has declined hospice care on several occasions as they are hopeful she will live a long time.

After several days in the ICU, she is extubated only to require re-intubation 36 hours post-extubation. She is deemed ventilator-dependent, and a tracheostomy is recommended by the ICU team. The patient – awake and alert on the ventilator – declines a tracheostomy even after repeated extensive discussions about the risks of prolonged oral intubation and the safety and comfort of a tracheostomy. After several weeks in the ICU, she is transferred to the ventilator floor (orally intubated). She does agree to insertion of a PEG feeding tube.

Several months pass; she cannot be discharged as no nursing home will accept her without a tracheostomy. Her sons, initially reachable by phone, do not visit and, eventually, do not return phone calls. She has no other family or surrogate decision-makers.

After three months on a patient floor, her PEG tube becomes dislodged. The patient – awake and alert on the ventilator – refuses to allow reinsertion of the feeding tube either via PEG or orally. When told that she will starve to death without a feeding tube, she closes her eyes and refuses to answer further questions.

When hospice care with a palliative extubation is offered, she again refuses to answer further questions. One of her sons is finally reachable by phone and he states that he will come into the hospital the next day to meet with the doctors and his mother. Unfortunately, he does not show up as promised and multiple messages are left with no return call. An ethics consult is called.

Ethical Analysis

The ethics committee discusses the patient's decision to continue uncomfortable and unsafe oral intubation and to decline artificial feeding. The treating team and subspecialists all concur that the patient has full understanding of the choices she has made and that repeated attempts to convince her to undergo a tracheostomy and allow for reinsertion of her feeding tube to prevent starvation have been rebuked. Her family appears to have abdicated any role in caring for her or assisting with decision-making.

The treating team is worried that their care is causing harm and does not want her to suffer. While non-maleficence (do no harm) is one of the four ethical principles, so is the right for patient self-determination (autonomy). The patient is deemed to have full capacity, and her rejection of a tracheostomy is consistent with her prior long-term wishes. Thus, while her decisions to continue a ventilator without food or nutrition appear illogical, it is her right to self-determine and reject those treatments which do not fulfill her desires. The ethics committee also recommends that at that time when the patient loses her capacity to make decisions, even if her family reappears, that her wishes be followed.

"HER FAMILY APPEARS TO HAVE ABDICATED ANY ROLE IN CARING FOR HER OR ASSISTING WITH DECISION-MAKING."

Resolution

The patient remains orally intubated with IV fluids as her only nutrition. She agrees with no further blood draws or needle sticks. After more than a month in this condition, she becomes increasingly agitated, delirious and visibly uncomfortable. Sedation is provided to alleviate her discomfort. She dies approximately six months after intubation and two months after PEG tube dislodgement. Her family does not respond to phone notification of her death.

Is Free Medical School Tuition the Way to Go?

Featuring Jeffrey Lazar, MD, MPH, Vice President, SBH Medical Staff

"If one considers everything that is wrong with our country's health care system, I'd rank medical school tuition down near the bottom."

The NYU Langone School of Medicine recently announced during its annual "white coat ceremony" that all present and future students would receive free tuition regardless of merit or financial need. They did this citing concerns about the overwhelming financial debt facing graduates – which averaged $184,000 in its most recent graduating class. NYU and other medical schools have expressed concerns that students facing significant debt will pursue high paying specialties rather than careers in primary care or research.

NYU says that it has raised more than $450 million of the $600 million that it anticipates will be needed to finance the free tuition plan. The scholarship covers the annual tuition of approximately $55,000. It is the only medical school in the country to make such an across-the-board offer, as several others have offered scholarships based solely on need or merit, or to cover specific programs.

So, how do others in the medical community see this? Dr. Jeffrey Lazar, deputy chair of emergency medicine at SBH, and vice president of the SBH medical staff, weighs in.

"Perhaps surprisingly, I find this idea of free tuition to medical school to be well-intentioned but, ultimately, sadly misguided. If one considers everything that is wrong with our country's health care system, I'd rank medical school tuition down near the bottom. The massive amount of money underwriting NYU's tuition might have been put to much more intelligent, effective and meaningful use by addressing problems that truly need fixing. With a bit more thought and insight, this gift could have touched many more individuals, in much greater need, than a small group of students at a premier medical school.

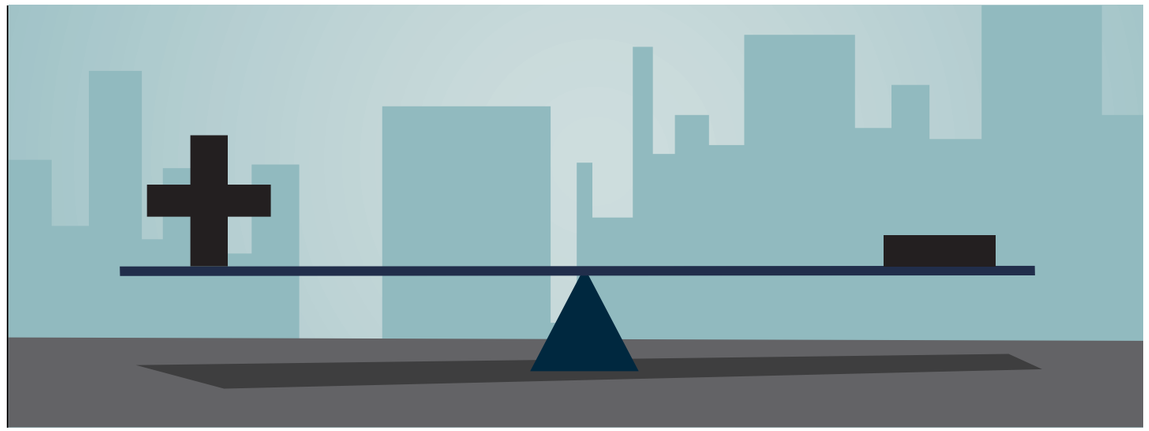
"U.S. physicians are very well-compensated; the average salary currently ranks third highest in the world. Current medical school tuition while substantial, is eminently manageable on a physician's salary. I also disagree with the idea that once tuition is minimized or abolished, that suddenly medical students are going to pursue primary care and other lower-paying specialties. It is the human condition to want to maximize one's income. Certain specialties and subspecialties will continue to lure young physicians as long as they are high paying.

"The individuals who need attention and support are the uninsured and disadvantaged, not our society's highest educated, and soon-to-be highest earning individuals. A recent "New York Times" article shared research that showed a more diverse physician workforce would significantly improve the health of minority populations; a gift aimed at increasing physician workforce diversity would have, I believe, a much more beneficial effect on society.

"Abolishing medical school tuition is the sort of charity that will mostly have the effect of helping the already fortunate become, well, even more fortunate. Increasingly in the U.S., we are seeing "charitable giving" that is of questionable charity and dubious beneficence. The $600 million being spent on this project could have been a transformative gift in so many other areas; we face innumerable public health crises both here at home and abroad. Granted this money could have been spent on even less worthy causes, or not given away at all. But what I'm sure feels like a lottery win for NYU students has left me depressed by an enormously wasted opportunity, and yet one more example of how our society tends to advantage those who are already advantaged."

DO YOU NEED AN MBA TO GET AHEAD?

By Steven Clark



Dr. Eric Appelbaum, SBH Health System's Chief Medical Officer, remembers being in business meetings at the hospital and not liking it when he found himself "on the wrong side of the equation" when it came to discussing financial issues.

So, he says, it didn't take much prodding from his boss, Dr. David Perlstein, SBH's president/CEO, to convince him to return to school in 2015 for an MBA degree.

"As you get more involved in administration you need to have more knowledge of finances and healthcare policy," says Dr. Appelbaum, who completed his degree from Marist College in June. "Having an MBA is almost a prerequisite today."

Hospital leadership positions expect this more than ever before. According to a 2017 "New England Journal of Medicine" Catalyst Insights Council Leadership survey, 20 percent of respondents now say the top leadership in their organization holds combination medical and MBA degrees. The number of medical schools that offer dual MD/MBA programs has doubled in recent years to accommodate this demand.

Dr. Perlstein started taking management courses through the American College of Physician Executives in 2005, around the time he became the hospital's associate medical director.

"My approach to everything has always been if you're curious then learn more about it," he says. "If you're not willing to explore and to grow, then you condemn yourself to being stuck in a single spot.

"I realized that one of my weaknesses was just reading a financial statement. I really didn't understand the rules of accounting, business plans, organizational theory. I went through a couple of introductory courses and then took a deep breath and thought, 'You know, maybe I should really just get the MBA.'"

Dr. Perlstein asked the hospital's then president/CEO Dr. Scott Cooper if he thought it was worth it for him to get an advanced business degree. "Scott said, 'You probably don't need it because you've been exposed to enough by now, but what it will do is send a message to anyone who's around you that you're serious about it.'"

Taking one or two courses a semester, it took Dr. Perlstein three years to earn his MBA from the University of Massachusetts' Isenberg School of Management. While he says the program gave him a better understanding of the language of business, it also enhanced his leadership skills and "emotional intelligence."

"What I got out of it was not an enhancement of the entrepreneurial spirit, which I think getting an MBA fosters in some people. It was more that I learned about organizational behavior, which allowed me to better understand the theory of why I acted the way I did and why the organization responded the way it did," he says. "It prepared me to be more objective and improved my ability to be more dispassionate when it came to decision making. That doesn't mean that I am not passionate about my job, just that it taught me to be a better listener and learner when it came to leadership."

As a result of his own experience, Dr. Perlstein strongly encouraged Dr. Appelbaum and Dr. Dan Lombardi, vice president, associate medical director, to return to school for their business degrees.

"Getting an MBA proves that you understand the business side of running an organization," he says. "There is business in everything we do. We don't just do stuff because it feels good. You have to be able to justify what you do."

AN EASY SELL

Like Dr. Appelbaum, it didn't take much to persuade Dr. Lombardi. "You go through medical school and you learn the medical side of taking care of patients. You learn how to diagnose, you learn how to treat, but you really don't get much exposure to the business side of taking care of a patient," says Dr. Lombardi, an emergency medicine physician, who will graduate from Marist with his MBA in December. "With an MBA in healthcare administration you understand not just the business side, but also the history of how we got to where the finances are in taking care of a patient.

"The other big piece is that there is a lot of leadership training. This really helps you guide and lead other people in the organization. Another important piece of it is that in finance there's a different lingo that you're not taught in medicine, and when you're in a room now making decisions and finance is involved, and other stakeholders are involved, you want to be on the same level and fully engaged in the dialogue."

When Dr. Dan Murphy, chair, SBH's Department of Emergency Medicine, returned to school to get his MBA back in 2001, there was only one other physician in his class at Hofstra University on Long Island. "And he lasted a month once he saw how much work there was," says Dr. Murphy, who graduated with his MBA two years later.

The MD/MBA pathway was a rather distinctive one back then. "My motivation was that it was becoming more and more obvious, especially in my specialty, that working within a hospital is more complicated than most doctors appreciate," says Dr. Murphy, who at the time was the number two person in the emergency department at Maimonides Hospital in Brooklyn. "I always wanted to know why there weren't more nurses, or another EKG machine, or why things were done the way they were done, and my medical education didn't answer these questions. To attend these meetings and understand budgets, to understand FTEs and capital and other management issues, and to becoming the control freak I wanted to be, I needed to know more."

There were two disciplines that particularly appealed to him – leadership training and operational management. These, he says, could only be found at the time in business school or the military academies.

MBAS FOR DOCTORS ONLY

While many physicians may find themselves in MBA programs with classes comprised of pharmacists, police officers, bank executives, teachers and others from different walks of life, the demand today for doctors to get their MBAs is so great that several universities offer physician-only programs. Dr. Robert Karpinos, assistant vice president, director of perioperative services and medical anesthesia at SBH, is halfway through a 16-month intensive program at the Heller School of Business Administration at Brandeis University in Boston.

"The understanding of what drives the medical system is sorely lacking in medical education," says Dr. Karpinos. "So, for me, it was a matter of a couple of things: trying to understand and do a better job at my current job, and being able to communicate with accounting, finance, budgeting, and other departments a little more clearly."

Unlike with the general MBA programs taken by Drs. Appelbaum, Perlstein, Lombardi and Murphy, where professors teach case studies involving corporations like Boeing, IBM or McDonald's, the sole focus here in the class of 42 physicians – who fly to Boston for two weeks every semester from countries as remote as Guam and United Arab Emirates – is on healthcare.

"All the cases we review and use as examples are healthcare related," says Dr. Karpinos. "We may do a distributorship of some manufacturing product to get the idea, but then most of the exercises are based on supply chain and operations within a hospital. So you really get a good flavor of interaction between materials management and supply chain, how they work and what Just-in-Time ordering really means as opposed to hearing the words and having to figure it out. Some of the leadership concepts may be drawn from other professions, but they're always reapplied to medicine and the case examples are pulled directly from medicine."

THE COMMITMENT

The financial and time commitment in getting an MBA for a physician can be daunting. Going part-time at Marist College took Dr. Appelbaum three years and, with some changes in the curriculum, will take Dr. Dan Lombardi, associate medical director, 2½ years when he graduates in December. Dr. Karpinos uses his vacation time to travel to Boston every semester. The weekly workload for all MBA candidates, regardless of the program, often exceeds 20 hours. The cost can range from $50,000 to nearly $100,000.

"You have to juggle your responsibilities at home and at work, and then there's a second kind of responsibility after the kids go to sleep when you have to focus a good two to three hours each day on classes and getting your work done," says Dr. Lombardi. "So it's a juggling act for sure."

Regardless of the price, they recommend it to others – as long as the timing is right.

"I think the timing was right for me," says Dr. Lombardi. "I had to have enough experience and I had to have my curiosity piqued by such and such happening or why we are in a certain state. It all sort of clicked for me and I was able to say, 'This is the right time, so go for it.'"

All the doctors agree that the degree is well worth the price – both from close up and from a 25,000 foot perspective. "It's helped me when it comes to looking at financial statements and understanding strengths and weaknesses and asking the right questions," says Dr. Appelbaum. "I can feel confident now saying something doesn't make sense or I need clarification."

Adds Dr. Karpinos, "I definitely have found better ways to communicate and interact. It's helped me to identify some of the things that can use improvement in myself and in my team, and it has allowed me to think more globally in managing the operating room.

"I've always had a lot of interest in the details in order to understand the bigger picture, and to me it's hard to separate forest and trees. I need to understand both. This has given me a much greater ability to understand each of the trees and how putting the trees together creates the forest." ■

Vinaya Gaduputi, MD, Gastroenterology

By Gerard A. Baltazar, DO, FACOS

Aspiring to create a positive change in the medical world, Dr. Vinaya Gaduputi began publishing peer-reviewed research during his residency in the Bronx. Since then, he and his collaborators have published or presented over 110 manuscripts, posters and abstracts.

Through this work, Dr. Gaduputi has helped augment the field of gastroenterology. Some of his most important findings are from studies on biliary disease among New York City's youth, research that can be put into practice to improve young patients' lives.

By analyzing the Statewide Planning and Research Cooperative System database, Dr. Gaduputi and his co-authors demonstrated that Bronx County, more than anywhere else in New York, has experienced a significant increase in teenagers developing gallstones. "With this data, we are ahead of the game and can develop better guidelines to treat gallbladder disease," Dr. Gaduputi explains.

A consummate teacher and associate director of the Internal Medicine Residency Program at SBH, Dr. Gaduputi aims to help novice researchers achieve similar success. He recommends to other medical educators that "you must mold them [medical trainees] when they're moldable, when they are young and dynamic."

Indeed, Dr. Gaduputi's efforts have allowed residents and fellows to produce a large volume of scholarly work and to present at major scientific conferences. At the upcoming Annual Scientific Meeting of the American College of Gastroenterology, a program that draws participants from all over the world, nearly 1% of research abstracts will be from SBH Health System.

Beyond opportunities to showcase work at conferences, Dr. Gaduputi believes that the process of learning and publishing science creates better caregivers. "In this day and age, you cannot afford to be confined to the four walls of your institution," he says. "[When doing research], you're motivated to read a lot more and learn the latest trends. The world is moving at a fast pace, and you may be the one bringing something new to where you work."

According to Dr. Gaduputi, SBH is a fertile place to develop research programs. "The Bronx has a very high rate of hepatitis C, decompensated cirrhosis, HIV, other immunosuppressed conditions and advanced pathology. We must make the most out of the opportunities in this challenging environment to advance medicine as best we can."

Dr. Gaduputi further advocates that "[SBH] has the resources and more than enough people to support and engender an academic culture," and often reminds his team members that "half the published research comes from hospitals just like SBH."

He hopes young doctors get involved with research early and labor through the difficulties of learning the new skill, reassuring that the work is truly enjoyable and does get easier with time and experience. Dr. Gaduputi analogizes that "the first million is the toughest for the millionaire; then, the money makes itself," and encourages that "the joy of seeing your name in publication is unparalleled; I think all residents should have this feeling."

The passion with which Dr. Gaduputi performs research and imparts scientific wisdom is quite palpable. He adds: "As physicians, our publications are the only legacy we leave behind. Even after we leave an institution, even when our bones are gone, our research can continue to inspire."

For further inquiry or to participate in research with Dr. Gaduputi, please email vgaduputi@sbhny.org

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